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:	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:	20 April 2021
Centre ID:	OSV-0000325
Fieldwork ID:	MON-0032442

About the designated centre

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

Brookvale Manor 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 57 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:	34

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
Tuesday 20 April 2021	19:00hrs to 22:30hrs	Catherine Sweeney	Lead
Wednesday 21 April 2021	08:30hrs to 17:30hrs	Catherine Sweeney	Lead
Tuesday 20 April 2021	19:00hrs to 22:30hrs	Brid McGoldrick	Support
Wednesday 21 April 2021	08:30hrs to 17:30hrs	Brid McGoldrick	Support
Wednesday 21 April 2021	08:30hrs to 17:30hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic at a time when national public health restrictions were in place. Contingency arrangements in place in the centre included dividing the centre into two units (pods) with residents and staff allocated to these pods and remaining within these pods at all times. Limited on-site visiting was observed to be facilitated on the days of the inspection. While visiting times had been restricted due to a delay in staff vaccination, the provider gave a commitment that visiting would be facilitated in line with the Health Protection Surveillance Centre (HPSC) visiting guidelines within a week of this inspection.

Some residents spoken with told the inspectors that they were happy in the centre. Inspectors observed improvements in the opportunities for residents to engage in activities and social engagement. Residents were observed enjoying card games, music and dancing. Some residents were observed outdoors availing of the secure internal courtyard. One resident reported that his television was very small and that there were few channels available for viewing.

There was a number of younger residents with complex health and social care needs accommodated in the centre. Inspectors observed that one of these residents remained in their room with little to do and that there was a requirement for a specific programme designed to help that resident's specific rehabilitative needs.

Resident’s bedrooms were observed to be decorated in a person-centred manner. A programme had commenced to replace the carpets in the centre and the day room floor had been upgraded since the last inspection. The communal areas in the centre were appropriately decorated with comfortable furnishings.

Capacity and capability

This was an unannounced risk inspection by inspectors of social services to follow up on the compliance plan submitted by the provider following poor inspections in November and June 2020 and to assess information submitted by the provider in response to a notice of proposed decision to reduce the number of residents living in the centre as a result of the identified levels of poor regulatory compliance and concerns about the provider's ability to safely care for a large number of residents.

During this inspection inspectors also followed up on issues identified in solicited and unsolicited information received by the Chief Inspector since the last inspection. The Chief Inspector had received three notifications in relation to serious incidents in the centre. Inspectors followed up on the investigation of these incidents and the actions taken to share any learning identified and strengthen the systems in place to

ensure the safety of residents.

On a positive note, the centre had recovered from two COVID-19 outbreaks and on the days of this inspection there were no residents with COVID-19. The centre had been divided into two independently staffed pods with each pod clearly defined with separate staff entrances and facilities. Each pod accommodated 17 residents. The person in charge and the assistant director of nursing were responsible for care delivery over the two pods. On the day of the inspection each pod was staffed with one staff nurse and five carers. There was also a social care facilitator, an activities therapist and a cleaner for each pod. The kitchen staff supported both pods. Each pod had a dining room where residents could dine and meals were also served in residents bedrooms, if requested.

The person in charge reported to a management team including a regional manager, a compliance manager and the company's chief operating officer, all of whom were involved in the management of the centre. However, the lines of authority and accountability in relation to the persons participating in the management of the centre were not always clear.

An on-going recruitment programme was in place. The person in charge was supported in the centre by a newly appointed assistant director of nursing and a team of nurses, five of whom had been recruited since the last 6 months. In addition, there had also been a significant numbers of new care, cleaning and catering staff recruited.

Notwithstanding the improvements set out above, the governance and management of the centre remained poor and did not provide assurance that the management structures in place was clearly defined or that the provider had appropriate systems in place to ensure that resident care was safe, appropriate, consistent or effectively monitored.

Key concerns included the following;

- lack of an effective system to support the induction and probation of all new staff. For example, induction records did not evidence a robust process to asses the competence of new staff in key aspects of resident care. In addition there was no evidence that identified deficits in the performance of existing staff were addressed with additional training or education offered, where necessary.
- failure to recognise and plan for the challenges in a significant program of staff recruitment over a short period of time
- poor staff supervision with staff on duty at the time of an adverse event for a resident unable to provide an accurate history of the event
- failure to provide accurate information resulting in delayed medical care for a resident

Following the inspection in November 2020, the provider committed to reviewing the training and development records of staff. While improvements were found in how staff training was recorded, significant numbers of staff did not have up-to-date training in manual handling techniques and fire safety. Training gaps were also

found safeguarding vulnerable adults, infection prevention and control, and the management of responsive behaviours. A training schedule was in place for 2021, however the completed training record did not reflect the information on the schedule.

Repeated non-compliance with governance and management was found on this inspection. This was evidenced by:

- inadequate risk management systems:
- inadequate fire safety management
- poor notification of incidents
- poor complaints management
- poor incident management
- poor policy management
- inadequate incident and accident investigation.

Regulation 15: Staffing

A review of the rosters found that they accurately reflected the staff in the centre on the day of inspection. This is a completed action since the last inspection. An increased number of cleaning staff allowed for adequate cleaning of both pods. The centre was found to be visibly clean on the day of the inspection.

A review of the staffing detail submitted by the provider as part of a representation was review and found to accurately reflect the staffing available in the centre.

This issue has been addressed since the last inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Following the last inspection the provider gave a commitment to complete an assessment of staff competencies. The record of this assessment was poorly documented and did not inform the development of an appropriate training schedule.

A review of resident documentation relating to a number of high risk incidents in the centre found significant gaps in nursing knowledge including

- poor infection control assessment
- inadequate understanding of advocacy/ residents' right's assessment and care planning

- poor assessment and clinical decision making following an injury to a resident

Inspectors also found that there was a lack of oversight and supervision in relation to the nursing team's assessment of adverse incidents and to the assessment of residents whose condition was deteriorating. Improved clinical supervision, oversight and support was required.

Judgment: Not compliant

Regulation 19: Directory of residents

A review of the directory of residents found that the information for some residents was inaccurate and incomplete. For example, a number of residents were documented as having been transferred to hospital without a return date being entered. Inspectors found that some residents codes were duplicated, making it difficult to assess the accuracy of the information recorded in the directory.

Judgment: Not compliant

Regulation 22: Insurance

Inspectors reviewed an up-to-date insurance certificate for the centre and found that it contained the requirements under regulation 22.

Judgment: Compliant

Regulation 23: Governance and management

The organisations structure in the centre was not always clear. The lines of authority and accountability were not clear. For example, a review of the complaints log found that the compliance officer participated in the investigation and management of a number of complaints in the centre, contrary to the centre's own policy. Furthermore, a review of the meeting records in relation to the management of a recent COVID-19 outbreak, the compliance officer is identified, on more than one occasion, as the ' director of nursing'.

The management systems in place to monitor care, such as audits, did not include a documented quality improvement plan. This meant that there was no way to review if actions taken are effective and result in improved outcomes for residents.

Inspectors reviewed the management of risk and found it to be poor. The risk

register contained generic risks that had not been reviewed. Inspectors found that significant risks in the centre had not been identified and managed in the risk register in line with the centre's risk management policy. These included

- fire safety systems
- Infection prevention and control
- risk to residents' rights from restrictive practice
- Supervision, training and development of staff

Repeated non-compliance with governance and management was found on this inspection as a consequence of this. This was evidenced by:

- inadequate risk management systems:
- inadequate fire safety management
- poor notification of incidents
- poor complaints management
- poor incident management
- inadequate incident and accident investigation.
- policies such as complaints, absconsion and fire safety required review.

Judgment: Not compliant

Regulation 31: Notification of incidents

Continued non-compliance was found in the notification of incidents from the centre. This was evidenced by

- late submission of two notifications
- an incident involving a resident who required hospital treatment following a fall was not notified to the Chief Inspector. A notification was submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints policy found that the procedures documented did not reflect the complaint's management practice in the centre.

A review of the complaints register found that detail relating to the follow-up of complaints with the complainant, the satisfaction of the complainant and any learning identified from complaints was not documented in the complaints register as required under regulation 34. Therefore there was no assurance that the issues

which gave rise to individual complaints would not be repeated.

The complaints policy had not been updated to reflect the changes in the personnel responsible for managing complaints.

Judgment: Not compliant

Quality and safety

Overall, the quality and safety of care delivery in the centre was found to be poor. Actions committed to by the provider following the last inspection had not been completed. Inspectors found repeated non-compliance's in infection prevention and control, fire precautions and health care. Further non-compliance was found in residents' rights.

The provider had not completed a risk assessment in relation to the restrictive practices in place for some residents in the centre. There was no plan in place to ensure that younger residents with complex health and social care needs had a care plan that included a pathway to independent living and appropriate accommodation. Referral to external social service support and advocacy for these residents was required.

Some improvement was noted to the documentation of residents progress notes, assessments and care plans. However, significant improvement was required in nursing assessment of resident's health and social care needs. For example, while every resident had their basic health care needs such as washing and dressing, eating and drinking and maintaining a safe environment assessed, a review of documentation found that assessment of residents following an incident or the assessments of a residents advocacy needs were not identified or developed in the residents care plan. Inspectors found that the nursing record of a resident's health and condition and treatment given did not provide the information required to ensure clear communication and positive outcomes for residents.

A review of a sample of resident's files found that residents had access to a general practitioner (GP) of their choice. However, access to a physiotherapist had been reduced to one visit every two weeks. This was not adequate to meet the mobility needs of the residents in the centre. In addition, a number of residents who were recovering from injury or with complex rehabilitation needs did not have access to occupational therapy.

The centre was relatively clean on the days of the inspection. Staff had access to appropriate personal protective equipment and alcohol hand gels. Access to hand hygiene facilities remained limited.

Following the last inspection the provider had committed to sub-divide the centre into two zones, now called pods. A dedicated isolation area for residents with a

positive and suspected diagnosis of COVID-19 was also available. The centre had recruited cleaning staff to ensure that each sub-divided area had allocated housekeeping staff. This was a completed action from the last inspection.

While a contingency plan was in place for the prevention and control of COVID-19, inspectors found that there was no plan in place for the recognition and management of an on-going possible outbreak of an unrelated infection.

The provider had not taken adequate precautions to ensure that residents were protected from the risk of fire or ensure adequate systems were in place to ensure the safe and effective evacuation of residents. Following the last inspection the provider had committed to have a full fire risk assessment by a suitably qualified profession completed and that all fire maps within the centre would be refreshed, that policies, procedures and resident evacuation plans would be reviewed and updated. These actions were not completed.

Regulation 27: Infection control

A number of residents in one of the pods in the centre had developed a potential infectious condition unrelated to COVID-19. Some of these residents had been seen by their doctor and care plans had been put in place. However, there was no evidence that nursing staff had considered the possibility of a potential infectious outbreak, no plan to address the potential infectiousness of the rash, or to assess the risk to residents, staff and visitors. This was an on-going issue since December 2020 with eight residents affected.

A programme had been put in place for cleaning carpets however, there was no co-ordinated system or provision of resources to complete the deep clean required in bedrooms with carpets.

There were insufficient clinical hand hygiene sinks available.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors reviewed the documentation in relation to fire safety in the centre and found that they did not meet the requirements under regulation 28. This was evidenced by

- fire risk assessments were not available for review
- fire drill record were not available for review on the day of the inspection. A drill record, completed following the inspection was subsequently forwarded to the Chief Inspector

- fire safety procedure notices around the centre contained inconsistent information. For example, the prefix to get an outside telephone line differed on three posters. This was of concern in light of the numbers of new staff and a repeated non-compliance from the last inspection.
- personal emergency evacuation plans (PEEP) detail did not reflect the assessed needs of residents.
- PEEP's were not located in a file accessible to all staff at all times.
- fire plans on display in the centre did not identify the size or layout of the compartments used to contain the spread of fire.
- the fire panel in the centre was located within a locked nurses station, this would reduce the response time in the event of a fire
- unused bedrooms were key locked and the keys were stored in a key box beside the fire panel. This meant that, in an emergency, staff would have to find the key of the room where the fire sensor had been triggered before attending to the fire. This could cause a delay in responding to an emergency.
- no risk assessment had been completed for the wooden smoking shed located within the internal garden
- fire safety induction for new staff did not include an evacuation drill
- staff knowledge of fire safety procedures was poor
- fire safety policy was not centre specific and required review

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Assessment and care plans were in place for each resident. Care plan documentation had improved since the last inspection. All assessments and care plans had been documented and reviewed in line with regulatory requirements.

Judgment: Compliant

Regulation 6: Health care

Inspectors found that gaps in nursing knowledge and process to manage residents with complex health and social care needs, identified on the last inspection in November 2020, had not been addressed. This included

- identification of infection control issues- an ongoing infection control issue, unrelated to COVID-19 had not been adequately assessed and therefore no plan was in place to ensure that the infection was identified, contained and controlled.
- assessment of residents following a fall or adverse incident- a review of the

nursing progress notes of two residents, who had recently sustained serious injuries in the centre, found that poorly documented incident reports and assessment of residents contributed to a delay in medical treatment.

In addition, the residents in the centre did not have access to an occupational therapist.

Judgment: Not compliant

Regulation 9: Residents' rights

Admission and advocacy procedures require review to ensure that younger residents with complex health issues would receive the necessary care and supports.

A review of the management of a resident's personal possessions was required to ensure that a resident retained control over the decisions made about the value of their possessions. Documentation reviewed found that a resident 's dentures had been lost. The issue had been discussed with the resident's dental practitioner and the residents' family, however, a decision was made on behalf of the resident not to replace the dentures. As the resident could not advocate for themselves, it was not clear what steps had been taken to ensure that the decision made was taken in the best interest of the resident.

Inspectors found that for some residents, disproportionate levels of restrictive practice were in place without a clear rationale or assessment of the impact of the restriction on the residents' rights.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Brookvale Manor Private Nursing Home OSV-0000325

Inspection ID: MON-0032442

Date of inspection: 20/04/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: S: All staff competencies have been further assessed using a modified National Carer's Competency Assessment tool from which an appropriate training schedule has been devised. Resident documentation has been reviewed to address assessments in the areas of infection control, advocacy and resident's rights, assessment, and care planning. In addition, all nursing staff are receiving further training to enhance their knowledge of gerontological nursing specific to the nursing home setting including falls management, recognition and management of the deteriorating resident and supporting residents with responsive behaviour. To further enhance the oversight and supervision of nursing staff, an additional AADON has been appointed to support the PIC. M: Through audit and review by the PIC and Regional Director. A: By the PIC and inhouse management team, supported by the Regional Team with onsite training by an specialist educator. R: Realistic. T: 31st July 2021	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: S: The Directory of Residents has been reviewed and updated to rectify any identified errors. To ensure ongoing accuracy and completeness, the directory will be audited monthly against our computerised system and updated on an ongoing basis to reflect any changes to resident information.	

M: Through audit by the PIC supported by the Regional Director.
A: By the PIC and inhouse management team.
R: Realistic.
T: 22nd April 2021

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
S: The complaints policy within the centre is under review and will be updated to acknowledge that a PPIM can participate in the investigation and management of a complaint in the absence of and/or in support of the PIC. All staff have been reminded on the correct lines of authority and accountability within the centre and on the role of the regional management team. The approach to audits is being revised to also include a documented quality improvement plan to assess the effectiveness of actions taken and resident outcomes. Risk management systems will be reviewed and enhanced to include for example an updated policy, risk register and assessments. To enhance governance and management in the areas identified, all relevant policies and procedures are currently being updated to reflect best practice. To support these actions, monthly governance meetings with the PIC, Regional Director and the Chief Quality Officer will be established with an agreed agenda, quality indicators, audit results and action plans. These meetings will be documented and further monitored by the RPR on a monthly basis.
M: Through audit by the Regional Director.
A: By the PIC, inhouse management team, Regional Director and Chief Quality Officer.
R: Realistic.
T: 31st August 2021

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
S: The PIC and RPR will ensure that all notifications are submitted in accordance with the relevant regulatory requirements. Compliance will be monitored at formal monthly governance meetings.
M: Review by the Regional Director.
A: By the PIC.
R: Realistic.

T: 21st April 2021

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
S: The complaints policy within the centre is under review and will be updated to acknowledge that a PPIM can participate in the investigation and management of a complaint in the absence of and/or in support of the PIC. The management of complaints will be the subject of monthly monitoring by the Regional Director and the RPR through a monthly governance meeting to ensure compliance with policy and regulatory requirements to provide assurance that complaints have been addressed and that the issues giving rise to individual complaints would not be repeated.
M: Monitored by the Regional Director and the RPR
A: By the PIC and Regional Director.
R: Realistic.
T: 31st July 2021

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
S1: The IP&C policy of the centre has been revised to ensure staff respond appropriately when any suspected IP&C risk emerges with reports and lessons learned which will be communicated to all staff.

S2: A coordinated approach to carpet cleaning has been introduced and appropriate resources are in place to address the areas highlighted on inspection.

S3: Additional clinical hand hygiene sinks will be installed in the centre.

M: Through review by the PIC, inhouse management team and Regional Director
A: By the PIC, inhouse management team, maintenance team overseen by the Regional Director
R: Realistic

T1: 28th June 2021
T2: 5th July 2021
T3: 31st August 2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
S: An independent fire inspection has been completed by a competent person. A full review of the Fire Management policy and procedures has commenced within the centre to ensure that it is centre specific and to include fire risk assessments, fire drill records, safety procedure notices and enhanced PEEP detail and location. Fire plans have been updated to identify the size and layout of compartments. The coded lock has been removed from the nurses station. The key of unoccupied bedrooms is accessible outside the individual bedroom doors. A risk assessment has been completed of the resident smoking area within the internal garden. An evacuation drill has been incorporated into the fire safety induction for new staff and all staff have been re-educated with regard to fire safety procedures.
M: Through audit and assessment.
A: By the PIC and Regional Director, overseen by the RPR.
R: Realistic.
T: 2nd July 2021

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
S: To enhance nursing knowledge and skill within the centre, a tailored programme of gerontological education that includes IP&C and post fall management, is being delivered onsite by external nurse training specialists.
M: Through the attendance and successful completion of the onsite training
A: By external nurse training specialists
R: Realistic.
T: 31st July 2021.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
S: A review of resident admission and advocacy procedures will ensure that all residents,

including younger residents with complex health issues, receive necessary care and supports. A review of the management of residents personal possessions will reinforce the advocacy for resident decisions in that regard. The use of restrictive practice within the centre is subject to ongoing review to ensure proportionality based upon assessment of the impact on resident's rights. The approach of working towards a restraint-free environment is maintained and the issues identified on inspection specific to one individual resident have been addressed.
M: Through review by the PIC and Regional Director.
A: By the PIC, inhouse management team and Regional Director, overseen by the RPR.
R: Realistic.
T: 17th July 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/07/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/07/2021
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	22/04/2021
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	31/08/2021
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	31/08/2021

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/08/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	02/07/2021
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	Not Compliant	Orange	02/07/2021

	fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	02/07/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	02/07/2021
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	02/07/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in	Not Compliant	Orange	21/04/2021

	charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.	Not Compliant	Orange	31/07/2021
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/07/2021
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate	Not Compliant	Orange	31/07/2021

	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.			
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.	Not Compliant	Orange	17/07/2021
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Not Compliant	Orange	17/07/2021