



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

Issued by the Chief Inspector

Name of designated centre:	CareChoice Ballynoe
Name of provider:	Carechoice Ballynoe Limited
Address of centre:	Whites Cross, Cork
Type of inspection:	Unannounced
Date of inspection:	11 February 2021
Centre ID:	OSV-0000210
Fieldwork ID:	MON-0031985

About the designated centre

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

Carechoice Ballynoe (known as Ballynoe) is a designated centre which is part of the Carechoice group. It is located in a rural setting of Whites Cross and is a short distance from the suburban areas of Ballyvolane and Blackpool, Cork city. It is registered to accommodate 51 residents. Ballynoe is a two-storey facility with lift and stairs to enable access to the upstairs accommodation. It is set out in three corridors on the ground floor called after local place names of Glen, Shandon and Lee, and Honan on the first floor. Bedroom accommodation comprises five single rooms with wash-hand basins, six twin rooms and 34 single rooms with en suite facilities of toilet and wash-hand basin; 15 residents are accommodated upstairs. Additional shower, bath and toilet facilities are available throughout the centre. Communal areas comprise a comfortable sitting room, Morrissey Bistro dining room, large day room and a large quiet room with comfortable seating. The hairdressing salon is located near the main day room. There is a substantial internal courtyard with lovely seating and may residents have patio-door access to this from their bedrooms; there is a second smaller secure courtyard accessible from the quiet room. At the entrance to the centre there is a mature garden that can be viewed and enjoyed from the sitting room and some bedrooms. Carechoice Ballynoe provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	28
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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
Thursday 11 February 2021	10:00hrs to 17:30hrs	Mary O'Mahony	Lead

What residents told us and what inspectors observed

This inspection of CareChoice Ballynoe on February 11th 2021 was unannounced and was conducted in light of an extensive outbreak of COVID-19 in the designated centre. Additionally, prior to the inspection four unsolicited concerns had been received between 1st February and 8th February, in relation to the high rate of infection with COVID-19 among residents and staff, the lack of availability of adequate staff numbers to care for the residents, the lack of adequate and available personal protective equipment (PPE) and reported ineffective interaction and communication practices between the provider of Ballynoe Nursing home and family members.

On the 11th February, the day of inspection, the upper floor of the centre was closed and the 28 remaining residents were living on the ground floor. A number of residents were still very ill with COVID-19 and as a consequence all residents remained in isolation. On the 11th February the inspector observed that staffing levels were sufficient to meet the needs of the residents in the centre and staff also reported receiving good support and direction from the general practitioners (GPs) who attended the centre. All staff were seen to wear full PPE and the inspector observed plentiful stocks of PPE available for staff.

On 11th February, the majority of nursing and health care staff, who usually worked in the centre, were still isolating at home. The inspector found that all five of the nurses on duty and the ten health care assistants on duty were agency staff or had been co-opted in from other CareChoice centres to ensure staffing of the centre at a time when the centre's own staff were unable to work. The person in charge described the communication difficulties associated with having new, co-opted staff and agency staff on duty, explaining that as the staff did not personally know the residents and their families, effective communication was sometimes not optimal.

The inspector observed several measures the provider had in place to support the care of residents during this COVID-19 outbreak. Each staff member was provided with a daily handover report document, this document detailed each residents' dietary, mobility, continence care needs and their current COVID-19 status. A copy of the documents used to provide relevant information to staff were provided to the inspector.

Information notices on managing the outbreak were circulated to each staff member on duty. A senior nurse manager was observed supervising staff and leading the staff 'huddle' in the afternoon. Staff told the inspector that 'huddles' were held at intervals to ensure that staff understood residents' medical, nutritional, emotional and communication needs. Staff told the inspector that they felt supported by the daily 'huddles' and the clear information provided at handover reports.

During the inspection, one resident was seen using her phone independently and a number of other personal phones were seen in residents' rooms. A receptionist was

on duty and the phone was noted to be answered promptly.

Relatives were encouraged to send in small comfort items to residents. During the inspection visitors were seen to come to the door of the centre to drop in 'get well' cards for a number of residents. There was documentary evidence also that the general practitioners (GPs) were in the centre a couple of times weekly. They were seen to have been in regular communication with the relatives of those who were ill.

In the afternoon, the inspector walked around the centre with the person in charge to observe staff practices, to evaluate the infection control processes in place and to observe the care being provided to residents. During the walk around the inspector identified the following issues which if unaddressed, increased the potential for the spread of COVID 19 in the centre:

- staff were seen congregating in the narrow hallways without appropriate adherence to social distancing
- staff congregating in groups were seen in the staff changing room
- a room, which was used for staff changing and staff breaks was cluttered with staff outdoor wear, coats and personal items and items were not stored appropriately
- a double door from a communal room leading into one isolation corridor was left open: this resulted in staff, wearing full PPE, entering this room to retrieve boxes of gloves and other items, on a number of occasions. Even when the door was closed at the request of the inspector, staff continued to push it open and enter the room in full PPE clothing, including gloves
- a staff member was observed wearing a mask inappropriately while in the staff room
- store rooms were cluttered with excess furniture and wheelchairs.
- the 'hairstyling room' which was currently in use for the storage of PPE was cluttered and untidy with additional items, such as a cleaners' trolley, pushed in there. It was very difficult for staff to evaluate the available stock of PPE when ordering additional stocks. In addition, the storage of PPE items with cleaning items meant that the PPE could potentially be cross contaminated.

The inspector saw that there were spacious communal and dining spaces available for residents. Due to the COVID-19 outbreak and in accordance with advice from the Health Services Executive (HSE) Outbreak Control Team (OCT) residents were cared for at this time in their bedrooms.

The inspector found that the centre was generally well maintained, nicely painted and suitably furnished. A number of items of furniture were due to be replaced and according to the person in charge this was to be addressed when the outbreak had resolved. There were easily accessible courtyard areas available to residents. The inspector saw that residents had free access to these areas from a number of the bedrooms. Residents were described as missing their visitors, the hairdresser, the social occasion of attending the communal room and the garden walks.

Staff assured the inspector that as soon as the outbreak was resolved, and declared over by the public health team, residents would be facilitated to return to using the

available communal spaces and gardens and to having their hair done weekly.

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

Capacity and capability

CareChoice Ballynoe is a member of the CareChoice group of nursing homes and is managed by CareChoice Ballynoe Ltd. It was registered to provide care for 51 residents with varied needs, aged over 18 years. The governance structure of the centre includes the chief executive officer (CEO), the board of directors, the regional director of operations, the director of quality and innovation, the person in charge and the wider care team.

Although this centre had remained COVID-19 free during the first waves of infection throughout 2020, between 7 January and 31 January 2021, 45 residents in the centre contracted COVID-19. Sadly, 19 residents passed away in the centre in the weeks leading up to the inspection of 11 February 2021. Despite the fact that an inspector of social services was in regular contact with the centre throughout the outbreak CareChoice Ballynoe Ltd. failed to notify the Chief Inspector of the deaths of many of these residents in line with their regulatory obligations (nine notifications were not reported verbally or by notification submitted within the required time line).

On this unannounced inspection the inspector found that the management team in the centre had undergone significant change in the months leading up to the outbreak. Two senior clinical nurse managers (CNMs) had left to take up other employment before Christmas and the assistant director of nursing (ADON) had stepped down from the post. During the outbreak two senior managers from within the CareChoice group supported the day to day operation of the centre providing enhanced clinical and supervisory support. The person in charge said whilst these additional managers provided supervision and management cover in the centre on a 24 hour basis during the outbreak, she acknowledged that the challenges were increased by the aforementioned management and staffing changes. Additionally, there was a clinical nurse manager (CNM) from another CareChoice centre on duty and a care team which included, nurses, care staff, administration, housekeeping, maintenance, kitchen and laundry staff, to meet the needs of 28 residents. As described earlier in the report the nursing team, the health care staff and the kitchen staff on the day of inspection were either staff co-opted in from other CareChoice centres or agency staff. This was due to staff from the centre being unavailable due to COVID-19.

In managing this COVID-19 outbreak the person in charge explained that a crisis management team established by the CareChoice group met twice a week to discuss

the management of the outbreak, to liaise with the OCT (Outbreak Control Team) and to discuss resources such as staffing and PPE. Management meetings were held twice daily within the centre and were attended by the senior management group on site. During the inspection the inspector viewed infection control information circulated to, and discussed with, each staff member updating them of the PPE protocol and outbreak controls. Despite these reported governance arrangements, on the 11th February inspection the inspector brought the following to the attention of the PIC;

- the infection control policy provided did not specifically advise staff on how to manage an outbreak of COVID-19
- the COVID-19 risk assessment conducted by the provider was not sufficiently detailed to indicate that all aspects of the hazard had been identified and appropriate controls put in place by way of example the registered provider did not ensure that all mandatory notifications to include unexpected deaths were notified to the Chief Inspector within the mandated time frame

During the 11th February inspection, staffing levels and skill-mix were sufficient to meet the needs of residents. The staffing rosters confirmed appropriate staffing levels for the days before and after the inspection as well. However, the high levels staff who were not familiar with the residents and their families meant that there were additional challenges in this centre when the outbreak occurred. The person in charge said that the CareChoice group were liaising with staff through the human resource department in relation to their return to work when they had recovered from the virus.

On a positive note, the provider had recognised and taken steps to manage the impact and the risk associated with a sudden reliance on agency staff or transferred staff who were not familiar with residents baseline health care status, as well as their needs and preferences at a time when such information was critical to their care. The previously described handover report documents, information notices and daily staff huddles were implemented to support staff to care for residents and to reduce the impact of any baseline knowledge deficits.

On the day of inspection, five cleaning staff were on duty and a household supervisor from the CareChoice group was also in the centre to provide supervision for the decontamination procedures. All laundry was done in-house including linen and residents' clothes. Laundry personnel spoken with were familiar with the correct temperatures for washing infected linen and also the protocol for handling such items. At the time of the inspection staff were allocated to work in cohorted teams to minimise cross infection risks. Separate staff dining facilities were located within each of the two sides of the downstairs section.

Despite the arrangements in place the registered provider and the CareChoice crisis management team failed to adequately recognise and address the adverse impact that the absence of regular staff, who knew the residents, would have on maintaining effective communication with families. By way of example, the registered provider did not have sustainable or effective operational arrangements in place to ensure effective communication at a time when the person in charge in the

centre was newly appointed and only beginning to build relationships with residents and families and significant numbers of regular staff were unavailable necessitating a reliance on a large number of new and unfamiliar staff to provide care and support to the residents.

On the day of inspection, the person-in-charge acknowledged that:

- communication was ineffective at the beginning of the outbreak
- staff were not always available to answer the phone when the receptionist was not present
- compassionate visiting had not always been facilitated at the beginning of the outbreak

The person-in-charge told the inspector that communication had improved and that she now maintained daily communication with relatives by phone or email. This view was supported by documentation viewed by the inspector including, a sample of emails to relatives from the week prior to the inspection, records which confirmed that a family member had been contacted on three occasions in one day about their resident's changing medical condition, records of the GPs interactions with relatives and, entries in residents' care plans and in the visitors' book which indicated that compassionate visits were taking place. On the day prior to the inspection one such visit for a resident who was in receipt of end of life care had been facilitated and a second visit was arranged for the evening of the inspection.

As part of this inspection, the inspector reviewed the annual schedule of audits that had been undertaken to assess the quality and safety of care. This included for example audits of medication management practices, care planning, infection prevention and control practices and residents' dining experience. In addition, there was evidence that residents' survey results and residents' concerns were discussed and had been overseen by the former person in charge. However, the audit system failed to identify specific issues which resulted in the issuing of an urgent action plan to the provider. The issues requiring urgent and immediate corrective action included medicine management, the safe storage of oxygen, respectful management of residents' personal possessions and adherence to best practices in COVID-19 infection prevention and control.

In addition, a sample of staff files were reviewed. The sample reviewed contained the required regulatory documents including vetting (GV) for the most recent employees. Documents on file indicated that there was a comprehensive staff induction programme and a staff appraisal system in place.

There is no doubt but that the outbreak of COVID-19 significantly challenged the provider to maintain effective governance and management arrangements in this centre. Whilst the provider had implemented measures to support the care of residents and to fill vacant positions, the provider underestimated the contingency planning required to include effective communication arrangements with the residents' loved ones, appropriate staff training and supervision, safe medication management and effective COVID-19 infection prevention and control practices.

Regulation 14: Persons in charge

The person in charge had the required regulatory qualifications and experience set out for a person in charge of a designated centre. She had been in the position of person in charge of Ballynoe since December 2020.

Judgment: Compliant

Regulation 15: Staffing

Notwithstanding on the day of inspection that the centre was predominantly staffed by agency nurses and staff generally unfamiliar with the centre - the number and skill mix of staff was appropriate to the size and layout of the centre and the assessed needs of residents, in accordance with Regulation 15.

There was an adequate number of managers, nurses, health care assistants, housekeeping staff and administration staff available on the roster for both day and night duty.

Judgment: Compliant

Regulation 16: Training and staff development

As detailed within the report a number of non compliances in infection prevention and control and medicine management were observed which indicated a need for further training and evaluation of the understanding of training.

Additionally, training in the management of medicines required particular attention as the relevant policies and professional guidelines were not followed, in a sample of records seen.

Supervision of staff was not adequate in relation to the use of the changing room, social distance, medicine management and not removing PPE when appropriate.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that the arrangements in place to ensure that the service was safe, consistent and effectively monitored were not to the required standard as evidenced by the failures detailed throughout this report including:

- Infection prevention and control
 - CareChoice Management were required to ensure that staff would be appropriately supervised in the management of residents in isolation and made aware of their responsibilities in adhering to the national guidelines on infection prevention and control throughout this public health emergency; an immediate action plan was issued on infection control compliance
- The safe storage of, and signage for when oxygen was in use; an immediate action plan was issued.
- The failure to ensure that that deceased residents' personal possessions were appropriately and respectfully stored while awaiting collection by relatives; an immediate action plan was issued.
- Medication management
 - CareChoice management were required to provide assurance to the Chief Inspector that staff understood the medicine management training, were retrained where applicable and were supervised in applying the training in their daily practice; an urgent action plan was issued.

Judgment: Not compliant

Regulation 31: Notification of incidents

On a number of occasions the person-in-charge did not notify the Chief Inspector of the unexpected death of a resident within the three-day time frame set out in the regulations.

Nine such notifications were submitted outside of this time frame.

Judgment: Not compliant

Regulation 4: Written policies and procedures

There were written policies and procedures available in the centre as required under Schedule 5 of the regulations. The registered provider ensured that these were made available to staff.

However, the inspector found that the infection prevention and control policy to include information on COVID-19 was not easily accessible or made available to the

inspector on the day of inspection. This policy, with COVID-19 guidelines included, was submitted following the inspection and the person in charge stated it had been made available and explained to all staff.

In addition, the medicine policy was not implemented in line with the guidelines set out in the policy.

Judgment: Substantially compliant

Quality and safety

The severity of the COVID-19 outbreak in the centre was devastating for residents, their loved ones and the staff working in Ballynoe. Throughout the inspection the inspector observed that the care and support given to residents was kind and respectful.

In line with public health advice, there were restrictions on residents circulating around the centre. Staff spoken with said that these restrictions were explained to residents. At the time of this inspection staff reported that a number of residents with COVID-19 were beginning to feel better even though they were yet to leave their rooms. One resident was observed sitting in his room while staff attended to his request, while another resident, was speaking on a personal phone. Two staff members were observed attending to the needs of a sick resident and another group were supplying fresh juices into residents' rooms. One resident, who was receiving subcutaneous (s.c.) fluids (fluids given under the skin), was seen to be sleeping peacefully and looked well cared for with clean nightwear and fresh bed linen.

In relation to care planning the inspector found that residents' preferences and assessment of their care needs formed the basis for their individualised plans of care. Residents' assessments were undertaken using a variety of evidenced based-assessment tools such as an assessment of residents' risk of malnutrition and residents' skin integrity. On the day of inspection, a sample of care plans reviewed were found to be person-centered. They had been updated every four-months as required under the regulations. They were sufficiently detailed to guide staff in the delivery of care. Advanced care plans were in place for all residents and the inspector found that discussions had been held with residents and relatives in relation to residents' care wishes, in the event of contracting COVID-19. However due to the changed needs of residents, for example those requiring oxygen therapy and s.c. fluids, additional care planning was required to supplement the daily narrative notes written by staff.

There was evidence of good access to medical staff and regular reviews took place. In the sample of care plans viewed the GPs (general practitioners) had documented frequent visits and individual reviews during the outbreak. It was evident from the documentation seen that the GPs were attentive to residents' care needs and they

had also recorded their conversation with staff. The GPs had access to a consultant geriatrician who provided advice to them on treatment options for residents with COVID-19. For out-of-hours medical needs the on-call GP service had been consulted and the inspector found that the advice provided was documented and adhered to by the staff. There was evidence of staff actively monitoring residents for signs of COVID-19 symptoms. Residents' care was reviewed and seen to be documented in individual care plans. Residents' temperature and oxygen saturation levels (SATs) were measured and recorded four hourly.

Access to a range of health care professionals was evident. Regular reviews by the physiotherapist, occupational therapist (OT), podiatry, tissue viability nurse (TVN), dietitian and the speech and language therapist (SALT) were documented, prior to the outbreak. The inspector found that three residents in the centre had detailed dietary consultations on the days immediately preceding the inspection. The CNM on duty stated that during the COVID-19 outbreak referrals were being carried out over the phone or by video link.

However, a number of serious concerns were found in relation to medicine management which resulted in an urgent action plan being issued in this key aspect of the quality and safety of care. The failings in medicine management indicated that the medicine recording system, supervision of practice and staff training methods were not sufficiently robust, thereby creating a risk to the health and safety of residents. Staff nurses spoken with agreed that the system had been difficult to navigate as it was new. The difficulties were compounded by the fact that new staff required training to operate it, as reported to the inspector on the day of inspection. The CNM stated that staff were not yet familiar with the system as evidenced in the failure to identify a recording error, prior to the inspector's findings.

There were five cleaning staff on duty during the inspection and the cleaning staff spoken with were aware of the products which were specified for use. Staff stated that training in PPE use had been provided and demonstrated knowledge of this. The housekeeping supervisor from the CareChoice group spoke with the inspector about the cleaning products, the training and the cleaning protocol in use for a room where a resident with COVID-19 had died. However, due to the extent of the clutter in the store rooms and in the staff room effective cleaning of these rooms was not possible until the rooms were cleared of excess items. The person in charge undertook to arrange for the rooms to be de-cluttered and cleaned appropriately.

At the time of the inspection one bedroom was undergoing a deep cleaning process and staff were found to be knowledgeable in the steps to be taken for this. Laundry staff spoken with said that precautions were in place for infected laundry, including the use of alginate bags which were found to be in stock. The laundry staff member spoke with the inspector about her training and was knowledgeable as to the correct temperature for washing infected laundry. The inspector saw that there were individual yellow clinical waste bins outside some bedrooms. The person in charge said that additional bins were on order to encourage staff to take off and dispose of their masks when leaving individual bedrooms. Clinical waste was collected at intervals and decanted into large yellow bins, appropriately stored on the nursing home grounds. Wall mounted hand sanitising gel dispensers were available within

each bedroom, at the point of care, which had been put in place following an audit.

Nevertheless, there were aspects of infection control which required review:

For example:

- staff were required to wash their hands in residents' personal sinks.
- there was only one dedicated hand washing sink available to staff which was located in the entrance foyer a good distance from the point of care.
- staff were seen entering communal rooms in full or partial PPE
- staff outer clothes were not stored in line with good infection control practices
- inappropriate storage of a large amount of deceased residents' personal possessions. These personal belongings were stored in large open boxes and bags. The inspector was not assured that the residents' items were safely stored and there was a high risk of possessions being mixed up as a number of items were not labelled or secured within the boxes.

The 28 residents living on the ground floor on the day of inspection were sharing three communal showers. There was a condition placed on the previous registration that the number of showers both upstairs and downstairs in the centre was to be increased by the end of March 2021. The provider informed the inspector, on the day following the inspection, that plans had been drawn up for this project which would proceed after the outbreak. The housekeeping supervisor explained that shared toilets and the communal showers were cleaned between each use and provided documentary evidence of this. The inspector spoke with a member of the cleaning staff who confirmed this practice.

On the day of inspection, February 11th 2021 the centre was closed to visitors in line with level 5 restrictions during COVID-19. A number of notices were displayed in the centre regarding this. This meant that residents and staff were aware of the guidelines and they were informed as to the reason for the restrictions. In addition, visiting arrangements were in place, in line with these guidelines, to enable relatives to visit with residents for end of life and compassionate grounds. The inspector saw evidence in residents' care notes that such visits were accommodated.

At the morning handover report staff were provided with written information as to the dietary needs and any modifications required for each resident. Staff were given a copy of this document which was written in a detailed and clear manner in order to support the new staff and the agency staff. Staff were seen to provide support to those requiring help with drinks within their bedrooms. Meals were served from a well equipped kitchen. The inspector saw that staff were required to complete intake and output charts for residents to ensure that they were hydrated and nourished. A sample of these documents were reviewed by the inspector. Where a resident was assessed as requiring additional fluids the nursing staff were trained in the administration of s.c. fluids where prescribed. The majority of these prescriptions were in place on residents' medicine administration sheets (MAR).

Staff with responsibility for activities were employed in the centre and a comprehensive activity programme had been set up. Evidence of this was seen in

residents' care plans which had assessments in place to collect information on residents' preferences. The activity programme on display around the centre and minutes of residents' meetings, recorded prior to the outbreak, indicated that activities were discussed with residents. During the COVID 19 outbreak the activity programme was not operating to its full extent at the time of this inspection as staff were dealing with the outbreak and supporting residents' medical needs. Nevertheless, one-to-one room activity visits were available for residents as an alternative to group sessions. Residents also had access to the daily newspaper, telephone facilities and 'WhatsApp' calls to facilitate them to stay connected and keep up to date with the news. Religious services were available on TV in each resident's room, if required.

Regulation 10: Communication difficulties

The regulation on communication needs relates to communication for residents. Positive findings were found in relation to this.

Residents were observed using personal phones in their bedrooms. 'WhatsApp' and video calls were also facilitated according to the CNM. Residents were kept up to date with local and national news by staff and from their personal TVs and radios. Residents were updated about the virus, hand hygiene procedures and PPE requirements for staff, according to minutes of meetings held immediately prior to the outbreak.

An updated care plan was seen to be in place to guide staff on supporting the communication needs of residents with dementia.

Concerns were raised in relation to inadequate communication with relatives and these were acknowledged at the beginning of this report and under Regulation 23 Governance and Management

Judgment: Compliant

Regulation 11: Visits

The inspector found that the visiting arrangements in place were in line with the current HPSC guidelines for level 5 restrictions. This meant that visits within the centre were currently restricted, apart from compassionate visits for those at end of life and 'window' visits.

At the beginning of the outbreak the person in charge said that compassionate visiting had not always been facilitated due to fear of the virus spreading further. This indicated to the inspector that all aspects of the visiting guidelines, which

specified that compassionate visits were to be allowed, had not been followed.

Compassionate visiting at end of life was now accommodated whenever this was requested. Records of these visits were recorded in the care plan of a resident who had died or who those who were at end of life at the time of the inspection.

The person in charge said that staff were committed to ensuring residents and their families remained in contact by means of information technology, email and telephone calls as appropriate. She admitted that communication was poor at the beginning of the outbreak and stated this had now improved.

Examples of emails to families were seen for the week preceding the inspection.

Judgment: Substantially compliant

Regulation 26: Risk management

The inspector viewed the health and safety statement, the risk management policy and the emergency plan for the centre. The risk register was populated with a number of risks. However, the risk assessment relating to COVID-19 was not included in the risk management policy. The risk assessment for COVID-19 in the risk register was scant and did not show that the provider had made an assessment of all the major risks associated with a COVID-19 outbreak, to include the illness itself and its effect on residents and staff as well as managing diminished staffing numbers and availability.

A comprehensive risk assessment and risk management policy would have set out the hazard, the risks, the controls currently in place for COVID-19 and the additional controls required to minimise the risk. In the absence of evidence of such a risk assessment and adequate control processes, the inspector could not be assured that all aspects of the outbreak had been considered and every effort made to minimise the risks.

A detailed COVID-19 risk assessment was retrospectively forwarded, following the inspection.

Judgment: Not compliant

Regulation 27: Infection control

A number of issues pertinent to infection prevention and control are set out previously in this report. In addition to those issues already detailed the following required corrective actions :

- poor management and control of COVID-19 e.g. the bedroom doors of most residents who were identified as COVID-19 positive were open,
- there was no signage on the bedroom doors of those who were isolating
- the facilities available for staff changing and dining required segregation of areas in the room for dining and changing
- a number of rooms used as temporary storage required clearing and tidying
- hand washing facilities were very sparse
- it was not clear to the inspector which residents had past the infective phase as all residents were still isolating: some at 20 days and over, post infection
- the wearing of PPE required training and supervision, such as protocol for staff wearing PPE when leaving the "red" (contaminated) zone: an immediate action plan was issued to the provider in relation to this
- the staff changing room, and the store rooms required deep cleaning as they were cluttered with a range of furniture and a large quantity of staff personal clothes, which impeded routine cleaning.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Due to the number of serious issues of concern in relation to medicine management the inspector issued an urgent action plan to the provider:

For example,

In a sample of medicines reviewed:

- staff had administered a number of medicines without a written doctors' prescription available on site
- it was not clear to the inspector that the prescriber's signature was present on the electronic prescription system available on site to the nursing staff
- a medicine which had been prepared by one nurse and signed as administered by that nurse, was found to have been administered by a nurse who had not signed her name as responsible for administering the medicine.
- there was no record on the electronic recording system that the aforementioned medicine had actually been given.
- This indicated a serious concern that the system was not appropriate or safe, particularly in relation to controlled drugs which are administered under very specific professional guidelines for nurses on the management of controlled drugs.

The Chief Inspector required assurance that the above practice would be addressed and that staff would be subject to supervision and re-training. Additionally, the person in charge was asked to seek advice from an appropriate body on the safety and suitability of the medication administration and recording system.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

All residents had a care plan maintained on an electronic format. These were updated within the regulatory time frame. The inspector viewed a number of residents' care plans during the inspection. A number of care plans for residents who had recently died from COVID-19 were also reviewed. These residents had documentation in place which indicated that they had been reviewed regularly by the GPs and the resident had been given appropriate medicines including oxygen and s.c. fluids where necessary. The sample of the records included information that relatives had been facilitated to visit where a compassionate visit had been requested. The person in charge confirmed that the compassionate visits had been welcomed by the relatives involved and that the GP was readily available to talk with residents and their relatives. Records of the GPs' phone calls to relatives were documented in the sample of care plans seen.

The daily narrative notes, written by nursing staff, were informative. This was particularly useful and significant during the outbreak as agency staff or staff from another facility could read all the relevant information on changes in clinical status and the care required, on one page. While care plans were updated in the narrative notes to reflect the current care needs of each resident, for example, for those residents requiring end of life care or when care needs had changed as they experienced symptoms of COVID-19, not all residents had an individual plan in place when their nutritional needs changed such as those requiring s.c. fluids and those requiring oxygen support.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had adequate access to medical services and they had regular pharmacy and general practitioner (GP) service. Medical notes seen were up to date and the GP visited the centre during the inspection. The centre's GP also had access to a consultant geriatrician for residents' care needs. For example, one resident with behaviour associated with the effects of dementia had been assessed and the resident's medicines had been reviewed to improve the resident's quality of life, as the outbreak had increased the resident's anxiety. The inspector found that information from other health care professionals such as, the physiotherapist, dietitian, chiropodist and the speech and language therapist (SALT) was available in residents' files.

Staff explained that access to these services was limited at present due to the virus, even though referrals were continuing over the phone, thereby maintaining a holistic

health care service for residents. Advice from recent phone referrals was documented.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

In a sample of care plans reviewed individualised, person-centred care plans were in place for the management of the behaviour and psychological symptoms of those residents with dementia (BPSD).

The use of restraint, for example bed rails, was documented to ensure that it was used in line with national policy. Documentation in relation to its use was available and the care team discussed alternatives prior to its use.

Judgment: Compliant

Regulation 8: Protection

Concerns raised by residents were recorded and investigated by the person in charge. Staff appraisals formed part of the quality improvement system for staff. Examples of these documents were seen in the sample of staff files viewed.

Protection of residents was routinely discussed at handover reports, according to the person in charge. Staff were trained in recognising and responding to abuse.

The inspector saw that residents' preference in relation to choice of carers and in relation to access to their personal phones was recorded on the daily handover sheet.

Judgment: Compliant

Regulation 9: Residents' rights

It was evident that there had been a good activity programme in the centre, prior to the outbreak of the virus. According to staff, residents had enjoyed the less restrictive family visits at Christmas time. At present residents had one-to-one visits with staff and phone or video conversation with relatives while awaiting the resolution of the outbreak. Compassionate visits were arranged where required or

requested. The inspector saw that local children had sent in cards and pictures to residents as part of an inter-generational project. Throughout this time of restricted visiting family contact was maintained through telephone, WhatsApp calls, photographs sent through emails and cards. This was facilitated by the CNM who spoke with the inspector about this. An external visitors' hub had been set up to facilitate window visiting. It was evident that residents had been consulted about the public health measures in place at the residents' meeting of 7th January 2021 prior to the outbreak. These minutes also indicated that staff members responded to the requests and choices of residents.

Residents and relatives were undoubtedly missing their usual staff team at this time. However, some of those staff who had been co-opted from other centres in the group said they were becoming more familiar with residents. A number of the regular staff were due to return to work at the time of the inspection, according to the person in charge. The person in charge said that the supervision and management support from the additional director of nursing and the CNM was helpful in supporting residents' rights.

Mass was available by video and audio link. Religious blessings were facilitated. The ministers for each religion were available to residents and visited when requested.

All staff spoken with were found to be very upset by the deaths of residents who had died due to COVID-19 and the suddenness of the loss experienced by their relatives. Some of the residents had resided in the centre for a number of years and they had built close relationships with staff. Management staff were aware and spoke about the fact that those residents who survived the outbreak would be emotionally effected by the loss of their friends and would require support.

Judgment: Compliant

Regulation 13: End of life

The inspector viewed a number of care plans of residents who had died in the previous week and those who were ill with the virus at the time of inspection.

End of life care plans were in place and end of life decisions and residents' choice had been recorded. In the sample of residents' records reviewed there was clear documentation available as to the progression of COVID-19 illness in residents, any deterioration of their condition was documented and their recovery was also recorded oxygen levels and vital signs such as temperatures were recorded four hourly. When these signs indicated any deterioration to the resident's usual medical condition the records indicate the the GP was contacted. GPs recorded the outcome of in person reviews and if the contact was by way of telephone the records showed that nursing staff recorded the advice provided by GPs over the phone. By way of example, in one situation the on-call GP had been contacted in relation to oxygen requirements for a resident, when it was found that his oxygen saturation levels had

decreased on the four hourly review.

Medicines to provide comfort to a resident at the end of their life were prescribed and administered.

Staff documented the phone calls made and contact with the relatives involved in the sample of care plans reviewed. Compassionate visits were addressed under Regulation 11. These visits were currently being facilitated on the day of inspection.

Judgment: 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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 13: End of life	Compliant

Compliance Plan for CareChoice Ballynoe OSV-0000210

Inspection ID: MON-0031985

Date of inspection: 11/02/2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Notwithstanding the request by the Registered Provider for the judgement of Not Compliant to be amended, below are the current and proposed actions.</p> <p>Infection Prevention & Control</p> <ul style="list-style-type: none"> • Training of all staff related to IPC is monitored as part of the training matrix under the guidance of the HR team. All staff completed online IPC training in November/December 2020 and have completed online IPC training again in January/February 2021. Post Covid outbreak all employees completed IPC training upon return. All new employees complete online IPC education prior to their commencement. • The PIC completed the following training in October 2020: Infection Control HIQA, Donning and Doffing PPE HSeLand, Hand Hygiene HSE. The PIC has completed a level 5 IPC course in March 2021 and is due to commence a level 9 course in September 2021. • Four additional staff members have completed a level 5 IPC course. • Education and information posters are posted throughout the building as issued by the HSE/HPSC, and the staff education board has information related to Covid-19 which is updated according to national guidelines by the level 5 trained staff. • The Home will continue to be supported by a group IPC nurse as required and will liaise with the HSE DOPH until an internal IPC nurse is appointed following completion of level 9 IPC training in Q4 2021 <p>Supervision</p> <ul style="list-style-type: none"> • Daily supervision on the use of PPE is undertaken and recorded, on the correct wearing of PPE, hand hygiene and social distancing by the senior nurse in charge. Staff will be retrained should a noncompliance occur, and this will be recorded on the employee file. • Safety huddles (includes information on hand hygiene, usage of PPE, standard precautions, cleaning and decontamination, waste management) are being undertaken by clinical management to communicate and reinforce the IPC guidelines as per HSE/HSPC toolbox talks. These are now completed at a minimum three times per week 	

and across all shift patterns. In the event of an outbreak these will be increased to daily

There are a number of auditing procedures in place as part of Governance and Management strategy in the home. These include:

- An Internal Monthly IPC audit which is unit specific
- A Quarterly Quality Dept IPC audit
- An Internal Annual Home IPC audit
- External audits include: Annual Regulatory audit (inc IPC), Quarterly Food Safety & Hygiene audits (Catering and Housekeeping)
- Monthly KPI reviews include review of Infections in the home and discussed between PIC & regional quality manager
- The Quarterly Clinical Governance meeting facilitates presentation of audit findings and action plans and there is a representation from all departments at this meeting
- Monthly IPC committee meeting is in place and includes the IPC level 5 trained staff.

All actions are reviewed by the PIC and the CMT in the home and actions that arise are closed within an agreed timeframe. All audit results, action plans and trends are discussed by the PIC with the staff in staff meetings and Clinical Governance Meetings.

Medicines Management

A full review was completed in light of concerns that the inspector had on the day of the inspection, this report was returned on the date requested.

There were three CNMs on duty on the day of the inspection. Medication rounds were completed in pairs so as to provide supervision and guidance. In addition, senior management also undertook to do the medication rounds, and medication competency assessments.

- All nurses were instructed to complete again the HSEland Medication Management online module and this was completed in February.
- A medication management training session was provided by the Pharmacist on Tuesday 24th February for all nursing staff.

Supervision

- All new members of the nursing staff are supervised by senior management during medication rounds
- Medication competency assessments are completed and reviewed by PIC to ensure compliance

Review & audit

- Internal Weekly medication audits are completed and reviewed by DON/CNM
- An Internal Annual medication audit is completed for 2020 and last completed in March 2021.
- A Monthly KPI review is completed on medication errors, discussed with PIC & regional quality manager and any trends identified are discussed with the nursing team.
- The Pharmacist completes a quarterly review, last review was completed in February 2021 and the next review is scheduled on 20th May 2021. Quarterly review and audit of medication management in 2021 will continue.
- All medication errors and trends are discussed at the Quarterly Clinical Governance meeting

All actions are reviewed by the PIC and the CMT in the home and actions that arise are

closed within an agreed timeframe. All audit results, action plans and trends are discussed by the PIC with the staff in staff meetings and Clinical Governance Meetings.

Audit education scheduled in May 2021 for Clinical Management Team (DON/ADON/CNMs).

Regulation 23: Governance and management

Not Compliant

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

Notwithstanding the request by the Registered Provider for the judgement of Not Compliant to be amended, below are the current and proposed actions.

The PIC is scheduled to attend a one day course in May 2021 on 'Governance of the Nursing Home, the Role of the Registered Provider, PIC and Beyond', which includes SI No 415 of 2013 Health Act 2007 regulations, National Standards and HIQA Guidance documents.

The PIC facilitates three monthly Clinical Governance meetings, the agenda includes IPC and Medication management. Minutes and action plans generated from these meetings are recorded and closed off.

Infections and Medication errors are recorded and monitored as part of the clinical KPIs and reviewed by the PIC and Quality Dept monthly. These medication errors and any trends are discussed with the nursing team and monitored by the DON/CNM.

The Regional Manager with responsibility for housekeeping and catering, has completed a level 5 IPC course, and supports the PIC in these departments. A robust housekeeping manual is in place to include daily records displayed in each room/area and verification of standards reviewed by PIC as part of these records. The regional manager with responsibility for housekeeping and cleaning is onsite in the home weekly to support the PIC, Chef & Housekeeping department.

The home's KPIs, to include infections and medication errors are reviewed as part of the Quality & Safety Committee pack. The CareChoice Quality & Safety Committee assists the Board in the discharge of its responsibilities with regard to quality and safety across all CareChoice homes. The membership of the committee includes the CEO, the Director of Quality & Innovation, the Director of Human Resources, Regional Operations Manager, H&S officer, a Consultant Geriatrician and a minimum of two Directors of Nursing from the CareChoice Group. The committee meets every two months. The minutes and action plans from this meeting are circulated to the wider CareChoice DON group.

As part of our continuing quality assurance, we complete internal audits and engage leading experts to conduct audits on an annual basis to ensure ongoing monitoring,

quality and standards to ensure compliance with the Regulation and National standards. In March 2021 an external audit was completed in the home of all 32 regulations and follow up actions are being completed. The PIC ensures that actions that arise are completed within the agreed timeframe. All audit results, action plans and trends are discussed by the PIC to the staff in staff meetings and Clinical Governance Meetings.

Infection Prevention & control

- Daily supervision is being provided to staff. The PIC ensures that staff are appropriately supervised and managed, and that there is a senior member of staff on duty and available to staff on a daily basis.
- The Infection Prevention & Control Policy and Covid 19 policy & Emergency plan are both available on the electronic HR system for ease of access for the staff. These are also printed and available at nurses' stations. A copy of all policies is retained by the PIC in the DON office.
- Throughout 2021, Safety huddles have been undertaken by management to communicate and reinforce the IPC guidelines as per HSE/HPSC toolbox talks including hand hygiene, usage of PPE, standard precautions, cleaning and decontamination, waste management, confidentiality and data protection. These provide opportunity for staff learning and questions at a minimum 3 times per week and depending on the needs of the home.
- Daily supervision is being undertaken and recorded on the correct wearing of PPE, hand hygiene and social distancing by the senior nurse in charge.
- All staff completed online IPC training in November/December 2020 and have completed online IPC training again Q1 Jan/Feb 2021. All new employees are completing online IPC education prior to their commencement. All employees returning to work post Covid 19 outbreak are completing IPC training prior to returning.
- The Home will continue to be supported by a group IPC nurse as required and will liaise with the HSE DOPH until an internal IPC nurse is appointed following completion of level 9 IPC training in Q4 2021.

Oxygen storage & signage

- On the day of inspection, we acknowledge that some rooms did not have the appropriate signage. When this was brought to the attention of the PIC it was immediately rectified. Areas where oxygen was stored on a regular basis had signage in place. An audit of all areas for appropriate signage has been completed by the PIC.

Deceased residents' possessions

- Residents' belongings were stored in individually identified labelled boxes and bags and were placed in the sitting room. This facilitated their safe keeping allowing ongoing passive surveillance. The CMT reviewed same on the day of the inspection and acknowledged that the boxes needed to be tidied and closed.
- At that time, it had been decided to leave the final sorting and preparation of items

until permanent staff returned to work, prior to returning to families. This has since been completed.

- All residents' belongings have been reviewed and are maintained in a suitable area accessible to the resident. There is a record in place of residents' belongings upon admission.

Medication Management

- A full review was completed in light of concerns that the inspector had on the day of the inspection, this report was returned on the date requested and actions implemented.
- There were three CNMs on duty on the day of the inspection. When appropriate e.g. new nursing team member or depending on the demands/changes in the home, Medication rounds were completed in pairs so as to provide supervision and guidance. In addition, senior management also undertook to do the medications and completed medication competency assessments which are reviewed by PIC to ensure compliance.
- Internal Weekly medication audits are completed and reviewed by DON/CNM, and any concerns are promptly discussed with nursing team.

Education

- All nurses were instructed to complete again the HSEland Medication Management online module and this was completed in February 2021.
- A medication management training session was provided by the Pharmacist on Tuesday 24th February for nursing staff.

Supervision

- All new members of the nursing staff are supervised by senior management during medication rounds
- Medication competency assessments are completed and reviewed by PIC to ensure compliance

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Notwithstanding the request by the Registered Provider for the judgement of Not Compliant to be amended, below are the current and proposed actions.

The centre was in regular contact with the inspectors during the period in question. The inspectors were made aware of the status at the time and the PIC was advised to complete the written notification as soon as possible.

20 NF01 notifications were made up to the date of the inspection. 11 were made on time and the remaining 9 of the notifications were no more than 3 days late.

Education

- The PIC has since reread HIQA's Notification Handbook and undertakes to complete all notifications within the designated timeframe going forward.
- The PIC is scheduled to attend a one day course on 'Governance of the Nursing Home, the Role of the Registered Provider, PIC and beyond', which includes SI No 415 of 2013 Health Act 2007 regulations, National Standards and HIQA Guidance documents.

Supervision

- The Quality Dept will review the timeframe of incidents that arise and the notification of same and will highlight late notifications to the PIC and their Line manager so they may be addressed. This will be completed as part of the monthly Quality review with the regional manager and PIC. Notifications form part of the monthly operations meeting and will be discussed accordingly.

Audit & Review

- All notifications are being reviewed monthly by the PIC and Quality Dept, actions arising are completed by the PIC.
- Notifications are further reviewed during the Monthly Operations meeting.
- A report on all notifications is made available to CareChoice Senior Management team for review monthly.

Regulation 4: Written policies and procedures	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Notwithstanding the request by the Register Provider for the judgement of Substantially Compliant to be amended, below are the current and proposed actions.

Infection Prevention & Control Policy

- The IPC policy dated October 2020 (Version 6) and the Covid 19 Policy and Emergency Plan dated January 2021 (Version 10) were both in place at the time of the inspection and clearly set out how to manage an outbreak of Covid-19 in sections 12 and 13 of the latter policy.
- The IPC Policy is a separate policy to the Covid-19 Policy but as noted both were in place.
- The current policy was also available to staff on the electronic HR system to read.
- The PIC will ensure that the latest version of the policy is available in her office and on each unit, so all staff have access to same.

- The PIC will communicate any changes to the policies as they arise, to staff during safety huddles and staff meetings. PIC will give direction to the staff to read changes and compliance on any changes will be supervised by the Clinical Management Team.

Medicines Management Policy

- The Medicines Management Policy was in place at the time of inspection, all nursing staff have re-read the policy and attended training (HSEland and training by the Pharmacist), to ensure that the policy is adhered to.
- Supervision and review/audit of same is commented under Regulation 16.

Regulation 11: Visits	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 11: Visits:

- The PIC has reviewed the home’s visiting procedures and is implementing compassionate visiting in line with national policy and guidance. This includes continued completion of risk assessment and taking into consideration the current general status in the home, the overall resident’s care needs, rights and wishes of the resident.
- A visiting schedule is in place and staff are allocated to ensure appropriate visiting is in line with policy and guidance. Suitable facilities are in place to accommodate the visiting schedule and the needs of the visitors.
- A visitor’s questionnaire is completed and retained as per policy.
- The Covid-19 Policy and Emergency Plan is updated to reflect HPSC revisions on visiting.
- Residents and families have been notified of any changes in visiting restrictions and/or guidance on visits related to the home during the months of January 2021 – current.
- The nursing home encourages families and friends to visit the residents and the PIC addresses any questions that residents or families may have.
- All visits are managed in line with government guidance and risk assessed at the time of engagement with families.

Regulation 26: Risk management	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management:

Notwithstanding the request by the Registered Provider for the judgement of Not Compliant to be amended, below are the current and proposed actions.

- The risk assessment for Covid-19 is referenced in the Risk Management policy, which in turn refers the reader to the Covid-19 Policy and Emergency Plan.
- The risk assessment relating to Covid-19 forms part of the home's Covid-19 Policy and Emergency Plan dated January 2021 (Version 10), which was in place at the time of the inspection. This policy clearly sets out how to manage an outbreak of Covid-19 in sections 12 and 13 including all the major risks associated with a Covid-19 outbreak.
- The risk assessment includes the illness itself and its effect on residents and staff as well as managing diminished staffing numbers and availability. In addition, an individual Covid-19 risk assessment covering medical history, sign and symptoms of Covid-19 and any specific clinical outcome and presentations.
- The PIC will ensure that the relevant and current documentation is made available to the inspector during an inspection going forward.
- The PIC with assistance of the H&S Officer has created folders with all the relevant information. This folder is available to the staff in the nurses station and a copy is now held in the DON office for easy access.

Regulation 27: Infection control

Not Compliant

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

Notwithstanding the request by the Registered Provider for the judgement of Not Compliant to be amended, below are the current and proposed actions.

a. poor management and control of COVID-19 e.g. the bedroom doors of most residents who were identified as COVID-19 positive were open,

- The HPSC Covid-19 Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of Covid-19 Cases and Outbreaks in Residential Care Facilities states, on page 32, "Room doors should be kept closed where possible and safe to do so". This requirement was adhered to.
- At the time of the inspection residents were positive for COVID -19 and all were nursed in their rooms. Due to the residents' conditions some of the residents' doors were open. A number of residents became distressed when the door was closed. In these incidents,

social distancing was maintained as the resident's chair or bed was greater than 2 metres from the doorway.

- Going forward, in an outbreak situation the PIC will ensure all bedroom doors are closed where it does not affect the resident negatively.

b. there was no signage on the bedroom doors of those who were isolating

- On the day of inspection, the residents' rooms and the corridors were in a "red" zone; signs were displayed on the entrances and exits to the appropriate zones.
- In the "orange" zone all the rooms were signposted.
- The nursing home implemented a zoning structure, cohorting Covid-19 residents together in accordance with guidance.
- Going forward, in an outbreak situation the PIC will ensure that signage is placed on all bedrooms.

c. the facilities available for staff changing and dining required segregation of areas in the room for dining and changing

- At the time of inspection there was a small staff dining room and a larger staff room which was divided into a dining room and changing room. The dining area and changing area were segregated.
- There were two changing rooms in operation to facilitate the increased staffing numbers due to the needs of the residents.
- A review of staff facilities is underway, and actions arising will be addressed.

c. a number of rooms used as temporary storage required clearing and tidying

- Storerooms were being used to their fullest extent. This was to limit the clutter within the home so as to facilitate good infection control practices in the home. Excess furniture and equipment were temporarily stored in a number of areas in the home that were not currently in use, this was to facilitate resident and staff cohorting and terminal/deep cleaning of rooms in use.
- A full review has been completed and an action plan is in place to provide external storage and to declutter the home.

d. hand washing facilities were very sparse

- Hand washing facilities are available at the entrance of the home, in the staff room and staff toilets outside residents' rooms.
- An Extensive number of hand gel dispensers are been put in place throughout the nursing home (over 80).

e. it was not clear to the inspector which residents had past the infective phase as all residents were still isolating: some at 20 days and over, post infection

- It is correct to say that, on the day of the inspection, residents were still being cared for in their individual rooms, as had been discussed with the OCT of the HSE on 9th February.

f. the wearing of PPE required training and supervision, such as protocol for staff wearing PPE when leaving the "red" (contaminated) zone: an immediate action plan was issued to the provider in relation to this

- Daily Safety Huddles are undertaken by CMT to communicate and reinforce the IPC guidelines as per HSE/HPSC tool box talks.
 - Daily supervision on the use of PPE is also undertaken and recorded on the correct wearing of PPE, hand hygiene and social distancing by the senior nurse in charge.
 - Educational and information posters throughout the building as issued by the HSE/HPSC. There is also a staff education board in relation to Covid-19.
- g. some items of furniture required replacing to facilitate effective cleaning
- Furniture replacement for IPC requirements is regularly reviewed, a further review has been completed following the recent Covid 19 outbreak, and an action plan is in place. Items identified as not suitable for cleaning have been withdrawn from the home and disposed of, orders have been placed for replacement items.
 - As noted by the inspector cleaning schedules are up to date. These are being maintained.
- h. the staff changing room, and the store rooms required deep cleaning as they were cluttered with a range of furniture and a large quantity of staff personal clothes, which impeded routine cleaning.
- Cleaning of the staff room was demonstrated by the cleaning schedules (twice daily), with high touch surfaces being cleaned three times per day.
 - Staff have been advised to remove non essential items from the staff areas.
 - Staff facilities are currently under review as stated in point 'c'.

Regulation 29: Medicines and pharmaceutical services	Not Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
 Notwithstanding the request by the Registered Provider for the judgement of Not Compliant to be amended, below are the current and proposed actions.

a. 'staff had administered a number of medicines without a written doctors' prescription available on site, it was not clear to the inspector that the prescriber's signature was present on the electronic prescription system available on site to the nursing staff'

- On review it was noted that GP signatures were not present on all of the electronic records of all medications that were administered, the GP had ordered the use of the medication and had recorded narrative note to this effect. A copy of the written prescription was on file. A full review was completed and the EMARS are signed off by the GP.
- The weekly medication audits are being completed which will identify any items requiring GP signature. Following the weekly medication audit the PIC will ensure that all actions are closed.

b. 'A medicine which had been prepared by one nurse and signed as administered by

that nurse, was found to have been administered by a nurse who had not signed her name as responsible for administering the medicine’.

- On review it was noted that the medication was signed out as per policy. The medication was brought to the resident's room. Two other nurses already present in the resident's room as the resident was in some distress and repositioning was taking place. The medication was administered and witnessed by the two nurses who had signed out the medication.

c. ‘there was no record on the electronic recording system that the aforementioned medicine had actually been given. This indicated a serious concern that the system was not appropriate or safe, particularly in relation to controlled drugs which are administered under very specific professional guidelines for nurses on the management of controlled drugs.’

- The error identified was a single documentary error within the system, which was caused by a changeover to a new version of the software, this was highlighted to the provider of the electronic system and was rectified immediately.

The Medication System has been reviewed with a senior pharmacist, as requested by the Inspector. The following comments compare the Medication Module against guidelines: ‘As per NMBI guidelines CareChoice have policies in place for recording all aspects of medication management and these are audited regularly. This includes all aspects of assessing, supplying, prescribing, dispensing, administering, reviewing and assisting people with their medicines. The policy includes that each medicine is prescribed electronically by the GP using their own protected password. This correlates to an electronic signature. Recently guidelines are been changed to include electronic prescriptions. All medicines are ordered and checked in – reports can be provided of medicines ordered, dispensed medicines checked in against orders and against current prescription via the electronic system. Nurses can sign entries using their name as entered on the Register of Nurses as maintained by the NMBI – Name does appear as they are password protected, Entries are in chronological order as they are date and time stamped, Entries are permanent and cannot be altered. Any modification of an entry is recorded as a separate entry and this ensures all entries are legible.’

The urgent action plan was completed as requested by the Inspector and returned on the date requested.

Regulation 5: Individual assessment and care plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Residents’ assessments and care plans are reviewed at a minimum every four months

and/or more frequently should the residents' health status change. The residents' care plan is discussed with the resident where possible and the residents' family upon consent of the resident.

Education

- Nurses attend care planning education and have an assessment & care plan toolkit to assist them in the process of assessment, planning, implementing and evaluating the residents care needs.
- A review was completed, and all nurses have completed the aforementioned training. New nurses are scheduled to attend and are being supported by the CNM's and the Regional quality person in the interim. In addition all nurses have completed 1:1 guidance on completing residents' assessments and care plans onsite in 2021.

Review & audit

- Internal assessment & care plans audit to recommence. The feedback on these audits is provided to the nurse allocated to lead the residents care needs. The CNM and DON are available to the nursing team to support their ongoing review and completion of updates in the resident's assessments and care plans.
- The Quality Dept supported the home in a recent audit of all residents' assessments and care plans. An action plan was provided and closed out by the CMT in the home.

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 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Substantially Compliant	Yellow	01/04/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/02/2021
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.	Not Compliant	Orange	01/03/2021
Regulation 23(c)	The registered	Not Compliant		01/04/2021

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.		Orange	
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	01/03/2021
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	01/03/2021
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.	Not Compliant	Orange	01/09/2021

Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Red	19/02/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	21/05/2021
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	01/03/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3	Substantially Compliant	Yellow	01/03/2021

	years and, where necessary, review and update them in accordance with best practice.			
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	01/06/2021