Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

# Issued by the Chief Inspector

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| Name of designated centre: | Carechoice Swords |
| Name of provider: | Carechoice Swords Two Ltd. |
| Address of centre: | Bridge Street, Swords, Co. Dublin |
| Type of inspection: | Unannounced |
| Date of inspection: | 09 July 2024 |
| Centre ID: | OSV-0007752 |
| Fieldwork ID: | MON-0039496 |

## About the designated centre

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

Carechoice Swords can accommodate up to 157 residents whose care dependency levels range from low to maximum dependency care.The nursing home has a total of 5 floors providing care for different categories of residents, including includes frail elderly care, dementia care, general palliative care as well as convalescent and respite care with varying dependencies. 24 hours nursing care may be provided to both male and female residents, generally aged 18 years and over. Accommodation is provided in 144 single and seven twin rooms, all with en-suite facilities. Residents have access to outdoor space in the main courtyard and terrace located on the ground floor as well as safe terraces located on the third and fourth floor. There are a number of communal facilities available which include an oratory, visitors' room, dining and lounge areas available on each floor, activities room, and quiet spaces. The centre's stated aims and objectives are to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their quality of life, health and wellbeing. The designated centre is located in a tranquil urban area within the Swords Village, close to local amenities. Underground car parking is available for visitors.

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

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| Number of residents on the date of inspection: | 128 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

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

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

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

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

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

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

| Date | Times of Inspection | Inspector | Role |
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| Tuesday 9 July 2024 | 08:35hrs to 16:35hrs | Lisa Walsh | Lead |
| Wednesday 10 July 2024 | 08:40hrs to 17:20hrs | Lisa Walsh | Lead |
| Tuesday 9 July 2024 | 08:35hrs to 16:35hrs | Aisling Coffey | Support |
| Wednesday 10 July 2024 | 08:40hrs to 17:20hrs | Aisling Coffey | Support |

## What residents told us and what inspectors observed

The overall feedback from residents was that they were content living in Carechoice Swords. The residents were highly complimentary of the staff and the care they received. The residents described the staff as "lovely", "attentive", and "top class". Even with the praise for staff members individually, some residents spoken with expressed their view that there needed to be more staff on duty and gave examples of waiting extended times for care and attention. The care provided to residents was observed to be person-centred. Staff were aware of residents' needs, and the inspectors observed warm, kind, dignified and respectful interactions with residents and their visitors throughout the two days of inspection by staff and management.

This unannounced inspection, conducted by two inspectors over two days, involved speaking with residents, staff, and visitors to gain insight into the residents' lived experience in the centre. The inspectors also observed the environment, interactions between residents and staff, and a range of documentation.

On the first inspection day, the deputy director of nursing guided inspectors on a tour of the premises. It was clear that they were very well known to the centre's residents and aware of residents' needs. They demonstrated a commitment to providing a good quality service for the residents.

The centre is set across six floors, accessible by stairs and lifts. The lower ground floor contained staff facilities and laundry. The fourth floor had a café and a rooftop balcony, which residents and visitors used to meet and socialise. Residents bedrooms were set out on the ground, first, second, and third floors. Each of these floors had a separate lounge and dining room. On the first, second and third floors, there was a quiet room and an activity room, while on the ground floor, there was a large oratory/quiet space that also hosted activities. A hairdresser visited the centre twice weekly and had an onsite hair salon on the ground floor. The third floor was a dementia-friendly unit. The floors within the centre are each named after a location in Swords; the ground floor is Aird Druim, the first floor is Jugbag Lane, the second floor is St Colmicelle's, the third floor is The Old Vicarage and the fourth floor is the Castle View Café.

Residents and visitors wishing to travel between the floors used the passenger lifts. The doors leading to the lifts on each floor were keypad-controlled. On both inspection days, inspectors observed that the code for the keypad was not displayed for those residents who wished to attend activities on another floor, use the internal garden or access the fourth-floor cafe independently. Additionally, inspectors observed one toilet on the second floor was locked with a keypad, meaning this facility was inaccessible to residents. Staff were also unaware of the code to open the toilet door.

Internally, the centre's design and layout supported residents in moving throughout each floor, with wide corridors and sufficient handrails to accommodate residents

with mobility aids. Communal areas were bright and spacious with comfortable seating, pleasant lighting, attractive furnishings and domestic features, such as flowers on the dining tables, which provided a homely environment for residents.

The bedroom accommodation consisted of 144 single rooms and seven twin rooms. Two of the centre's twin rooms were operating as single rooms. Each bedroom had en-suite facilities, including a shower, toilet, and wash-hand basin. Bedroom accommodation throughout the centre had a television, call bell, wardrobe, seating, and locked storage facilities. The second floor had a number of vacant bedrooms as refurbishment was being completed and new equipment were being installed. Residents had personalised their bedrooms with photographs, artwork, religious items, and ornaments. The size and layout of the bedroom accommodation were appropriate for residents needs. Residents informed the inspectors that they were satisfied with their bedroom accommodation.

Outdoors, the centre had a large, secure internal garden off the main reception area. This area had level paths residents could walk upon and comfortable seating. The garden was clean, tidy and pleasantly landscaped, with features including raised flower beds, potted plants, bushes and decorative ornaments. On the third floor there was access to a balcony area, this had limited seating and decoration. Inspectors were informed that this area, as well as other balcony areas throughout the centre, were being redecorated to be made more appealing to residents.

There was a relaxed atmosphere in the centre, and staff were seen responding to resident requests with dignity and respect. There were two activities coordinators on duty on both inspection days. On the first inspection day, six residents were seen flower arranging in the ground floor oratory/quiet space. Residents on the first floor in the lounge were getting their nails painted. After lunch, 18 residents played bingo in the ground floor oratory/quiet space. On the second inspection day, activities staff played the tin whistle in the ground floor lounge in the morning, followed by parachute games enjoyed by nine residents in the ground floor oratory/quiet space. Residents participated in a relaxation gym activity on the first floor in the morning and later on the second floor before lunch. Five residents on the third floor spent time in the sensory room reminiscing before lunch. The hairdresser was present during the inspection, and residents proudly displayed their new hairstyles. Some residents chose not to partake in communal group activities and relaxed in their bedrooms, aligned with their preferences to read or watch television.

Residents could receive visitors in the centre within communal areas, such as the lounges, fourth-floor cafe, or in the privacy of their bedrooms. Many families and friends were observed during the inspection days visiting. Inspectors spoke with several visitors. Overall, their feedback was similar to that of the residents. While visitors expressed their satisfaction with the kindness and attention shown by individual staff members, they expressed their view that there were insufficient staff on duty. They gave examples of inadequate supervision at times and occasions where their loved ones' care and routines were not met in a timely manner. Visitors informed inspectors that the centre's management were aware of their concerns,

and the provider had a forthcoming meeting scheduled to discuss the outcome of several initiatives being trialled to address the concerns.

Lunchtime at 12.30pm was observed to be a sociable and relaxed experience, with residents eating in the dining rooms or their bedrooms, aligned with their preferences. Meals were freshly prepared onsite in the centre's kitchen and served from a bain marie on each floor. The menu choices were displayed in the dining room, and residents were shown plates of food with the available menu options for the day to aid them to make their dinner choice. There was mixed feedback from residents and families concerning the food. Some residents expressed that the food was not always hot enough or served in a way that aligned with their preferences. Residents and families stated they had made the provider aware of their concerns and had a meeting with the provider to discuss this. They acknowledged that the provider had recently introduced the bain marie service to address the temperature of the food while catering staff informed inspectors that each resident's likes and dislikes were recorded in each food service area.

While the centre was pleasantly decorated, generally clean and in good repair, some areas were experiencing wear and tear and required maintenance to ensure residents could enjoy a pleasant living environment. Staff practices in managing storage and decontamination of equipment required review, as outlined under Regulation 27: Infection control.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted 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

While there were established management structures to support staff in this centre, inspectors found that some improvements were required in the management systems for the effective oversight of individual assessment and care planning, healthcare, managing behaviour that is challenging, residents rights, infection control and premises.

This was an unannounced inspection to assess the registered provider's ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and review the registered provider's compliance plan following the previous inspection on 23 August 2023.

Carechoice Two Limited, the registered provider, operates Carechoice Swords. The person in charge of Carechoice Swords reported to the Regional Director of

Operations, who in turn reported to the Chief Executive Officer. The person in charge was supported in their role by a deputy director of nursing, two assistant directors of nursing, four clinical nurse managers, a team of nurses, healthcare assistants, catering, housekeeping, laundry, maintenance, activity coordinators, administration staff and a physiotherapist.

Since the last inspection on 23 August 2023, there have been several changes in the governance and management of the centre, including four changes to the person in charge. The current person in charge, an experienced nurse manager, had been in the position for less than one week on the inspection day. There had also been a recent change made to the management structure, whereby the general services manager role had been replaced with a deputy director of nursing. This recent change had affected the lines of authority and accountability for catering, maintenance and housekeeping staff, whereby staff had reported that their current reporting relationships were unclear and that their lines of communication on matters occurring within the centre had been negatively impacted.

There was documentary evidence of communication between the person in charge and the chief executive officer. Two minutes of governance meetings in 2024 were available to inspectors, confirming the discussion of occupancy rates, finance, human resources, training requirements, premises and facilities, catering, quality metrics, complaints, risk management and health and safety. The provider had committed to establishing several committees to monitor the quality and safety of care delivered to residents, including a falls review committee and a nutrition committee. The minutes of these meetings were not available for inspectors to review. Therefore, it was unclear what level of oversight these committees had regarding these key quality and safety areas. Within the centre, at unit level, communication occurred at staff meetings and safety huddles where aspects of quality service delivery, including falls prevention and meal supervision were discussed. The records of these meetings were limited; some consisted of a sign-in sheet and the topic title. There was no time-bound actions identified, nor were persons responsible identified for implementing these actions.

The provider had an audit schedule covering areas such as medication management, infection control, falls management, restrictive practices, responsive behaviours, wound care, call bells, dining experience and complaints. The provider also had systems to oversee accidents and incidents within the centre. It was evident that incidents, such as falls or weight loss, had been thoroughly analysed on an individual resident basis. There were clear records detailing the circumstances surrounding the concern, the full suite of supports provided to the resident, and assurances that the resident's care plans had been updated to reflect any emerging needs or risks to improve the resident's comfort and safety. Notwithstanding this good oversight on an individual resident basis, when incidents such as falls were reviewed collectively gaps in oversight were identified. For example, data from a recent annual review of falls found that almost one-third of falls occurred at night when residents were alone in their bedrooms. An action from this analysis was to ensure staff responded to call bells promptly. However, reviewed records showed that a call bell audit had last been completed in December 2023, while an audit of call bell response times at night was last completed in July 2023. The inspection

found that some areas of auditing and oversight needed to be more robust to effectively identify deficits and risks in the service to drive quality improvement.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2023. The inspectors saw evidence of the consultation with residents and families reflected in the review.

The centre's staffing rosters for a four-week period were reviewed. Based on these rosters and what inspectors saw over the two days of inspection, there was an appropriate number and skill mix of staff, to support the residents' assessed needs. There were seven nurses on duty during the day and six at night.

## Regulation 14: Persons in charge

The person in charge was new to the centre and worked full-time. They had the relevant experience and qualifications to undertake this role. They were knowledgeable of their remit and responsibilities.

Judgment: Compliant

## Regulation 15: Staffing

While the feedback from some residents and visitors was that there needed to be more staff on duty due to waiting extended times for care and attention, inspectors found that the centre had sufficient staff. Based on a review of the worked and planned rosters, sufficient staff of an appropriate skill mix were on duty each day to meet the assessed needs of the residents. At night, there were six registered nurses in the centre.

Judgment: Compliant

## Regulation 21: Records

A sample of staff files reviewed by 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. Evidence of active registration with the Nursing and Midwifery Board of Ireland was also seen in the nursing staff records viewed.

Judgment: Compliant

## Regulation 23: Governance and management

While there was an established organisational structure in place, it was found that the lines of authority and accountability for catering, maintenance and housekeeping staff were unclear due to the recent change in the management structure. The general services manager role had been replaced with a deputy director of nursing. Following this change, some staff reported that their lines of communication on matters occurring within the centre had been negatively impacted.

While the registered provider had several assurance systems in place to monitor the quality and safety of the service provided, action was required in the following areas:

- The auditing system was not fully effective in identifying risks and driving quality improvement. For example:
    - The infection control audits did not identify gaps in the decontamination of resident equipment or storage practices, posing a risk of cross-contamination.
    - The restrictive practice audits did not identify a locked toilet, which was inaccessible to residents.
    - Call bell audits had yet to be completed in 2024 despite call bell response times being identified as an area requiring managerial oversight to reduce the risk of falls.
- The oversight systems for monitoring care planning did not ensure that each resident had an up-to-date care plan to meet their identified needs, as discussed under Regulation 5: Assessment and care plan and Regulation 7: Managing behaviour that is challenging. Action was also required to the oversight systems in place ensured that all residents had access to appropriate healthcare as outlined within their care plan.
- A review of the schedule of activities was required to ensure that all residents across the centre had opportunities to participate.

Judgment: Substantially compliant

## Quality and safety

While the inspectors observed kind and compassionate staff treating the residents with dignity and respect, as described above, the management systems in place to ensure the service was safe and appropriate impacted on the quality of care being delivered to residents. The impact of this is described under the relevant regulations

below, including assessment and care planning, healthcare, managing behaviour that is challenging, residents rights, infection control and premises.

The person in charge had arrangements for assessing residents before admission into the centre. Comprehensive person-centred care plans were based on validated risk assessment tools. These care plans were reviewed at regular intervals, not exceeding four months. Inspectors found that residents were supported in communicating freely and had specialist communication requirements recorded in their care plan. Notwithstanding these areas of good practice in care planning, some gaps were observed concerning assessments and care plans, which will be outlined under Regulation 5: Individual assessment and care plan.

The health of residents was promoted through ongoing medical review and access to a range of external community and outpatient-based healthcare providers such as chiropodists, dietitians, physiotherapy, occupational therapy, speech and language therapy and palliative care services. Notwithstanding this good practice, inspectors found some gaps in residents access to healthcare as required which was outlined in their care plan.

Inspectors viewed documentation related to the use of restricted practices in the centre. An up to date policy was in place and guided staff on best practice. Residents who displayed responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had care plans in place. However, these were not always reflective of the residents current needs. In addition inspectors observed the use of some restrictive practices which were not in accordance with the nation policy.

In general, residents' choices and preferences were seen to be respected and inspectors saw that staff engaged with residents in a respectful and dignified way. Residents had access to local and national newspapers, radios, television, and internet services. Inspectors observed posters on display in the centre for independent advocacy services and residents were support to access these services if required. Residents were able to exercise their religious rights with Roman Catholic Mass services broadcast on television. A resident also facilitated rosary recitation in the centre for other residents to attend. The provider also had arrangements in place to support residents of other denominations practising their faith and maintaining contact with their religious leaders.

There were two activity schedules in place with two activity coordinators scheduled each day of the inspection. One activity schedule was specifically for the third floor dementia unit, and the second activity schedule was for the remainder of the centre. Inspectors were informed that one activity coordinator was always based on the third floor to facilitate dementia-friendly activities and the second activity coordinator moved between the other floors to facilitate the other activities. While there were plenty of activities observed on the ground, first and second floors throughout the inspection, there were insufficient meaningful activities for residents on the third floor. Inspectors observed that there were lengthy periods of time

where many residents were observed sitting in the communal area watching television without other meaningful activation.

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.

While the centre's interior was generally clean on the inspection day, cleaning resident equipment and storage practices required review to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

## Regulation 10: Communication difficulties

Inspectors found that residents with communication difficulties had their communication needs assessed and documented. Staff were knowledgeable about the communication devices used by residents and ensured residents had access to these aids to enable effective communication and inclusion.

Judgment: Compliant

## Regulation 11: Visits

Inspectors observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had suitable private visiting areas for residents to receive a visitor if required.

Judgment: Compliant

## Regulation 13: End of life

Residents approaching the end of life had appropriate care and comfort based on their needs, which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. Residents' religious preferences were seen to be respected. Records confirmed residents' families were informed of their condition in accordance with the resident's wishes and were permitted to be with the resident when they were at the end of their lives. The resident's preferred location for care and comfort at the end of life was facilitated.

Judgment: Compliant

## Regulation 17: Premises

While the premises were 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:

- Decor in some areas, such as corridors and bedrooms, showed signs of wear and tear, with visible damage to walls, doors, and doorframes.
- Ventilation required review. The third floor was found to be very warm on the day of inspection. This was a repeat finding from the August 2023 inspection.

Judgment: Substantially compliant

## Regulation 27: Infection control

The decontamination of resident care equipment required review, for example:

- A sample of crash mats and bed wedges were observed to be damaged and visibly dirty with footprints and other debris. Furthermore, tears on the crash mats would prevent effective cleaning.

Storage practices posing a risk of cross-contamination required review, for example:

- Clean and dirty clinical equipment were stored alongside each other in the centre's store room.
- Staff were unclear if the equipment in these store rooms was clean or dirty, as there was no identifiable mechanism to determine this and ensure residents received clean equipment.
- Some items were being stored inappropriately, for example a bed mattress was found on the floor of an assisted bathroom.
- Store rooms throughout the centre had objects and boxes stored directly on the floor, which would impact the ability to effective clean the area.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Individual assessments and care plans were in place for all residents. However, care plans were not always revised following assessment of changes in the residents' condition. For example:

- Some residents risk of falls assessments had been completed, however, the relevant care plans had not been updated to reflect the residents' current risk.
- A residents mobility had been reassessed and they required the use of a wheelchair to travel long distances. However, this was not recorded in their care plan.
- Some residents end of life care plans were not updated following assessment and did not contain fully completed up-to-date information.
- A resident predisposed to episodes of responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had a care plan in place. The resident did not have a recorded incident of responsive behaviour in over a year and their care plan had not been updated to reflect the residents current needs.

Judgment: Substantially compliant

## Regulation 6: Health care

Notwithstanding the access residents had to a range of healthcare professionals, action was required to ensure that all residents had access to appropriate healthcare as outlined within their care plan prepared under Regulation 5. For example:

- Inspectors found one example where no records of neurological observation assessment were monitored and documented in line with the centre's policies for a resident who had an unwitnessed fall. Such assessments allow for early identification of clinical deterioration and timely intervention.
- Inspectors reviewed the nutritional care plan for a resident who was assessed to be at high risk of malnutrition. This care plan had input from a dietitian however, it also referred to following speech and language therapy guidance on the consistency of food and fluids prescribed to this resident. Inspectors found evidence that the resident had been referred to a speech and language therapist, however, there were no records available of this speech and language assessment or their recommended guidelines on the modifications to the residents diet.
- Inspectors reviewed the mobility care plan and communication care plan for a resident who required hearing aids to communicate effectively. Both care plans referred to the resident requiring hearing aids and the fact that these hearing aids were broken. There were no records of this resident being referred to audiology services to facilitate the repair of the hearing aids.

Judgment: Substantially compliant

## Regulation 7: Managing behaviour that is challenging

Some restrictive practices used in the designated centre were not used in accordance with the national policy and had no valid rationale for such restrictions on some floors. For example:

- The doors leading to the passenger lifts on each floor were keypad-controlled. The code for the keypad was not on display for residents who wished to attend activities on another floor, use the internal garden, or access the fourth-floor cafe independently.
- A toilet on the second floor was locked, meaning it was inaccessible to residents. Management and staff did know why the door had been locked and did not have the code to open the door.
- A resident predisposed to episodes of responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had a care plan in place. The care plan did not contain information for the use of a PRN medication (medicines only taken when the need arises). However, following an incident the resident was given a PRN to in response to their behaviours. Furthermore, there was no evidence that a least restrictive alternative was tried before given the PRN.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

The provision of activities observed for residents on the third floor, on the days of inspection, did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capacities. While plenty of activities were taking place on the ground, first and second floor, the residents on the third floor in the dementia unit sat in the sitting room with television as the main source of stimulation.

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** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication difficulties | Compliant |
| Regulation 11: Visits | Compliant |
| Regulation 13: End of life | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 7: Managing behaviour that is challenging | Substantially compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Carechoice Swords OSV-0007752

## Inspection ID: MON-0039496

## Date of inspection: 10/07/2024

**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:

• CareChoice Swords follows a regular audit schedule for Infection Control, the audit tools will be used effectively to identify gaps in any decontamination of Residents equipment and gaps in storage as flagged in the report. Increased oversight by ADON/Deputy/Director is now in place, which includes random sampling of completed audits. Training for all Clinical Nurse Managers in auditing process was completed in July, 2024 with further Toolbox talks scheduled for the month of August and September 2024.
• A review of all public access bathrooms was completed. The lock on the 2nd floor bathroom was removed immediately following the inspection. Full review of the bathrooms across all units conducted and no other bathrooms were found to be locked in this manner.
• A call bell audit has been completed in July 2024. This will now be completed on monthly basis with oversight by the Deputy Director of Nursing.
• Actions relating to care planning and managing behaviours that are challenging are addressed under Regulation 5: Individual assessment and care plan and Regulation 7: Managing behaviour that is challenging.
• An updated Organisational Chart has been developed to provide clear lines of accountability and communication for non-clinical staff. Staff meeting has already taken place since the Inspection with follow up meetings planned for August 2024.
• The Activities calendar has been reviewed and now includes a broader range of activities that includes Arts and Crafts, re-modelling a shared space as a Sports and Social Café, introduction of cinema hall and increased community engagements.
• Members of the Activities team have attended external training in August 2024 which focused on Creative Arts and using Arts & Crafts in Dementia and non-Dementia settings. Several further training sessions are booked for 2024 for the team.
• An extended program covering all floors has been developed and is currently being trialed. The new calendar provides Activities across the home, using all spaces including

the Castle Café on the 4th floor. It aims to include Residents who live on the 3rd floor in Activities across the home so as to foster a more inclusive program.
• Working with the CareChoice Dementia Liaison we are continuing to evaluate specific Activities for Residents who live on the 3rd floor. This includes using tools such as Tovertafel, Reminiscence Therapies, Aromatherapy and Music to provide appropriate stimulation throughout the day.

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

• A maintenance program is currently in place across the service. Currently work is being untaken on the 2nd floor as part of this schedule which is updating décor, painting of resident rooms, communal areas and adding new furniture. This program will continue for 2024 on this floor and will move to 1st Floor in 2025.
• A series of inspections are being carried out by the newly in post Director of Nursing and specific maintenance/touchup repairs are being listed and scheduled to be completed by the onsite Maintenance person. While this work will continue on an ongoing basis throughout the year, the initial batch of repairs will be completed by end of September 2024.
• Improved ventilation will be a part of the upgrade works for the outdoor area on the 3rd Floor. Timelines for this work will depend on the input from external contractors. As an interim measure multiple fans have been purchased and are being placed by staff around the unit to provide better airflow. Doors and windows are being opened daily to increase natural ventilation.
• A feasibility report is due to be completed by mid-September regarding the installation of aircon units into communal areas on the 2nd and 3rd floor.

| Regulation 27: Infection control | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:

• The damaged/dirty crash mats and bed wedges noted on the day of inspection were cleaned immediately. Some items were deemed to be in need of replacement and this has taken place. An updated schedule of spot checks by the Housekeeping supervisor has been put in place with particular reference to beds, mattresses and crash mats.

• Regular auditing as part of the Environmental Audit schedule takes place with action items assigned as they arise. This has identified a number of pieces of equipment that have already been replaced so as to allow better adherence to Infection control best practice.
• Clean and dirty clinical equipment stored alongside each other, which was noted on the day of inspection have been segregated and removed. This will be monitored by CMT through daily floor walks.
• An improved equipment labelling system is now in place to clearly identify equipment that needs to be cleaned. This forms part of the duties of night staff each day and will be monitored by nurse managers.
• Excess equipment has been removed from all storerooms across the service to allow for better segregation and identification of clean versus dirty equipment. A dedicated area is now marked in store rooms for equipment that requires cleaning so as to provide segregation within store rooms.

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| 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:

• Full review of residents mobility care plans completed and have been updated to include information on resident current risk, use of mobility aids for both long/short distances in line with physio recommendations. careplans are updated when there is a change in residents baseline.
• A review of residents end of life care plans underway to include all up-to-date information.
• The resident who required an updated responsive behaviour care plan has had their care plan to reflect the residents current needs. A full review of Responsive Behaviour Care Plans for all other residents are under way and due to be completed in August 2024.
• Toolbox Talks on Care Planning is scheduled for nurses in August and September, 2024.
• CareChoice Swords maintains a regular audit schedule for all Resident records including Care Plans. This now includes random sampling of records by Deputy Director of Nursing and Director of Nursing to help ensure compliance with standards.

| Regulation 6: Health care | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 6: Health care:

• A series of Toolbox Talks has been planned to be delivered by Clinical Nurse Managers with all nursing staff. For August the focus is on Best Practice around Falls and post-Fall assessment, which includes monitoring and accurate recording of neurological observations.
• The gap identified in the Residents Nutritional Care Plan has been addressed and all Nutrition Care Plans have been reviewed to ensure that MDT recommendations are documented.
• All nursing staff have been educated as to the need to include timely information regarding referrals to MDT which would include Audiology and to clearly document any outcomes in the relevant part of a Residents record. This forms part of ongoing audit and oversight by the Clinical Nurse Managers and Assistant Directors of Nursing.
• An MDT referral system is in place and is recorded on the electronic system which is closely monitored by Clinical Management team to ensure all referrals and their recommendations are recorded promptly.

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

• An audit of all resident accessible keypad locks was completed on the 2nd day of the inspection. Keypad codes are now displayed across all keypad access doorways to allow residents and their families to have unrestricted entry and exit from each floor and to the internal garden.
• The lock on the second floor bathroom was removed post inspection. No other bathrooms were found to be locked in this way.
• A medical review of the resident in questions was conducted, we have also engaged with the wider MDT and support services from within the HSE to provide support for this resident. The resident has had their care plan updated to include information about the behavioral trends, patterns, known triggers and that non-pharmacological measures to be trialed first to ensure that the least restrictive option is used before administering PRN medications.
• Nurses have been educated on the use of PRN medications when dealing with an episode of Responsive Behaviour. PRN psychotropic checklist will be completed prior to administering PRN medications. The National Guidelines are followed when devising Responsive Behaviour Plans for all Residents.

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| Regulation 9: Residents' rights | Substantially Compliant |

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

• The activity schedule has been reviewed and now includes a broader range of activities that caters to the interest and capacities of residents on the third floor.
• Members of the Activities team have attended external training in August which focused on Creative Arts and using Arts & Crafts in Dementia and non-Dementia settings.
• An extended program covering all floors has been developed and is currently being trialed. The new calendar provides Activities across the home, using all spaces including the Castle Café on the 4th floor. It aims to include Residents who live on the 3rd floor in Activities across the home so as to foster a more inclusive program.
• Working with the CareChoice Dementia Liaison we are continuing to evaluate specific Activities for Residents who live on the 3rd floor. This includes using tools such as Tovertafel, Reminiscence Therapies, Aromatherapy and Music to provide appropriate stimulation throughout the day.

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
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| Regulation 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 | 03/02/2025 |
| Regulation 23(b) | The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | Substantially Compliant | Yellow | 05/08/2024 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service | Substantially Compliant | Yellow | 12/07/2024 |

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| | provided is safe, appropriate, consistent and effectively monitored. | | | |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. | Substantially Compliant | Yellow | 12/07/2024 |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Substantially Compliant | Yellow | 30/09/2024 |
| Regulation 6(1) | The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based | Substantially Compliant | Yellow | 30/09/2024 |

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| | nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | | | |
| Regulation 6(2)(b) | The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment. | Substantially Compliant | Yellow | 12/07/2024 |
| Regulation 7(2) | Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive. | Substantially Compliant | Yellow | 30/09/2024 |
| 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 | Substantially Compliant | Yellow | 31/08/2024 |

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| | Health from time to time. | | | |
| 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 | 15/10/2024 |