Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cahercalla Community Care
Name of provider:	Cahercalla Community Hospital Company Limited By Guarantee
Address of centre:	Cahercalla Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	16 January 2025
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0045606

About the designated centre

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

Cahercalla Community Care is located on the outskirts of the town of Ennis. It provides care to long-term, respite, and convalescence residents and also has five designated hospice beds. The original building consists of a three storey units, Ground floor, St. Joseph's and Sacred Heart The centre also has a two storey building with two units, Garden wing ground floor and Garden wing first floor. The centre is registered to accommodate 112 residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	108

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
Thursday 16 January 2025	09:30hrs to 17:30hrs	Una Fitzgerald	Lead
Thursday 16 January 2025	09:30hrs to 17:30hrs	Sean Ryan	Support

What residents told us and what inspectors observed

Overall, residents living in Cahercalla Community Care were happy living in the centre. Comments made by residents when asked about the care included "care is excellent", followed by positive comments on the service delivered. Residents had a high level of praise for the staff as individuals, and as a group. Residents were satisfied that their call bells were answered in a timely manner.

Following an introductory meeting, the inspectors walked around the centre. The centre was divided into five separate units. The centre was spacious and generally well laid out to meet the needs of the current residents. Each unit had communal sitting and dining rooms for resident use. In the main, inspectors observed that the premises was clean. Following the last inspection in March 2024 the provider had a programme of renovation in progress. Refurbishment works to the walls and corridors on the ground floor memory care unit had been completed. Significant improvement to the overall state of repair of the premises had taken place. On the day of inspection, external contractors were in the premises replacing damaged flooring. The provider confirmed that all parts of the premises had been assessed and that all areas of concern such as damaged flooring was being addressed. Inspectors found that the provider had addressed the standard of cleanliness in communal bathrooms, kitchenettes and sluice rooms.

Resident bedroom accommodation comprised of shared and single bedrooms. Residents' bedrooms were personalised with items of personal significance such as photographs and ornaments. Many resident bedrooms were noted to be spacious and in the main, there was sufficient storage space for resident personal possessions. Privacy screening was in place that ensured residents privacy and dignity was maintained.

Residents complimented the staff who they described as 'polite and caring'. Residents told the inspectors that staff supported them to get up from bed at a time of their choosing, and that they could have a shower when they wished. Residents were positive in their feedback about the décor of their bedrooms.

Resident had access to a variety of communal rooms including dining rooms, sitting rooms, a coffee shop and a spacious chapel. There was sufficient private and communal space for residents to meet with visitors. Inspectors observed a number of residents receiving visitors during the inspection.

The inspectors observed that there was a welcoming feel to the centre. There was a calm, friendly, and relaxed atmosphere in the centre throughout the inspection. In conversations with the residents, the inspectors were told that the management had a visible presence in the centre and were available at all times. While staff were observed to be busy attending to the residents care needs, they were seen to take the time to address all residents by name as they passed them in the corridor. Staff engagements were patient and kind. The inspectors observed that residents were

well-dressed, and residents confirmed that staff assisted them in a kind and patient way.

The social activities calendar in the centre was important to the residents. Residents described the variety of activities they could choose to attend. These included arts and crafts, exercise sessions and music activities. There was a member of staff appointed to activities seven days a week. Activities staff spoken with were familiar with the residents and were familiar with the individual care needs of the residents. Staff were knowledgeable about residents who choose not to attend group activities, and, time for one-to-one individual residents sessions was allocated daily.

Residents were served their lunch in the dining room and in their bedrooms. Residents stated that they were offered choice at mealtimes and were very complimentary regarding the quality of food provided. Meals were observed to be appetising and well-presented. Residents who required assistance were attended to by staff in a respectful manner.

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre. Residents stated that they were consulted about the quality of the service frequently and told the inspectors that they 'felt listened to' by the staff and management.

In summary, the residents in the centre received a good quality service from a team of staff that were committed to supporting the residents. The care was person-centered. The following sections of this report detail the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

The findings of the inspection reflected a commitment from the provider to ongoing quality improvement that would enhance the daily lives of residents. The governance and management was well-organised and the centre was sufficiently resourced to ensure that residents were supported to have a good quality of life. The inspectors followed up on the last compliance plan from the last inspection in March 2024. The findings of this inspection were that the provider had taken significant action to improve the quality of the premises for residents. Notwithstanding progress made, the governance and management, and fire precautions were not in full compliance with the regulations. The inspectors found that the system in place to ensure adequate identification and oversight of residents that were at risk of malnutrition was not always effective. Inspectors found that the provider had inadequate oversight over the effectiveness of some aspects of staff training.

This was an unannounced inspection conducted over the course of one day to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. Cahercalla Community Hospital Company Limited by Guarantee is the registered provider of the centre. The centre was registered to accommodate 112 residents. On the day of inspection, there was 108 residents living in the centre, with four vacancies. There were sufficient numbers of suitably qualified nursing, healthcare and household staff available to support residents' assessed needs. Within the centre, the person in charge was supported by an operations manager, an assistant director of nursing, a team of clinical nurse managers, nurses, healthcare assistants and administration staff. This management structure was found to be effective.

The inspectors reviewed a sample of staff files. The files contained the necessary information as required by Schedule 2 of the regulations including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Records reviewed by the inspectors confirmed that training was provided. All staff had completed role-specific training in safeguarding residents from abuse, manual handling, infection prevention and control, and fire safety. However, the inspectors found that the provider had not assessed the effectiveness of the training. For example; staff responses to what action to take in the event of the sounding of the fire alarm were inconsistent and not in line with documented procedures.

The management team held weekly management meetings and all areas of care delivery was discussed. There were management systems in place to monitor the quality and safety of the service provided that included a schedule of audits. Inspectors reviewed a sample of completed clinical audits and found that some audit tools were not effective to support the identification of risks and deficits in the quality and safety of the service. For example, audits of residents' at risk of malnutrition failed to identify that the completed assessments were not always an accurate reflection of the residents nutritional care needs. This impacted the provides ability to identify and manage this risk.

Additionally, inspectors found that improvement actions documented from audit findings were not always implemented. For example, the management team had identified a high number of falls in the centre and as a result had identified in October 2024, the need to establish a falls committee to review the current falls prevention programme and reduce the incidence of falls. However this action had not been progressed and there continued to be a high incidence of falls in the centre.

The person in charge held responsibility for the management of complaints. At the time of inspection, all logged complaints were been managed through the complaints policy.

Incidents were appropriately notified to the Chief Inspector of Social Services, within the required time-frame.

Regulation 15: Staffing

The number and skill mix of staff was appropriate with regard to the needs of the current residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to and had received appropriate training.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place monitoring the care was not fully effective. This was evidenced by;

- Poor oversight of clinical assessment to ensure accurate and consistent recording and assessment of resident's weights to identify unintentional weight loss, and subsequent risk of malnutrition. This impacted on the providers ability to appropriately identify the risk and implement systems of escalation to ensure an appropriate pathway of care was implemented in response to a resident's risk of malnutrition.
- Inadequate systems of auditing. For example, improvement action plans, informed by audit findings were not consistently implemented, subject to time frames, or progress review. For example, actions in relation to the management of resident falls in the centre had not been fully implemented.
- Oversight of fire safety procedures and staff responses on what action to take on the sounding of the alarm were inconsistent.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents that required notification to the Chief Inspector had been submitted, as per regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the logged complaints found that concerns were promptly managed and responded to, in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Residents living in this centre received care and support which ensured that they were safe and that they could enjoy a good quality of life. While the provider had taken significant action to ensure the physical environment met the care and safety needs of the residents, and to ensure residents' safety in relation to fire safety, the action taken was not sufficient to being the centre into full regulatory compliance. In addition, this inspection found that some residents individual assessments and care plan were not always reflective of their actual care needs.

The inspectors reviewed the arrangements in place relating to fire safety. Inspectors found that regular fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up-to-date. The centre was equipped with a fire detection and alarm system which covered all areas. The inspectors found that while the provider had taken some action to address fire containment issues within the centre relating to some fire doors, the provider had not fully identified all potential deficits with the fire doors in the centre. In addition, fire safety procedures did not fully ensure that robust fire management systems were in place. This is further discussed under Regulation 28, Fire precautions.

The centre was found to be visibly clean in areas occupied by residents, such as the communal dayrooms and dining room, with the exception of areas of the centre where deficits in the premises, such as impaired floor coverings, compromised effective cleaning. There was a cleaning schedule in place to support the systematic cleaning of all areas of the centre. This included both occupied and vacant bedrooms, storage area, communal dayrooms and toilets, and kitchenettes. Nonetheless, there were some aspects of the physical environment that continued to impact on effective infection prevention and control. This included floor coverings in some en-suites, toilets, and communal dayrooms that were in a poor state of repair and impacted on effective cleaning.

A review of a sample of residents' assessments and care plans found that care plans were not always informed by a comprehensive assessment of the resident's care needs. Consequently, the care plans reviewed did not always reflect person-centred, evidence-based guidance on the current care needs of the residents. For example, some residents with significant weight-loss were not assessed as being at risk of malnutrition, and were not identified as such within their nutritional care plans.

Residents were reviewed by a medical practitioner, as required or requested. Arrangements were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was evidence that recommendations made by professionals had been implemented to ensure best outcomes for residents.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Residents' rights were promoted in the centre. Residents were free to exercise choice in how to spend their day. Activities were observed to be provided by dedicated activities staff, with the support of health care staff. Residents told the inspector that they were satisfied with the activities on offer. There were opportunities for the residents to meet with the management team and provide feedback on the quality of the service.

Regulation 28: Fire precautions

Fire safety management systems were not fully effective to comply with the requirements of the regulations.

Arrangements for the containment of fire were not adequate.

- The deficits to fire doors presented a risk to the fire containment of the centre. A number of fire doors were observed to be impaired. For example, some did not close fully while other doors were stuck on the floor when opened. Some doors contained significant gaps when closed. This had the potential to impact on the containment of smoke and fire in the event of a fire emergency.
- Some fire doors were observed to be held open by items such as bins and trolleys. This had the potential to impact on the function of the fire door to contain smoke and fire in the event of an emergency.

The arrangements for evacuating, where necessary in the event of a fire, all persons in the designated centre and the safe placement of residents was not adequate. A review of the completed fire drills found that drills did not provide assurance that all residents could be evacuated at all times, to a place of safety, in the event of a fire

emergency. For example, the drills did not include the evacuation of a full compartment, to a place of safety.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents care needs. A number of resident who had experienced significant weight loss did not have an accurate assessment of their nutritional risk completed. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. The care plan of a resident discharged from hospital had not been reviewed or updated following a significant increase in their nutritional care and support needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life and palliative care.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities for residents occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities on offer.

Residents were provided with the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents meetings and taking part in resident surveys. Residents told the inspector that they could exercise choice about how they spend their day, and that they were treated with dignity and respect.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cahercalla Community Care OSV-0000444

Inspection ID: MON-0045606

Date of inspection: 16/01/2025

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: • The PIC will ensure that a thorough review of all residents' nutritional assessment and weight review is undertaken. Any inaccuracies identified in nutritional assessments will be addressed without delay. • The PIC will ensure that nutritional assessments are continued to be discussed at daily safety pause, weekly and monthly management meetings. Residents who are identified as a high risk of malnutrition are identified, risk assessed and highlighted to the management team without delay. • The PIC will ensure that all nurses have up to date training completed in nutritional assessment and its application to a resident need. • Since the inspection the center has developed a falls committee who will meet monthly to discuss the falls within the home. • The committee will complete a full review monthly of all residents falls and develop an analysis to identify any common trends, contributing factors or recommendations to be implemented to assist in reducing the risk of falls . • The ADON will continue to attend the Regional falls committee within the organization and share practices within the staff meetings to assist in the management of falls within the home. • Falls and falls management will be discuss daily at safety pause, weekly at the management meetings and monthly as part of a quality and safety review. • The PIC with the support of the ADON will ensure any recommendations to be implemented will be completed and reviewed without delay. • The PIC will ensure that Quality improvement plans implemented will be reviewed monthly to ensure each recommendations is achieved, and its effectiveness measured accordingly. • The PIC will ensure that staff have a thorough understanding of how to apply theoretical learning to practice, especially in relation to Fire Safety • Fire safety will be discussed each day during the Safety Pause on each ward and this will assist staff in understanding how to respond in the event of a fire	

• The PIC will ensure that fire drills, simulating night-time conditions, are conducted regularly, using a scenario-based model; staff will be required to reflect on their individual and group response and actions after the drills, which will assist them in understanding how to apply the principles of fire safety to a real-life emergency/evacuation situation. The scenario will be evaluated to determine what went well and identify quality improvements for future safety drills.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A review of all fire doors has been undertaken. The PIC, with support of the Operations Manager , will ensure that consistent checking of the fire doors is carried out and any deficits will be addressed immediately.
• The Operations Manager will complete a full review of fire doors and will arrange for gaps to be repaired
• The management team will conduct regular checks to ensure that doors are not wedged open. The PIC will conduct a risk assessment to determine which doors require an automatic door release mechanism (Door guard). The PIC will liaise with Fire safety trainer to ensure that this matter is highlighted and discussed as part of fire safety training
• Door closure and fire safety doors will be checked as part of regular fire safety checks and will be discussed as part of Health & Safety Committee meetings and monthly management team meetings.
• Compliance with door closing practices will be spot checked by the PIC/ADON /Operations manager and CNMS.
• The PIC with the support of the Operations manager will ensure Fire drills completed identify multiple occupancy compartments to be evacuated and timed to ensure that all staff are confident in the practise of evacuating a compartment and ensure residents are evacuated safely.

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: • The PIC will complete a weekly audit of clinical documentation to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care and that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident's expressed preferences. • The PIC with the support of the ADON and CNMS will ensure when resident return from hospital assessments are completed in a timely manner and any changes to their care needs is identified, recorded, and shared within the clinical team without delay. • Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.	

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 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/04/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are	Substantially Compliant	Yellow	30/04/2025

	aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/04/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/04/2025
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	30/04/2025