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

Issued by the Chief Inspector

Name of designated centre:	Brookvale Manor Private Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Hazelhill, Ballyhaunis, Mayo
Type of inspection:	Unannounced
Date of inspection:	14 October 2021
Centre ID:	OSV-0000325
Fieldwork ID:	MON-0033558

About the designated centre

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

Brookvale Manor Nursing Home is a purpose-built single-storey premises located in a residential area a short drive from the town of Ballyhaunis. The centre is registered to provide long and short term care for 37 residents, both male and female, over the age of 18 years. Twenty-four-hour nursing care is provided. Residents' accommodation comprises of single rooms and double rooms all of which have full en-suite facilities including a shower, toilet and wash hand basin. Adequate screening to protect residents' privacy is provided in the shared bedrooms. The centre has a variety of communal space and the arrangements provide residents with a choice of quiet areas or spaces where they can socialise. There are two large sitting rooms and a dining room to the front of the building, an additional sitting/activity area that is centrally located and a foyer at the front that some residents use to read or to see their visitors. Other rooms include a laundry, sluice facilities, kitchen and staff areas and offices. There is a safe secure outdoor garden for residents to use and this was accessible from several points of the building. It was well cultivated, provided with appropriate seating and had interesting features such as a summer house where residents could sit in the shade.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	30

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 14 October 2021	09:30hrs to 17:30hrs	Catherine Sweeney	Lead
Thursday 14 October 2021	09:30hrs to 17:30hrs	Ann Wallace	Support

What residents told us and what inspectors observed

There were 30 residents accommodated in the centre on the day of the inspection. Overall, residents spoken with stated that they were well cared for and the staff treated them with kindness and respect. Inspectors spent time observing the interactions between staff and residents and found them to be relaxed and respectful.

There had been numerous changes in the staffing of the centre, including the management team, since the last inspection. The provider explained that the staff turnover was due, in part, to the recent reduction in the number of registered beds from 57 to 37. Residents spoken with reported that they found the recent staff changes difficult. They explained that while the majority of staff knew their needs and preferences, some staff were not aware of their routines. Residents reported that they found this frustrating. They added that this issue was compounded by some staff not being fluent in English. This made communicating their needs to some of the new staff difficult.

Inspectors found that the living environment was clean and well maintained. Residents' rooms were observed to be homely and decorated with personal items such as family photos and pieces of furniture. Residents reported finding their rooms comfortable and suitable for their needs. The provider had installed a number of hand washing sinks around the centre which facilitated the staff to maintain appropriate infection control procedures. Staff reported that this was a positive and effective change.

Residents were observed taking part in activities throughout the day of the inspection. An activity schedule was in place and residents were observed to be facilitated to engage in the activities of their choice. Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. While there were a number of small group activities taking place in the communal areas, inspectors observed and spoke with residents who preferred to remain in their bedrooms during the day. From a review of the records, it was not clear how activities were planned to meet the individual social needs of each resident. Furthermore, there was a limited record of the residents level of social engagement on a day-to-day basis.

Residents were overwhelmingly positive in relation to food and mealtimes. Residents spoke of being offered choice at each mealtime and that the quality of meals was consistently high. Inspectors observed the dining room to be decorated in an attractive and thoughtful manner. Tables were prepared in an attractive manner for each mealtime. Residents were also facilitated to have their meals in their rooms if they wished.

Residents had unrestricted access to an internal garden which was observed to be

used on the day of the inspection.

Visiting, in line with national guidelines was facilitated and inspectors observed a number of visitors coming and going throughout the day of the inspection. Staff were familiar with the visitors who attended on the day and made them welcome greeting them and updating them on their loved one's progress.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability of the centre and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Following an outbreak of COVID-19 in the centre in April 2020, three risk inspections had been carried out in this centre. The last inspection took place in April 2021. As a result of the continued non-compliance found on these inspections, the Chief Inspector, through the registration process, had reduced the occupancy of the centre from 57 to 37 registered beds and attached a condition to the registration of the centre which stated:

'Notwithstanding the requirements paced on the registered provider to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, the registered provide shall take all necessary action to comply with
• Regulation 6 Health care Needs
• Regulation 16 Training and Staff Development
• Regulation 23 Governance and Management
• Regulation 27 Infection Control
to the satisfaction of the Chief Inspector no later than 30 June 2021'

As part of this inspection, inspectors reviewed the action taken by the provider to ensure that the conditions of registration were being met.

Overall, the findings of this inspection were positive, with improvement noted in general compliance with the regulations. A quality improvement plan was in place and inspectors found that action had been taken to improve the governance and management of the centre.

While inspectors acknowledge that substantial improvements had been made, further improvement was required in relation to staffing, governance and management, fire safety and protection, to ensure that the service provided was

safe, appropriate, consistent, and effectively monitored.

The organisational structure of the centre had been revised since the last inspection. A newly appointed person in charge was supported in the management of the centre by a regional manager. Within the centre, two acting assistant directors of nursing, working in a supervisory capacity, support the person in charge, providing nursing oversight and supervision.

The provider was in the process of introducing a number of new governance systems such as electronic auditing, revised policies, risk management systems, and staff training record keeping which were found to have improved the overall governance of the centre. A record of staff meeting notes were available for review on the day of the inspection. These meetings were used to communicate issues such as clinical and environmental audit results, falls prevention and infection prevention and control updates.

The management team informed the inspectors that there was frequent governance meetings to discuss, plan and review the ongoing quality improvement plan for the centre. However, there was no documented governance meeting notes available for review. It was therefore difficult to review the progress that had been made in relation to the quality improvement plan, any outstanding actions, the persons responsible, or any review of interventions that had been completed. This was particularly evident in relation to the recruitment and retention of staff and the impact of this on the residents in the centre.

A review of staffing in the centre found that staff turnover was high. Inspectors acknowledged that staffing levels had been reduced in line with the reduced occupancy of the centre. However, a review of the recruitment and leaver records, and the staffing rosters found that found that:

- the level of staff turnover was high. Staff changes included members of every department including management.
- the numbers of health-care assistants available did not align with the numbers committed to by the provider in the statement of purpose for the number of residents in the centre.

The impact of this staff turnover was evident when speaking with residents. Some residents told the inspectors that they were frustrated by the changes in the staffing, including within the management team. They explained that some staff were not familiar with their needs and others were not fluent in English.

A review of the training matrix in the centre found that all staff had received mandatory training in fire safety, manual handling, safeguarding of older adults and infection prevention and control. A staff competency assessment had been completed for all staff since the last inspection and a training schedule had been developed to meet the identified training needs of the staff. This included training for nurses in clinical documentation, training in advocacy and residents' rights and training specific to the management of older person care such as the management of falls and responsive behaviours. A review of the residents' files found improved documentation reflecting the effectiveness of the training on quality of the nursing

documentation.

The supervision of care staff had also improved. An assistant director of nursing and an additional clinical nurse manager had been appointed since the last inspection. This increased level of nursing supervision provided oversight and support to the care and support staff.

A review of the complaints management system found that while all complaints were documented and investigated, some complaints did not record the satisfaction of the complainant as required under regulation 34.

Regulation 14: Persons in charge

There was a newly appointed person in charge who was suitably qualified and experienced for the role. The person in charge demonstrated an awareness of their obligations under the Health Act.

Judgment: Compliant

Regulation 15: Staffing

While the number and skill-mix was appropriate to meet the assessed needs of the residents on the day of the inspection, the numbers of available staff did not reflect the staff numbers described in the centre's statement of purpose for the number of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Improvements were noted in the oversight and documentation of staff training records. An up-to-date training record was available to review. Inspectors found that staff had received training commensurate to their role.

Judgment: Compliant

Regulation 23: Governance and management

Action was required to enhance the governance and management including

- stabilising the workforce, including the management team
- oversight of measures to safeguard residents from abuse
- documentation of governance and management meetings
- clear documentation of a quality improvement plan, including actions completed
- fire safety oversight.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints register was in place to record complaints. This register continues to be updated in line with the centre's complaints policy. However, a review of the oversight of the complaints procedure was required as a number of complaints did not record the complainant's satisfaction as required under Regulation 34.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A review of policies in the centre found that all policies required under schedule 5 of the regulations had been updated and were available for review. This was a completed action from the last inspection.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents' needs were being met. However, improvements were required to ensure that all residents were supported and encouraged to have a good quality of life in which they were able maximise their potential and access local services and amenities. This inspection also found that the processes that were in place to protect the residents from abuse were not consistently implemented and two recent incidents had not been managed in line with the designated centre's own policies and procedures. This was a recurrent non compliance from the last inspection.

The inspectors found that care was person-centred and that staff were encouraged

to get to know the residents and to understand their preferences for care and support. However, the high turnover of staff in the past year meant that a number of staff on duty were recently employed and were getting to know the residents and their families. This was reflected in the residents feedback to the inspectors. However, those staff who spoke with the inspectors were knowledgeable about the needs of the residents for whom they were providing care. Staff understood the importance of support from families and friends in each resident's ongoing life in the centre and staff made visitors welcome in the centre on the day of the inspection. Inspectors were assured that visiting was managed in line with the current guidance.

Nursing and care staff attended a handover at the start of each work shift where they received an update on each resident and any changes in their health or well-being or to their usual daily routines. Nursing staff liaised with the housekeeping and catering teams in relation to any changes that were relevant to their departments. As a result, staff were clear about what was expected of them in their work and were observed to work well together as a team. This helped to create a calm and pleasant atmosphere for the residents.

Staff were respectful in their interactions with the residents and were seen to maintain a calm and friendly approach with residents and their visitors. The inspectors observed however that when one resident displayed responsive behaviours, the care staff who was assisting them was unable to calm the resident or distract them. A more experienced member of staff intervened promptly and was able to support the resident through their anxiety by distracting them and walking with them to the lounge to listen to some music. The centre was working towards a restraint free environment and there was clear evidence that progress had been made to reduce the number of bed-rails in use since the last inspection.

Each resident had a comprehensive assessment of their needs prior to their admission to ensure that the designated centre was able to meet their needs and to organise equipment and support prior to their admission. The assessment was completed on admission and used to develop a care plan with the resident and their family. Overall, care plans were comprehensive and person centred. However, resident's social care plans did not clearly identify their needs and abilities or preferences, especially in relation to those younger residents who wished to go out into the community and access local services and supports. The provider had acknowledged the need to improve in this area and was in the process of arranging advocacy and community supports for two residents in the centre.

Residents had access to a general practitioner (GP) from the local practices and out-of-hours GP services were available when needed. Residents saw their GP for reviews and if their needs changed. Residents had access to wider health and social care services such as physiotherapy, occupational therapy, dentist and optician. However, the protocol for referring a resident with nutritional needs to dietetic services was not clear and one resident whose nutritional risk had increased had not been referred in a timely manner. In addition, another resident had not been facilitated to attend a follow-up hospital review and had been removed from the

waiting list.

Inspectors observed that the centre was clean and odour free on the day of the inspection. The housekeeping staff who spoke with the inspectors were recently employed and were settling into their roles. House keeping staff were knowledgeable about cleaning schedules, cleaning products and appropriate infection prevention and control practices.

Overall, infection prevention and control (IPC) processes had improved since the last inspection; however, further improvements were required as discussed under Regulation 27. The inspectors were satisfied that the provider had an IPC quality assurance and improvement plan in place. This included a clinical nurse manager scheduled to attend additional IPC training so that they could become the IPC lead for the centre in line with the National Standards for Infection Prevention and Control in Community Services 2018.

There were comprehensive fire safety precautions in place and the provider was in the process of carrying out a fire safety risk assessment of the service.However, not all staff who spoke with the inspectors were clear about the procedure to take in the event of a fire emergency. The provider was required to carry out a simulated night time evacuation drill as part of their fire safety risk assessment following the inspection. Improvements were also required in the visual checks of fire doors as inspectors observed one fire door needed repair which had not been identified by staff working in the centre.

Inspectors acknowledged the commitment of the provider to ensure that each compartment in the centre accommodated no more than eight residents to ensure that each compartment could be safely evacuated in the event of an emergency.

Regulation 26: Risk management

The recording of incidents did not include a record that the learning following a serious incident had been communicated to the relevant staff and implemented in practice.

Judgment: Substantially compliant

Regulation 27: Infection control

Overall infection prevention and control practices had significantly improved since the last inspection. However, further improvements were required to ensure full

compliance with Regulation 27;

- There was no clear Infection Prevention and Control lead person in the centre.
- A small number of staff did not comply with the 5 moments of hand hygiene at all times.
- Plastic aprons stored in the personal protective equipment (PPE) stations were seen trailing against the hand rails along a number of the corridors.
- There were not sufficient wall mounted hand sanitisers along one corridor at the rear of the building.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required in the measures that the provider had in place to ensure the safety of residents in a fire emergency;

- Not all staff who spoke with the inspectors were clear about the procedure to follow in the event of the fire alarm sounding in the building.
- The intumescent strip on one fire door was not securely fixed into place and did not ensure that the fire door would prevent the spread of smoke and flames in the event of a fire in this area. This was repaired at the time of the inspection.
- There had not been a periodic check completed of the electrical installations in the designated centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Each resident had a comprehensive assessment of their needs prior to their admission and on their admission to the designated centre.

Overall, care plans were person centred and up to date. Care plans described the residents' current needs, their self-care abilities and their preferences for care and daily routines. Improvements were required into the assessment, planning and recording of each resident's social care needs and this is discussed under Regulation 9.

Judgment: Compliant

Regulation 6: Health care

A review of appropriate access to health-care in line with residents identified needs was required. For example, one resident had been removed from a waiting list for follow-up orthodontal review although the resident had not made this decision. This had not been followed up by nursing staff.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Some staff working in the designated centre did not have the appropriate knowledge and skills to respond when a resident became anxious and displayed responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Judgment: Substantially compliant

Regulation 8: Protection

Measures to protect residents from abuse had not been implemented in line with the centre's own policies and procedures. Two incidents had occurred in recent weeks that may have constituted abuse and these had not been followed up in line with the centre's own policies and procedures.

In addition, a recent management audit found that two members of staff did not have adequate knowledge in relation to safeguarding and there was no record that this had been addressed with the relevant staff.

Judgment: Not compliant

Regulation 9: Residents' rights

Facilities for occupation and recreation were not aligned to a person-centred care plan to describe each resident's preferred activities, types of entertainment and their access into the local community. In addition, the records for what activities each resident had taken part in each day were not available on the day of the inspection. As a result, inspectors were not assured that each resident was consulted about and

provided with opportunities to participate in activities in accordance with their interests and capacities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brookvale Manor Private Nursing Home OSV-0000325

Inspection ID: MON-0033558

Date of inspection: 14/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: S - A thorough review of the SOP has been completed which now reflects the staffing complement for 37 residents. This includes a graduated increase from 32 to 37 residents. M – Through review and in compliance with our SOP and the needs of the service. A – By the in house management team. R – Overview by the regional team in conjunction with the RPR. T – 1st November 2021	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: S- A full review of the staff team has been completed. A plan is in place and staff who left the service when bed numbers reduced to 37 have been invited to reapply to all future vacancies. The Regional Director and RPR provide ongoing support to the Director of Nursing though in-person and virtual meetings. Clinical governance meetings are held monthly to provide support and oversight and issues such as safeguarding, fire safety and quality improvements for example are reviewed, actioned, and documented accordingly. Action notes are taken of each meeting and used to inform the action plan going forward. M- Through improvements in the service, review of the documentation ensuring actions are completed A – By the in house management team. R – Overview by the regional team in conjunction with the RPR. T – 30th November 2021 and ongoing	

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
S – Complaints are discussed as part of the monthly governance meetings and any learning identified is used to inform future practices within the centre. The level of satisfaction of a complainant is now recorded as per Regulation 34 in advance of a complaint being closed.
M – Through learning to improve quality of service delivered
A – Through audit and review.
R – Realistic
T – 1st November 2021

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
S – All incidents are reviewed during monthly governance meetings and all identified learnings highlighted. Staff now receive education and training on the learning identified to ensure the actions are implemented in practice. All learning from incidents will be clearly documented in the incident report before the incident is closed.
M – Through learning to improve quality of service delivered.
A – Through audit and review.
R – Realistic
T – 1st November 2021

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
S- The centre’s IPC-Link nurse has completed a dedicated IPC course. Update training has been provided to all staff to cover the 5 moments of hand hygiene. Staff have been re-educated on the correct position of aprons to prevent cross infection. Additional wall-

mounted alcohol hand gel dispensers are now in place
M – Through enhanced monitoring.
A – Through audit, reflection, and learning.
R – Overview by the regional team.
T – 30th November 2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
S- In-house fire safety practices have been escalated to weekly to ensure all staff have good understanding of what to do if the fire alarm sounds. The intumescent strip identified by the inspector was replaced on the day of inspection. A weekly audit of all fire strips is now in place to monitor and identify any deficient. The number of residents in our largest compartment is 8 and simulated evacuation drills have been completed with all staff during the day and at night. A full review will be arranged by a competent person on the electrical installations of the centre.
M – Through learning to improve quality of service delivered.
A – Through audit and review.
R – Realistic
T – 1st November 2021 (and 31st December 2021 for completion of review of all electrical installations)

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
S- All residents' nutritional risk assessments are monitored by the Director of Nursing. Any resident at nutritional risk is referred to the Dietitian and the GP. The resident identified in the report had been referred prior to the inspection, was on ongoing review and had identified interventions are in place. All follow up appointments identified for residents will be discussed with the resident and their next of kin. Any appointments which have been cancelled of removed from a waiting list will be fully documented and followed up accordingly.
M – Through enhanced monitoring.
A – Through audit, reflection, and learning.
R – Overview by the regional team.
T – 30th November 2021

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:
S- A comprehensive review of staff training needs in relation to responsive behaviours including resident communication of physical discomfort and supervision has been completed. Training has been arranged for staff where deficits have been identified. Observation sessions are completed weekly using the QuIS tool to monitor the interventions identified.
M – Through enhanced monitoring.
A – Through audit, reflection, and learning.
R – By the in house management team
T – 30th November 2021

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
S- Education and training was provided to the Director of Nursing and the nursing team in relation to safeguarding which focused on the identification of all incidents which could be identified as a safeguarding incident.
M – Through enhanced training for identified staff by the safeguarding trainer
A – Through audit, reflection, and learning.
R – By the in house management team supported by the Regional Director
T – 30th November 2021

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
S- A full review and re-assessment of residents has been completed to identify each residents occupational and recreational needs. Training has been provided to the therapy assistant to ensure she has a good understanding of documentation which includes consultation with, and participation of residents in activities which meet their interests and capacities.
M – Through learning to improve quality of service delivered.
A – Through audit and review.

R – Realistic
T – 30th November 2021

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	01/11/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	30/11/2021

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	01/11/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/11/2021
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	Yellow	01/11/2021
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	31/01/2022

	testing fire equipment.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	01/11/2021
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	01/11/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure	Substantially Compliant	Yellow	01/11/2021

	that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	30/11/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/11/2021
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/11/2021
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/11/2021
Regulation 9(2)(b)	The registered	Substantially	Yellow	30/11/2021

	provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Compliant		