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:	Aperee Living Ballygunner
Name of provider:	Aperee Living Ballygunner Limited
Address of centre:	Bishopscourt, Ballygunner, Waterford
Type of inspection:	Unannounced
Date of inspection:	22 March 2023
Centre ID:	OSV-0000236
Fieldwork ID:	MON-0037164

About the designated centre

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

Aperee Living Ballygunner was purpose built as a designated centre in 2006. It provides continuing, convalescent, palliative, dementia and respite care for up to 64 residents. It is situated on the outskirts of Waterford City and is in close proximity to all local amenities. It is a mixed gender facility and caters for residents of all dependency needs from low to maximum, predominately to people over the age of 65 but also caters for younger people over the age of 18. The centre comprise of two floors, with two elevators servicing each floor. Resident's accommodation is provided in 54 large single bedrooms, in one large four bedded room and in three twin bedrooms all which are en-suite. A number of bedrooms also have their own sitting room area provided in a suite type accommodation. There is a large central dining room, a sunroom, an oratory and a number of sitting rooms for residents use. Plenty of outdoor space is available including an internal courtyard with raised flowerbeds and seating areas. Nursing care is provided 24 hours a day, seven days a week supported by General Practitioner (GP) services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

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
Wednesday 22 March 2023	08:45hrs to 17:15hrs	Catherine Furey	Lead
Thursday 23 March 2023	08:00hrs to 15:15hrs	Catherine Furey	Lead
Wednesday 26 April 2023	10:40hrs to 18:10hrs	Noel Sheehan	Support
Monday 15 May 2023	14:10hrs to 16:10hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

On the first three days of inspection, the inspectors arrived unannounced to the centre. The fourth day of inspection was announced in advance, to facilitate the review of a number of documents pertaining to the protection of residents' finances.

Inspectors met with a number of residents throughout the inspection to gather feedback on their lives in Aperee Living Ballygunner. Residents reported feeling happy in the centre, and were complimentary of the staff and management, whom they said treated them well. Overall, whilst the inspectors found that residents living in the centre gave positive feedback about the centre and were complimentary about the staff and the care provided, inspectors were not satisfied that the overall governance and management of the centre was sufficiently robust and that effective management systems had been implemented to protect residents, particularly in relation to the protection of residents finances.

On arrival to the centre each day, the inspectors saw that the main door was accessed via a coded keypad entry. Inspectors observed that regular visitors to the centre were aware of this code and could freely enter into the lobby area. On each occasion of the door opening, an alarm was sounded until the door was closed again. It was explained by the management team that as the reception was a significant travel distance from the main living areas and the nurse's station, the alarm was required to ensure that residents did not leave the centre unattended.

On each morning, residents were seen to be up and about, with some who woke early, having already been assisted to get up and dressed for the day. Most residents chose to spend some time in the centre's communal room, specifically the large sitting room on the ground floor, which was seen to be a hive of activity. This area was where residents gathered to take part in scheduled activities and to spend time relaxing in each others company. Inspectors saw a number of activities throughout the days of inspection including a general knowledge quiz, and sing-song, which were seen to be fun and enjoyable, with good resident participation. The weekly schedule of activities included visiting musicians and a twice-weekly book club which met in a smaller sitting room upstairs.

Bedroom accommodation was laid out over two floors. The majority of rooms were single ensuite rooms. There are also three twin bedrooms and one large four-bedded room. The four-bedded room was being used by two residents, and as such was not currently configured to meet the requirements of four residents. The large size of the room would allow for the appropriate configuration of furniture to ensure residents' privacy and dignity is maintained in a shared occupancy room. Residents were all provided with a lockable facility to store items. Residents said that they were generally happy with the laundry service provided, and that if items went missing, it was rectified quickly by staff. Residents were encouraged to personalise their rooms with familiar objects, furniture and keepsakes from home. Inspectors

spoke to residents who said that bringing in their personal items made it seem more like their home.

Residents' could access all levels of the centre via a passenger lift. There was a choice of communal spaces that residents could use on the ground floor including a large reception area, an oratory, day room, large dining area and sun room. The dining room downstairs was large and bright and had a small kitchenette where staff could make tea and coffee, there was fridges to store snacks and meals, for easy access to residents. Inspectors observed mealtimes and found that meals were delivered to residents in a warm and appetising fashion. Residents complimented the range of choices on offer, and said that there would be no issues if they requested something that was not on the day's menu. A smaller dining room was reserved for a group of residents who told the inspector that they were "ladies who lunch". These residents told inspectors that they chose to take their meals here as they felt that it was a little quieter and more private than the main dining room. There was some disparity in the provision of meals to residents, whereby some residents were seated at tables which were nicely set, and others had no table settings. This is discussed further in the Quality and Safety section of the report.

Generally, the centre was clean, however the oratory room was found to have a deeply stained carpet, cobwebs in corners and unclean windows. A review of cleaning schedules identified that this room was not part of the daily cleaning schedule. Additionally, inspectors saw that a range of items including resident equipment, boxes of resident's belongings, and activity supplies were haphazardly stored within the oratory. This detracted from the sense of an oratory as a place of comfort and quiet reflection. The first floor had a dining area, lounge area, physiotherapy gym and library room. There was suitable seating throughout and the centre had many feature walls decorated with photographs of the local area. The ground floor area had access to attractive garden spaces. There were outdoor smoking areas for residents who chose to smoke.

Residents were encouraged to give their views and opinions on the service provided, through regularly scheduled residents meetings. Residents who spoke with inspectors said they would be confident to speak to a staff members should they have any issues or concerns. Residents said that they were generally very happy with the service provided, including their choices in how to spend their day, and that staff were respectful of their individual rights. Inspectors observed staff to be kind and compassionate in their interactions with residents during the inspection.

Inspectors observed that visiting was facilitated throughout each day of inspection. Residents told inspectors that there was no restrictions and they could welcome visitors to their rooms or the communal areas of the centre

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

Capacity and capability

Inspectors were concerned about the governance and management of the centre especially in areas of healthcare, residents' finances and the areas of continued non-compliance which had not been addressed by the provider. Inspectors continued to be very concerned about the registered provider's ability to safely sustain the business of the centre. This concern was heighten due to poor safeguarding practices by the provider in relation to residents own money held by the registered provider.

During this inspection, actions resulting from the previous inspections in July 2022 and November 2022 were reviewed and inspectors found that the commitments and templates outlined in the centre's compliance plans had not been actioned, specifically in relation to fire safety, the premises, and governance and management. Additionally, this inspection found that the governance and management arrangements were not sufficiently robust to ensure a safe and consistently monitored service.

Fire safety concerns had been identified during previous inspections of the centre, and there was a lack of progress in actioning these areas of high risk. Following ongoing communication and interaction with the provider, the provider had submitted an action plan to the Chief Inspector with dates and times for the completion of these fire works. Inspectors found that there had been no progress made regarding the issues relating to fire safety. This is further discussed in Regulation 28: Fire precautions.

This inspection was carried out following receipt of an application to renew the registration of the centre and to follow up on previous commitments given to address fire safety issues in the centre. In addition the inspection was also inform by information of concern relating to the alleged mismanagement of residents finances. Regarding this information, the inspectors found that the provider did not take all reasonable measures to protect residents finances as evidenced by the findings under Regulation 8: Protection.

Aperee Living Ballygunner is operated by Aperee Living Ballygunner Limited, the registered provider. The Chief Inspector is concerned about the registered provider's ability to provide a safe, quality service. There had been ongoing regulatory engagement with the provider including provider meetings, cautionary meetings and warning meetings in relation to governance and management and fire safety. As part of the provider's commitment to improve the governance of the centre, the provider had appointed a new Chief Executive Officer in January 2023 but the inspectors were informed that this person was no longer in the employ of the provider. The current governance structure which as outlined above is supported by a company external to the registered provider comprised two newly appointed regional managers, a newly appointed HR manager, HR and finance team and a chief operations officer. On site, the management team comprised the person in charge, assistant person in charge, clinical nurse manager, and, care team. The

inspectors were informed the regional manager had attended the centre on a regular basis and the chief operations officer was available to the service. Inspectors were concerned that in the absence of strong governance, there was an over-reliance on the person in charge and the clinical management team to provide the governance and leadership for this service.

The registered provider had submitted the appropriate notification advising the regulator of the appointment of persons participating in management (PPIMs) of the service. These notifications were for the regional managers and the chief operations officer who inspectors were informed were available to the service.

The staff training record showed that staff members were up-to-date with the training requirements according to their roles and responsibilities including medication management, infection control, manual and patient handling, and safeguarding of vulnerable adults. A schedule of training was in place for those due for refresher training. Nonetheless, inspectors observed examples of staff not adhering to good practice outlined in these training courses, for example in relation to the use of personal protective equipment (PPE), as discussed under Regulation 16: Training and staff development. An issue was identified whereby staff supervision, particularly at night was not sufficient. This was being addressed by the management team.

A company-wide schedule of audits was in place. These were completed predominantly by the director and assistant director of nursing. The outcome of some audits included well-developed plans for improvement, including audits of call bell response times, falls and restraint. However, inconsistencies we were seen in some areas, as discussed in regulation 23: Governance and Management. Record keeping in the centre also required review, to ensure that all required documents and relevant detailed records were maintained in the centre.

Staffing levels in the centre on the days of inspection were seen to be sufficient to meet the collective and individually assessed needs of the residents. Agency use had dramatically reduced in the previous months, and the person in charge outlined that due to planned absences, there was approximately 84 hours of healthcare assistant agency staff, and 24-36 hours of nursing staff being used each week. This equated to seven healthcare assistant shifts and two to three nursing shifts a week. This was confirmed by staff and from a review of rosters. These shifts were predominantly covered by long-term agency staff who were familiar with the centre and the residents.

Registration Regulation 4: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of the centre. The application was submitted to the Office of the Chief Inspector in a timely manner and included the information set out in Schedule 1 of the Registration Regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulation and was found to be knowledgeable of the regulations and standards, and of their roles and responsibilities within the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels in the centre were found to be in line with the whole time equivalents (WTE's) outlined in the centre's statement of purpose. Staffing levels on each day of inspection were sufficient to meet the collective and individually assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Supervision of staff practices required review, as evidenced by the following;

- inspectors observed a knowledge deficit in relation to the correct use of PPE. For example, the inspector observed staff not adhering to the correct procedures when caring for a resident with suspected COVID-19 infection. On one occasion staff entered the isolation room without any PPE. On another occasion, staff attended to the resident wearing insufficient PPE. The inspector observed staff donning (putting on) and doffing (taking off) PPE incorrectly

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was maintained in accordance with the requirements of the regulations.

Judgment: Compliant

Regulation 21: Records

The following residents' records were not available in the designated centre on the days of inspection;

- a record of any incident of pressure ulcers and of treatment provided to the resident; as discussed under Regulation 6: Healthcare, daily notes did not always include detail on the management and treatment of residents' wounds
- a record of each drug and medicine administered signed and dated by the nurse administering the drugs and medicine; there were gaps in some medication administration records
- a record of the resident's decision not to receive certain medical treatments and a record of any occasion where a resident refuses treatment; some continuous gaps seen in medication administration records were explained by staff as a refusal by a resident to take certain medications, however, there was no associated notes made to confirm this
- an accurate record of worked rosters was not available, for example, agency staff were not reflected on the rosters provided for review.
- records of all money or other valuables deposited by a resident for safekeeping or received on the resident's behalf
- a record of each test of the fire equipment; no records of the servicing or testing of the emergency lighting system since October 2022 were available.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had an up-to-date contract of insurance which was due for renewal on 31 May 2023.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place in the centre were not stable and not clearly defined. The senior management team had seen a number of changes in the previous months, with further changes advised during the inspection. The provider, Aperee Living Ballygunner Limited, comprised of only one director.

The availability and access to the director was limited and the current lines of authority and accountability were not clearly defined. Issues of serious regulatory concern had not been fully addressed, and additional issues were identified during this inspection, which further evidenced that the management structure in place was not sufficient to provide a safe service. For example,

- works to address fire safety issues in the centre had not commenced. This was in spite of a number of commitments from the registered provider that works were to have started in mid April 2023.
- wound care audits did not identify the issues seen on inspection, as discussed under regulation 6: Healthcare. The data collected was not accurate, and therefore the information could not be relied upon, and appropriate quality improvement plans were not put in place
- audits carried out by nursing staff after days one and two of inspection identified that a number of wounds and skin integrity issues had not been identified previously or did not have supporting care plans and had not been referred to tissue viability specialists. Records were not available to identify action to mitigate these issues. This information had not been escalated for the attention of senior management.
- resources were not sufficient to ensure the safety of residents in the centre in relation to fire risks in the centre. The provider had arranged for an external consultant to conduct a fire safety risk assessment of the premises in January 2022. This assessment identified a number of high and medium fire safety risks in the centre. The inspector found that a number of these risks had yet to be addressed on the day of inspection and many of the issues remained outstanding. These were further discussed under Regulation 28: Fire precautions.
- prior to the third day of inspection, management had identified deficits in relation to the supervision of staff leading to poor practice in relation to wound care and other skin integrity issues. Action taken to address these issues was in progress.
- the systems in place for the management of residents finances required immediate action to ensure the service provided is safe, appropriate, consistent and effectively monitored. The current systems in place were wholly inadequate and did not ensure residents were safeguarded from financial abuse.

In addition, there were significant concerns about the availability of sufficient resources to ensure the effective delivery of care, in line with the statement of purpose. A review of the banking records showed residents monies were used on a number of occasions to pay the ongoing costs of running the centre. Whilst this money was returned to the account, this was not an appropriate or correct use of residents monies and did not ensure that residents monies were protected.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of three residents' contracts of care were reviewed. These were seen to be agreed on admission to the centre and included the terms on which the resident resides in the centre, including the terms related to the bedroom to be provided and the number of other occupants of the room.

Judgment: Compliant

Regulation 3: Statement of purpose

An updated statement of purpose was available in the designated centre which contained the information set out in Schedule 1 of the regulations. However, details of the updated structure was not included.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the centre's accident and incident log confirmed that the provider had notified the Chief Inspector of incidents set out in Schedule 4 of the regulations within the required time frames. All submitted notifications were well managed in line with the centre's own policies and procedures.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place and up-to-date in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life in Aperee Living Ballygunner, aided by a team of staff who were respectful and kind. Residents' independence was promoted insofar as possible, and residents told inspectors that they were consulted with about how they wished to spend their days. There was evidence that residents had opportunities to participate in activities of their interest, and had access to good medical care. Nonetheless, inspectors found that improvements were required to ensure that residents were in receipt of a high level of evidence-based nursing care, particularly in relation to the management of wounds, and the management of pressure-related and incontinence-associated skin conditions. Additionally, inspectors found that significant improvements were required in the management of residents finances and ensuring residents rights were fully met.

There were established cleaning schedules and procedures in place, and in general, the centre was cleaned to a high level. There was two cleaning staff on duty each day to ensure this level of cleanliness. Residents' bedrooms, corridors and most communal areas were seen to be clean on each day of the inspection. Deficits to the premises did not promote good infection prevention and control practices, for example, scuffed and worn surfaces on furniture and equipment which could not be effectively decontaminated and cleaned. These were repeat findings from the previous inspections in November 2022, however there had been no attempt to rectify the issues found, as detailed under Regulation 17: Premises. Significant improvements were required in relation to the infection prevention and control procedures in the centre. For example, inspectors observed improper use of PPE, which had the potential to impede on the containment of infectious diseases such as COVID-19.

Residents had good access to GP services and medical notes showed regular reviews by their GPs, including quarterly reviews of medications to ensure best outcomes for residents. Multi-disciplinary team inputs were evident in the care documentation reviewed. Timely referrals were requested to specialist services such as psychiatry of old age, dietician, speech and language therapy, optical and dental services. However, the specialist input of a tissue viability nurse was not always sought when required, and this resulted in delayed wound healing. Additionally, the advice that was given following a review by the tissue viability nurse, was not implemented and did not inform part of the residents care plan. Regulation 6: Healthcare outlines the detailed findings in this regard.

A system of electronic care planning and documentation was used by staff. As identified earlier in the report, the daily records maintained by staff did not provide consistent detail in relation to the resident's overall health and treatment provided. Assessment and care planning records were viewed by inspectors. Assessments carried out by nursing staff included a range of validated clinical assessments such as risk of wandering, falls and malnutrition. These were generally found to be well-developed and detailed the individual interventions required to meet the resident's individually assessed needs. There was inconsistency in some care plans with regard to the timelines in which they were reviewed, and some had not been updated within the four-month time period outlined in the regulations. Medication management practices were reviewed by inspectors and while good systems in

relation to the ordering, storing and administration of medications were in place, further strengthening of the procedures around transcribing of medications was required, to minimise the risk of medication-related errors occurring.

Restraint use in the centre was well-managed and residents had a full risk assessment completed prior to any use of restrictive practices such as bedrails. Assessments were completed in consultation with the residents and were reviewed regularly to ensure appropriate usage in line with national guidance. Some improvements were required in relation to the management of residents presenting with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), as detailed under Regulation 7: Managing behaviour that is challenging. Oversight and analysis of these behaviours is required, to ensure that all residents are adequately protected and to minimise the use of restrictive interventions.

Inspectors found that the local management team were making every effort to mitigate the existing fire safety issues in the centre, which had been highlighted fully during the inspection of November 2022. One day a week was dedicated to fire safety awareness for staff. The assistant director of nursing held discussions about the importance of fire doors, escape routes and what to do in the event of a fire. The fire alarm was sounded weekly; staff were allocated to each area of the building to check that fire doors were closing correctly on sounding of the alarm. Staff documented if doors were not functioning properly. However, the registered provider did not take action to repair or replace the malfunctioning doors. In addition, Inspectors were informed that a full review of the emergency lighting had taken place in February 2023, however, the registered provider had not put plans in place to address the findings of this review. Staff continued to practice fire evacuation drills, including large compartment evacuations and there was good practice seen in relation to residents' personal emergency evacuation plans, which were up-to-date and detailed each residents individual requirements for evacuation.

A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a safeguarding concern arise. All staff spoken with were clear about their role in protecting residents from abuse. Safeguarding training had been completed by all staff. A sample of staff files reviewed by the inspectors provided evidence that Garda Síochána (police) vetting disclosures were in place prior to commencement to employment. There were systems in place for the safeguarding of current residents' money and personal possessions handed in for safekeeping. The provider did not act as pension-agent for any of the current residents residents. However, inspectors noted that the financial arrangements in place were inadequate to protect finances of deceased or past residents from financial abuse and will be discussed further under Regulation 8: Protection.

Residents rights were predominantly observed to be upheld. Some issues in relation to maintaining privacy and dignity for residents are outlined under Regulation 9: Residents' rights. The inspector found that residents were free to exercise choice about how they spent their day. Residents had access to television, radios, newspapers, telephones and internet connection. Residents had access to a full

activity schedule each day of the week, including weekends. There was dedicated staff in place to support the implementation of the activities programme, and residents who spoke with the inspectors said that they enjoyed the activities on offer. This was echoed in the minutes of residents meetings, whereby satisfaction with the activities programme was a standing agenda item for each meeting. These meetings were held frequently and there was evidence that all suggestions and feedback brought forward by residents was followed up and actioned.

Regulation 11: Visits

The registered provider had made appropriate arrangements to facilitate visiting in the centre. Residents could meet their visitors in the privacy of their bedrooms or in designated visiting areas in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents clothing was carefully laundered on-site. Systems were in place to ensure residents own clothing and soft furnishings such as throws and blankets were identifiable, which minimised the risk of items become misplaced. Within their bedroom accommodation, residents were each provided with appropriate facilities to store their personal possessions and clothing including a lockable storage area.

Judgment: Compliant

Regulation 17: Premises

The actions required following the previous inspection had not been completed, including the following;

- the linoleum flooring in some corridors was torn
- there was water damage to a wall in a laundry store from a former leak
- the wall to the lobby to the laundry store and sluice room was damaged
- the inspector observed some ceiling tiles had been cut to allow down stands for the provision of magnetic devices for fire doors, however in some cases the damaged ceiling tile was not repaired
- the assisted bathroom was now being used for hoist storage, a small first floor dining room as a physiotherapy room, and a nursing office as a store room; these were not reflected on the registered floor plans

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector found that all residents, including those who required a modified diet had a choice of menu at each meal time. Residents were provided with adequate quantities of nutritious food and drinks, which were safely prepared, cooked and served in the centre. Residents could avail of food, fluids and snacks at times outside of regular mealtimes. Support was available from a dietitian for residents who required specialist assessment with regard to their dietary needs.

Judgment: Compliant

Regulation 20: Information for residents

A printed, up-to-date residents' guide was available to all residents. This guide contained all of the required details as specified under the regulation.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspector reviewed residents' records and saw that where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, staff ensured that all relevant information was obtained.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place to inform the management of risks in the centre. This contained reference to the five specified risks as outlined under Regulation 26. There was a major incident emergency plan in place, in the event of serious disruption to essential services.

Judgment: Compliant

Regulation 27: Infection control

The registered provider had not ensured that procedures, consistent with the *National Standards for Infection Prevention and Control in Community Services (2018)* published by HIQA were implemented.

- the inspector observed staff not adhering to the correct procedures for isolation of residents with suspected COVID-19 infection. On one occasion staff entered the isolation room without any PPE. On another occasion, staff attended to the resident wearing insufficient PPE. The inspector observed staff donning (putting on) and doffing (taking off) PPE incorrectly
- on the second day of inspection, there was no clinical waste bin outside the isolation room. Additionally, a clinical waste bin was kept in the nurse's treatment room which was not appropriate
- bags of soiled laundry were found in a bath, inside a communal bathroom. This bathroom was being used inappropriately to store resident equipment such as hoists, cleaning equipment, and laundry trollies
- the carpet in the oratory was deeply stained
- some items of furniture and equipment required repair or replacement as there were breaks in the integrity of the surfaces which did not facilitate effective cleaning and decontamination, for example; bedside lockers, assistive hand rails, cupboard doors and bedrails.

Judgment: Not compliant

Regulation 28: Fire precautions

Works to address fire safety issues in the centre had not commenced. This was in spite of a number of commitments from the registered provider that works were to have started in mid April 2023.

The inspectors noted over three days of inspection that the registered provider was not taking adequate precautions to ensure that residents were protected from the risk of fire, nor were fire precautions being adequately reviewed.

- four red risks, identified in the fire safety risk assessment in January 2022, had not been actioned
- the centres emergency plan had not been updated in line with the centres own fire policy to reflect the identified fire risks
- the inadequate containment to service shafts meant that fire could spread vertically

- hoist batteries units were observed to be loose on the ground and were not appropriately mounted to the wall

The arrangements for providing adequate means of escape including emergency lighting were note effective:

- escape routes were not adequately protected from fire risk rooms due to deficient fire doors
- the external escape route to the rear consisted of a gravel pathway and would not be suitable for evacuation aids or for residents who experienced mobility impairments
- adequate emergency lighting was not provided along all external escape routes
- the directional arrow to an exit sign at first floor was not in the direction of the stairs exit

The arrangements for maintaining fire equipment were not effective:

- fire doors were not being maintained in good working order. Examples of deficiencies included: excessive gaps where double leaf doors met, broken hinges, screws missing to hinges and automatic closers not effective to fully close the door
- there was no documented evidence that the emergency lighting system had been serviced since October 2022

The procedures to follow in the event of a fire were not prominently displayed:

- the floor plans displayed included a 'you are here' and escape routes. They were difficult to read and did not include any procedures to follow
- the floor plans adjacent to the fire alarm panel were small and it was not clear what information was contained within them as they were difficult to read
- procedures were displayed for visitors, however not for staff

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The centre's medication management policy outlines that transcribing of medications should only be done in an emergency. The inspector found evidence that this policy was not followed:

- residents' medication Kardex were routinely transcribed by nursing management
- the transcribed Kardex were not always checked by a second nurse
- The transcribed Kardex were not always signed by the GP. The inspector identified an error which occurred during transcription which led to confusion

with staff regarding the correct dose of a medicine to be adminstered. it was unclear what dose the resident was currently receiving.

There was no systematic procedure for the storage and disposal of medicines no longer in use. As a result, a number of unused medicines were stored in the drug cupboard and the medicines fridge, which could lead to potential errors in administration.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector examined a sample of residents' assessments and care plans and found evidence that these were not always updated in line with the required time frames. It was not always clear if the resident concerned, or where appropriate, their family, had been consulted with in relation to the care plan.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider did not ensure that a high standard of evidence-based wound care was provided for all residents. A review of a sample of residents' wound care records identified the following:

- a resident had sustained a minor wound due to a incident. There was no documented assessment of this wound, and no care plan put in place to ensure that the wound was healing. There were no associated notes made in any of the residents records about the progress of the wound, apart from in the original incident report.
- a resident who had a serious wound, had no care plan in place that supported the healing of the wound. Additionally, there were gaps in the wound assessment and dressing notes, for example, a five day gap in documentation when the wound was due for a change of dressing after three days.
- a resident with a pressure ulcer had been reviewed by a wound care specialist nurse and a recommended dressing was advised. There was no evidence that this dressing was commenced for the resident. Additionally, a review of this residents' documentation highlighted that for a seven-day period, there was no nursing or medical notes made about the pressure ulcer.
- a resident with a pressure ulcer was found to have large gaps in the documentation of the assessment and dressing of the wound. Gaps of five, six and eight days were seen for this resident, despite the assessment

indicating that the wound should be reviewed at a maximum of four-day intervals.
- a wound care specialist nurse had remotely reviewed a residents wound by examining photographs. The advice was to monitor closely as there was a high risk of deterioration, and to re-refer back to the specialist if required. The wound had deteriorated and there was no evidence that the wound specialist nurse had been contacted for advice.
- on the third day of inspection records showed that 10 residents had an incontinence associated dermatitis. Actions to address staff supervision were in progress.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Inspectors examined documentation including care plans for residents identified as displaying responsive behaviours. Alternative interventions and de-escalation techniques to minimise the impact of the behaviour were outlined to be trialled prior to administering medication. However, it was found that this plan was not followed in practice, and that medication had been administered without sufficient assessment and trialling of alternative methods. There was no use of behavioural analysis tools to document the potential triggers and responses to the behaviour, in order to minimise recurrence.

Judgment: Substantially compliant

Regulation 8: Protection

The provider did not take all reasonable measures to protect residents finances as evidenced by the following findings:

- a review of information pertaining to the Aperee Living Ballygunner Limited current account showed that it contained a large sum of money belonging to a number of residents who have passed away and their funds have yet to revert to their estates. Contrary to good practices and assurances given to the Chief Inspector in November 2022, Aperee Living Ballygunner does not have a separate resident client account, therefore residents monies are paid into the centres current account and residents monies remain in this current account. Additionally, there were five current residents who paid their fees monthly by standing order that resulted in a build up of excess monies in the centre current account.
- A review of the bank statements since the start of 2023 showed that the current account regularly went below the amount that is the property of

these residents and which should have been protected for their use. A review of available records suggest that at times residents would not have been able to access their monies should they wish to do so and that their money was used to support the day to day operations of the centre.
- it was seen during the inspection that money was transferred out of the current account in Aperee Living Ballygunner to other accounts and many of these transfers were seen to include residents monies, meaning that the registered provider directed residents funds to be used for purposes other than the residents own use.

Judgment: Not compliant

Regulation 9: Residents' rights

While the dining experience in the centre was generally pleasant, improvements were required to ensure that the residents who had a diagnosis of a cognitive impairment, or who required additional assistance, were afforded the same experience as those residents who were less dependant. For example, tables in the main dining room were nicely laid with place mats and cutlery, however in the area where residents were receiving more assistance, the tables were not laid, and cutlery was piled into the middle of the table. Additionally, in the main dining room, soup was served in bowls, and for residents requiring assistance it was served mainly in beakers. There was no rationale provided for this practice.

Residents' privacy in a small number of rooms was compromised; bedroom windows which faced the main carpark were not adequately protected and any person accessing the car park could see into these bedrooms.

Inspectors identified that residents rights were not being protected in the centre as residents were not made aware that their monies were being used at times to fund the centres day to day running of the centre and residents permission was not sought in relation to this practice.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Aperee Living Ballygunner OSV-0000236

Inspection ID: MON-0037164

Date of inspection: 24/03/2023

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Introduction of IPC Tuesday discussing PPE, Covid, and all IP&C related matters to increase awareness with staff and promote good IPC procedures amongst staff and increase compliance on correct use of PPE. Training is provided online for staff and files have been checked to ensure completion however this will be further supplemented with in house training with ongoing monitoring for compliance and to identify quality improvements.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A full review of resident's skin integrity was completed onsite by DON, ADON and ROM following inspection. This involved TVN input and GP input and in some cases reclassification of skin related issues. All this information was collated and presented to the nursing team and education on care planning and wound management. All associated care plans were updated. This quality review and initiative has resulted in significant reduction in IAD and pressure ulcers within the home and staff have an increased vigilance and knowledge regarding skin integrity and its management. Audits for wound care were reviewed and updated to ensure they reflect current wound management, care plan reviews, record keeping and action plans. A review of resident Kardex's is currently underway. Any resident who refuses medications for three days or more will trigger contact with the resident's GP. Resident	

reason for refusal will be documented in progress notes and reflected using legend on medication administration record sheet by nursing staff on duty. Any changes decided by the GP will be actioned and documented in the resident's progress notes and care plan as appropriate.

Roster review completed and rosters are being accurately maintained and recorded to reflect whom is on duty including any rostered agency staff.

We continue to keep records of all monies and valuables deposited by residents within the home for safe keeping.

Emergency lighting will be updated and maintained to Irish Standard I.S. 3218.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Current Governance and management systems in place is undergoing change/ review to include addition of further Director/s. Management restructure will include a process to provide robust review arrangements and oversight of the service provided in Aperee Living Ballygunner.

The lines of accountability and authority will be clearly defined at individual, team and service level, all staff will be informed of the management structure and facilitated to communicate regularly with management.

The organizational structure will be outlined in the Statement of Purpose.

The management of fire safety, and the systems associated with Fire Safety will be enhanced to ensure the service provided is safe. The Registered Provider is committed to ensure all outstanding risks identified in the homes fire safety risk assessment shall be addressed.

As the required works are implemented, The RPR in conjunction with the Director of Nursing shall take steps to mitigate the issues and implement any controls or improvements identified.

The Provider shall evaluate its safeguarding practices, its approach to identifying, responding to, managing and learning from safeguarding concerns and the resulting outcomes.

A full review of resident's skin integrity was completed onsite by DON, ADON and ROM

following inspection. This involved TVN input and GP input and in some cases reclassification of skin related issues. All this information was collated and presented to the nursing team and education on care planning and wound management. All associated care plans were updated. This quality review and initiative has resulted in significant reduction in IAD and pressure ulcers within the home and staff have an increased vigilance and knowledge regarding skin integrity and its management. Audits for wound care were reviewed and updated to ensure they reflect current wound management, care plan reviews, record keeping and action plans. The nursing team now escalate all skin integrity concerns to senior management for review and input.

Senior management continue to ad-hoc present to the home overnight to supervise staff in their duties. Senior management also work closely during the days to oversee care being provided to residents. Increased education given to staff regarding skin care and skin integrity which has also resulted in significant reduction in IAD/pressure ulcers. This initiative will continue and will be measured through monthly KPIs with the regional operations manager.

The policy for management of personal property, personal finances and possessions has been updated to include the process for managing residents pension agents and deceased residents funds in the centre and the requirement for a resident specific account.

Pension agents and deceased funds arrangements in Aperee Living Ballygunner are being updated in line with National Guidance by the Provider. The process of setting up a resident client account has commenced. On opening of same, any Pension agent's monies or deceased resident monies will be transferred immediately to this designated client account.

In the interim/ timeframe of the opening of this new Resident Client account all residents' monies are protected, and balances monitored by the Accounts Department. Residents' funds will not be used for any other purpose other than the resident's own use.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been updated to reflect the current structure. The SOP is a live document and will be updated to reflect any future changes.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The wall from the lobby to laundry and sluice room has been repaired and painted.

Limonium flooring and stained/damaged ceiling tiles will be replaced as part of planned capitals work. On completion of capital works the floor plans will be adjusted and updated to reflect the current layout of the home.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Introduction of IPC Tuesday discussing PPE, Covid, different infection control procedures to increase awareness with staff and promote good IPC education amongst staff.
Ongoing education on the correct use of PPE including position of clinical waste bins is underway. Staff will be educated regarding the appropriate management of soiled linen.

Training is provided online for staff. Staff files have been checked to ensure completion however this will be further supplemented with in house training with ongoing monitoring for compliance.

As part of our program of capital works the bath will be removed and this room converted to an official storage area with change of use reflected on the updated floor plans. Residents still have access to bathing facilities if requested.

As part of our program of capital works all carpets, furniture and handrails and cupboards will be addressed and plans put in place to replace and/or repair.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider commits and undertakes to complete all outstanding risks identified in the Fire safety risk assessment and recent Inspection findings.

The centre's emergency plan will be updated to reflect identified fire risks.

Hoist battery units will be mounted appropriately to the wall.

The RPR has engaged with a fire safety consultant with a view to updating all floor plans displayed in the centre, ensuring they are clear and outlining procedures to be followed in the event of a fire.

Procedures for fire evacuation for staff have been updated and this will be placed beside the procedures for visitors around the home.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Nurses have received education on medication administration and two nurses will transcribe medication in line with Aperee's policy on medication management. Any transcribed prescriptions will be actioned for signing by the resident's GP in a timely manner.
• A procedure is now in place for the return of unused or out of date medication so that a record is maintained of what and whose medication is returned to Pharmacy and when. This medication will be stored in a designated box, away from in-use medication until returned to Pharmacy.

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:
Care plan and assessment reviews will be conducted 4 monthly with resident input or where appropriate, with the resident's representative. These care plan reviews will be done on Epic and resident/representative consultation will be reflected on each individual careplan update. Careplan audits will be completed on a monthly basis and resident/representative consultation will be reviewed as part of the audit process. Care plan training has also been provided to nursing staff.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All incidents of skin damage will be recorded as such and supported by a wound care plan and dressing plan. This plan will detail the treatment or dressings used, a description of the wound including grading if appropriate and timelines for interventions . Dressings/treatments will be done in line with planned or prescribed timelines and the care plan, progress notes and dressing plan adjusted accordingly. Wound progress will be detailed in each dressing change by the nurse completing the task. Specialist interventions by TVN will be sought and implemented in a timely manner and these interventions will be reviewed for compliance and effectiveness during the wound audits. All MDT referrals will be documented and any changes in wound bed/wound area that indicates deterioration of wound will be acted on by seeking TVN/GP input as appropriate. This skin care initiative has been highlighted to all nursing staff whohave been education on classifications of skin conditions. All care staff have been educated on the management and prevention of IAD with positive outcomes thus far.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Staff have been educated on the use of PRN psychotropic medications to address residents' anxiety/depression/behaviors that may be deemed challenging. Staff have been reminded that any medication administered for indicated use should be used as a last resort and all other interventions as documented in their careplan should be trialed first. ABC chart to be completed indicating interventions trialed and their outcomes. ABC charts completed or any occasion where PRN Psychotropic medications are been used is to be communicated to the senior management team for review. This review will form part of our initiative on restrictive practices.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Resident deceased funds and pension agent arrangements in Aperee Living Ballygunner are being updated in line with National Guidance by the Provider. The process of setting up a resident client account has commenced. On opening of same, any deceased resident monies will be transferred immediately to this designated client account.

In the interim/ timeframe of the opening of this new Resident Client account all deceased residents' monies are protected, and balances monitored by the Accounts Department. Residents' funds will not be used for any other purpose than the resident's own use.

Subsequent to inspection, the accounts department is actively working on returning any deceased residents' monies by communicating with NOK's and solicitor firms.

Residents have been informed that the company is updating its policy and all additional funds (additional funds greater than normal weekly contribution) currently being held in the company main account will be transferred to a separate Resident Client account immediately on the opening of same. Records will be maintained and available. Statements will be provided to residents.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Review of the dining experience will be conducted to ensure that all residents are afforded the same positive dining experience irrespective of a diagnosis of cognitive impairment. The option of taking soup from a bowl, cup or beaker will be discussed with the resident in the context of their will and preference, swallow safety, and promotion of independence. This rationale will be detailed in the resident careplan.

Each resident whose privacy could be compromised in a small number of rooms that face the main carpark, will be met with (or their representative) individually with the purpose of ascertaining their thoughts on the matter.. This feedback will be documented in their care plan and actioned upon as they so wish.

Residents have been informed that the company is updating its policy for management of personal property, personal finances and possessions policy and all additional funds (additional funds greater than normal weekly contribution) currently being held in the company main account will be transferred to a separate Resident Client account immediately on the opening of same. Records will be maintained and available. Statements will be provided to residents.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/08/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/08/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient	Not Compliant	Orange	30/07/2023

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	30/08/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/11/2023
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	30/11/2023

Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Orange	30/11/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Orange	30/08/2023
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.	Substantially Compliant	Yellow	07/07/2023
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in	Substantially Compliant	Yellow	07/07/2023

	accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	03/07/2023
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	30/08/2023
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that	Substantially Compliant	Yellow	30/08/2023

	resident or where the person-in-charge considers it appropriate, be made available to his or her family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/06/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/06/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	31/07/2023

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/07/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/06/2023
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	30/06/2023