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:	23 June 2022
Centre ID:	OSV-0000325
Fieldwork ID:	MON-0035407

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:	32

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 23 June 2022	09:25hrs to 19:30hrs	Michael Dunne	Lead
Thursday 23 June 2022	09:25hrs to 19:30hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

Overall, the inspectors found that residents were generally content living in the designated centre. Residents had good opportunities for social engagement and were supported to participate in activities. However, gaps identified with regard to effective pre admission assessments and the provision of person centred care plans meant that the service provided was not always appropriate and responsive to resident need.

The inspectors met with the residents, staff and the registered provider during the inspection. Overall feedback from residents was positive regarding their quality of life and the services that were provided. Residents told the inspectors that they were happy and felt safe living in the designated centre. However, two residents were not content with the service provided and felt that their placement was not well-planned, and did not adequately identify the resources that were required to meet their needs. These concerns were verified on the inspection and inspectors found that some of the services provided were not effective in meeting the needs of individual residents.

On arrival to the centre, inspectors were welcomed by members of the management team. The atmosphere was calm and relaxed. Inspectors observed a number of residents attending activities, whilst others were observed having their breakfast in their rooms. There were activities provided throughout the day. A number of residents were observed engaging in individual activities as well as attending a group exercise class. Residents also enjoyed an afternoon of live music, with residents encouraged and supported to participate.

The centre was a single level designed building located a short drive from the town of Ballyhaunis, Co Mayo. There was a well maintained, enclosed garden available for resident use. Residents' accommodation was arranged in single bedrooms and in twin bedrooms with en-suite facilities. Bedrooms were personalised with photos and personal belongings. Handrails were in place in on both sides of all corridors. The inspectors observed that a number of areas required upgrade and these findings are described in more detail under Regulation 17, however the registered provider was working towards improving facilities and there was a programme of refurbishment in progress.

Inspectors observed a number of sitting rooms which were spacious and tastefully decorated. These rooms were in constant use by residents throughout the day of the inspection. The dining area was clean and well-designed to meet the needs of the residents. There were a number of designated storage rooms in the centre, however the segregation of supplies in these rooms was not effective and inspectors observed that items were not organised and stored appropriately to ensure that good standards for infection prevention and control were maintained.

Inspectors observed that staff wore face masks during the provision of direct care to

residents. Alcohol hand gel dispensers and personal protective equipment (PPE) were readily available along all corridors for staff use.

Resident's were seen to receive visitors throughout the day and those who spoke with the inspectors were satisfied with the arrangements that were in place.

Residents were complementary of the food provided and said that there were always other options available if you did not like what was on the menu. The dining room was well-appointed with sufficient numbers of tables and chairs available for residents to use.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact 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 Centre for Older People) Regulation 2013 (as amended). This inspection also focused on the registered providers actions to address non compliance's with the regulations found on previous inspections, which resulted in a restrictive condition being applied to the current registration, where the registered provider was requested to take all necessary steps to comply with

- Regulation 6 Health care
- Regulation 16 Training and Staff Development
- Regulation 23 Governance and Management
- Regulation 27 Infection Control

Overall, the findings of this inspection indicated that the registered provider had made positive steps to achieve compliance with the regulations, however more focus and resources were required to bring the centre into full compliance and to ensure that the improvements that had been made were sustained. In addition the processes around short term admissions did not ensure that the centre was able to meet the needs of some of these residents.

For example inspectors found that pre admission assessments were not comprehensive which meant that key areas of clinical need such as specialist equipment were not identified before the resident was admitted and as a result some residents did not have access to the specialist equipment they required during their admission.

The registered provider for this centre is The Brindley Manor Federation of Nursing Homes Limited. This company is part of Brindley Health care which consists of a

total of nine nursing homes that operate in Ireland.

The management team consists of a person in charge, two acting assistant directors of nursing and a team of nursing staff, health care assistants, hospitality and catering staff. The designated centre is also supported by activity, administration and maintenance personnel. Additional governance support was provided by a newly appointed associate regional director and by the return of a previous regional director who was well-known to the designated centre.

Inspectors saw improvements in relation to the maintenance of a stable staff team. The management team told inspectors that there was a plan in place to recruit staff in line with staff numbers identified in the designated centre's statement of purpose. A review of the training records confirmed that all staff were in receipt of appropriate training to support them in their roles.

There were also improvements found in governance structures regarding the holding of regular meetings at local and senior management level. However, despite these improvements inspectors were not assured that information collected through monitoring systems such as audits and through internal communication channels were being used effectively to monitor the safety and appropriateness of care and services delivered to residents. In addition inspectors found that risks were not well managed which meant where risks were identified an effective risk assessment was not created to monitor or control the risk.

The complaints records indicated that there were four complaints received since the last inspection in October 2021 with all processed in line with the designated centres complaints policy.

Regulation 15: Staffing

Inspectors found that there were sufficient numbers of staff available with an appropriate skill mix having regard for the needs of the residents and the layout of the centre. A review of the rosters confirmed that there was a nurse on duty at all times in the centre. At the time of this inspection the registered provider was recruiting for three health care assistants and one chef. All gaps on the rosters were found to be covered by internal resources.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had attended mandatory training which included training on fire safety, manual handling and safeguarding. In addition, a review of training records indicated that staff either completed or had access to training in dementia,

medication, care planning, restrictive practice and Infection prevention and control. Staff were aware of their individual roles and responsibilities and felt that training equipped them to carryout their roles more effectively.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors identified a number of gaps in the governance and management arrangements of the designated centre to ensure that the service provided is safe, appropriate, consistent and effectively monitored, these gaps included;

Where a resident is referred for specialist treatment or where additional professional expertise is required that residents have access to such treatment in a timely manner. Inspectors found delays with regard to the accessibility of a tissue viability nursing input in the management of wound care.There was poor oversight regarding the availability of equipment to promote residents rehabilitation requirements.

Comprehensive assessments to identify residents health, person and social care needs did not always clearly identify their needs. This resulted in care plans not being effective in identifying the appropriate interventions to support residents. Inspector's found that there were gaps in the identification of residents communication needs and as such no effective care plan was in place to meet this need.

Arrangements for the identification and mitigation of known risks required greater oversight. Inspectors found that concerns related to evacuation equipment did not trigger a risk assessment or be entered onto the designated centre's risk register.

Additional resources were required to ensure effective delivery of care in accordance with the designated centres statement of purpose, this was evidenced by:

Inappropriate sluicing facilities, inspectors found that the hand hygiene sinks in these facilities did not meet the required specifications. Racking equipment was not available in these areas to facilitate the storing of cleaned equipment.

An area of the designated centre was found not to have fire doors in place to facilitate the containment of fire.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts for the provision of

services and found all contracts reviewed were in an accessible format, and stated clearly the terms and conditions upon which the agreement was made including the type of room offered to the resident. The contracts reviewed were signed and dated and set out the costs of the placement. There was no additional costs charged to residents for the provision of in-house activity services..

Judgment: Compliant

Regulation 31: Notification of incidents

The majority of notifications required to be submitted to the office of the Chief Inspector were done so in accordance with regulatory requirements. However, notification of a restrictive practice used on several occasions, had not been notified in the required time-frame, as required by Regulation 31.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place which was accessible for residents and their families if they wished to register a complaint. The policy set out the steps to be taken in order to register a formal complaint and also identified the timescale for the complaint to be investigated. The policy also incorporated arrangements for feedback to the complainant and an appeals process should the complainant be dissatisfied with the outcome of an investigation.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a quality of life which was respectful of their wishes and choices. There were many opportunities available for social engagement and staff were observed to be respectful and kind towards the residents. However, inspectors found that one resident had not been referred to specialist health care in line with their needs. In addition a number of care plans were not person centred and did not reflect a person centred approach to delivering care and services.

The pre-admission assessment process required oversight to ensure resident needs could be adequately met by the designated centre. Inspectors found that some

assessments lacked detail and did not identify resources required to meet the resident needs. For example : resources to aid communication and medical equipment which was required to support post operative rehabilitation were not always available. This was a particular issue for residents admitted for short term care. This did not support staff to provide person centred care and this did not ensure that the residents social, personal and health care needs were being adequately met.

The inspectors reviewed a sample of residents files and there was evidence that the resident's needs were being assessed using validated tools. Assessments included the risk of falls, malnutrition, assessment of cognition and dependency levels. Care plans were informed using these assessments. However, some records did not include a comprehensive assessment of need. Inspectors also found that some care plans did not provide assurances that they were being completed in consultation with the resident. A number of care plans did not reflect individual preferences, wishes and usual routines, and as such were not person centred.

Residents had regular access to a general practitioner (GP) who visited the centre. There was evidence of access to dietetics services and speech and language therapy. However, inspectors found that where tissue viability specialist consultations were recommended to individual residents, they did not visit residents in the centre and their consultations could not be obtained in a timely manner. This did not ensure nursing staff could provide the most appropriate wound dressing treatments to ensure wound healing.

There was a restraints policy in place. However, restrictive practices were not always completed in accordance with this policy or the national restraint policy guidelines. Oversight was required to ensure alternatives to restrictive practices were trialled and on the creation of effective risk assessment regarding the safe use of bed rail restraints.

Residents had access to an independent advocacy service, information about this service was displayed in the reception area of the centre. Resident meetings were found to be convened monthly basis. Agenda items included Covid 19 ,visiting arrangements, meals and outings. Minutes were reviewed by the person in charge and there was evidence of action plans developed to address suggestions or concerns raised. Residents had access to local and national newspapers, television, radio.

Visiting was facilitated in line with the latest COVID-19 guidance on visitation to residential care facilities.The inspectors observed visitors coming and going throughout the day of inspection . Residents spoke of having regular visitors and identified that they were happy with the arrangements in place.

Residents were observed enjoying a variety of activities on the day of inspection. Residents spoke about a recent outing and were looking forward to more occasions such as these. Residents were also supported to attend sporting events.Residents had access to religious services within the centre and wider community. Residents were supported to practice their religious faiths .There was an oratory in the centre

and mass was held weekly.

Infection prevention and control measures were in place and monitored by the senior management team. Whilst there was evidence of good practices in relation to infection control, further oversight was required in relation to storage of supplies and furniture. There was no system in place to segregate clinical and non clinical supplies which increased the risk of cross contamination. This is discussed further under Regulation 27: Infection Control.

There was up-to-date records in place to monitor fire safety in the designated centre which included the maintenance of fire equipment and of fire detection equipment. Staff were familiar with the fire procedure and had attended fire training and had participated in simulated evacuations. However despite these good practices inspectors found that a set of fire compartment doors which were identified on the designated centre's floor plan were not in place. This meant that there was an extended travel distance to move residents from one compartment to another in the event of fire. At the time of the inspection there were seven residents residing in this part of the building.

Regulation 10: Communication difficulties

The systems in place to ensure residents with communication difficulties could communicate freely required oversight. For example:

- A resident who had communication requirements did not not have those requirements recorded in their care plan.
- Communication resources were not place to support staff to provide person centred care and as direct result some practices observed reflected a lack of understanding of the resident needs.

Judgment: Not compliant

Regulation 12: Personal possessions

There were systems in place to ensure residents had access to and could retain control over their personal property, possessions and finances. Residents had lockable storage in their bedrooms. There was adequate space to store clothing and personal possessions. There were adequate laundry facilities with systems in place to ensure that residents' own clothing was returned to them.

Judgment: Compliant

Regulation 17: Premises

At the time of this inspection there were 35 residents living in the centre, most residents were accommodated in single rooms, with one resident who was the sole occupants of a twin room. A review of the premises found,

- Poor ventilation in an assisted bathroom.
- One toilet had no grab rails or emergency pull cord in place.
- Poor sluicing facilities
- Unsuitable storage facilities.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspectors saw that the daily menu was displayed in several locations within the centre. The menu was varied and included meat and fish dishes. Residents had access to refreshments and snacks at their request. There was evidence of regular discussion about food at resident meetings. Meal times were coordinated to ensure residents had appropriate assistance to enable them to eat and drink where necessary.

Resident nutritional and hydration needs were monitored. Inspectors saw evidence of food intake charts and completion of monthly nutritional assessments. Fluid intake was recorded for individual residents. Residents at risk of weight loss were referred to a dietitian. Additional nutritional supplements were provided when it was recommended by dietitians. Residents who were identified as having swallowing difficulties had access to speech and language therapy.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place which contained details regarding the identification of risk, the assessment of risk and the measures and controls in place to mitigate against known risks. While there was a comprehensive risk register which was maintained by the registered provider,a number of risks were identified by inspectors during the inspection which were not recorded on the register and are discussed under regulation 23 governance and management and under regulation 28 fire precautions. The risk management policy contained all the necessary information to meet schedule 5 of the regulations.

Judgment: Compliant

Regulation 27: Infection control

While some improvements had been made since the previous inspection, the inspector found a number of practices that were not consistent with the standards for the prevention and control of health care associated infections published by the Authority. For example:

- The clinical hand wash sinks in the sluice rooms, laundry and cleaning room did not comply with current recommended specifications.
- Suitable equipment drying racks were not available in either of the two sluice rooms
- Cleaning equipment and chemicals were stored on the floor of the cleaning room which meant floor surfaces could not be adequately cleaned
- In the absence of adequate storage space, a number of vacant bedrooms were being used to store large quantities of mixed medical supplies and furniture . Furniture, equipment and boxes were seen stored on floors in vacant bedrooms, this meant these surfaces could not be adequately cleaned. There was no system for segregation of items stored in vacant rooms, residents equipment was stored with clean and clinical supplies which increased risk of cross contamination.
- Medical waste was inappropriately disposed of in an open bin in a storage room, increasing the risk of cross contamination.
- Some equipment in place for resident's care was worn and therefore could not be effectively cleaned, for example; a pressure relieving cushion.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not taken adequate precautions to ensure that residents could be safely evacuated in the event of a fire emergency. This was evidenced by:

- A simulated evacuation had identified that a ski sheet was not secured to a mattress and as a consequence came loose and detached. This risk was not added to the risk register nor was there evidence that a review of ski sheets had been undertaken by the registered provider.

Inspectors found that the provider had not ensured adequate means of escape in all areas of the building. This was evidenced by:

- A large hole in the ground outside of a fire exit, which was secured by an inappropriate cover and had the potential to cause risk to residents using this

fire exit, in order to gain access to the fire assembly point. The registered provider immediately secured this area with an appropriate safe cover when this was pointed out to them.
- Two single rooms (51 and 52) had fire exits located in these rooms to aid escape in the event of a fire. However, both of these fire exits were unusable due to the current layout of these rooms. Both rooms were unoccupied at the time of the inspection.

The registered provider had not made adequate arrangements for containing fire in a fire emergency. This was evidenced by :

- The current floor plan indicated that there was a set of compartment doors located by rooms 17,18 and 19,20 however on inspection these doors were missing this meant that the existing fire compartment had extended. The registered provider indicated that a new set of compartment doors were to be fitted to reduce the size of the existing compartment.

The provider had not taken adequate precautions to ensure that those residents who chose to smoke were able to do so in a safe environment that protected them and other residents from the risk of fire.

- The smoking shelter did not have a fire blanket in place. Some surfaces of the smoking shelter had not been finished with flame retardant paint.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of resident care plans. Care plans reviewed lacked information detailing the resident or their family's involvement or consultation in the care planning process.

Assessments were completed however, the assessments were not comprehensive and lacked sufficient detail to develop person centred care plans.

Some of the care plans reviewed by the inspector did not include sufficient up to date information in relation to the resident's current needs to provide staff with the information they needed to give safe and appropriate care. For example:

- a resident who was observed exhibiting 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), did not have a responsive behaviours care plan in place.
- a resident who had communicated specific preferences for personal care, did not have these wishes recorded in their personal care plan.
- a residents who was observed to decline certain foods, did not have any food likes and dislikes recorded in their nutritional care plan.

- a resident who had a wound did not have a plan in place to support wound management.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that residents' wound care required oversight to ensure wounds were managed in line with evidence based wound care procedures. Access to this tissue viability specialists was limited to remote consultations. Inspectors found evidence that where tissue viability nurse specialist expertise was recommended, it could not be obtained in a timely manner. This did not ensure nursing staff could obtain the most effective treatment plan, in order to ensure wound healing.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

There was a low level of restraints in use throughout the centre. Records showed that when restraints were considered, a risk assessment was completed. However further oversight was required to ensure that risk assessments were accurate and restraint was managed in line with national policy. For example:

- a risk assessment which had been completed for the safe use of a bed rail, did not include consideration of additional equipment to ensure the bed rail was used safely.
- there was evidence that alternatives to restrictive practices were not trialled on some occasions, therefore the immediate response taken to risk taking behaviour was not always the least restrictive.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had policies and procedures in place to protect residents for all forms of abuse. The safeguarding policy and procedure set out the how allegations of abuse were investigated and identified the measures that were needed to protect residents living in the designated centre. Discussion with staff on

the day of the inspection indicated that staff were familiar with these policies and how to implement them to keep residents safe.

Judgment: Compliant

Regulation 9: Residents' rights

There was an activities schedule in place which was coordinated by an activities coordinator and functional assessment therapist. There were a number of communal and private areas which were available for residents to participate in activities, or to receive visitors. Residents had access to an independent advocacy service.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Not compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brookvale Manor Private Nursing Home OSV-0000325

Inspection ID: MON-0035407

Date of inspection: 23/06/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: S: A review and update of the current system is underway to ensure that residents who require a specialist treatment including the input of a TVN are supported to access same. In the event that this treatment is unavailable in the community, the resident will be referred to hospital for additional support. By 30/8/2022 S: A full review of existing residents' needs in respect of rehabilitation equipment has been completed and all such equipment will be in place for new residents pre-admission. By 30/8/2022 S: Guidance and update training has been provided to nursing staff to inform the completion of assessments and care planning. By 30/8/2022 S: A review of the identification and mitigation of known risks is underway. Following this review, update training will be provided to all staff on risk identification, documentation and management. 30/9/2022 S: Refurbishment of the centre continues and will include the upgrading of hand hygiene sinks to meet the required specifications. By 31/12/2022 S: As already agreed with previous inspectors, no more than 8 residents reside in the largest compartment. Additional fire doors are on order and will be installed by 30/9/2022 M: By the PIC, Associate Regional Director and the maintenance team A: Through review and monitoring of completion by the regional management team R: Overview by the Regional Director in conjunction with the RPR. T: 31/12/2022	
Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: S: All notifications will be submitted in accordance with regulatory requirements. M: By the PIC and in-house management team A: Through review and monitoring by the regional management team R: Overview by the Regional Director in conjunction with the RPR. T: 13/8/2022	
Regulation 10: Communication difficulties	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication difficulties: S: A full review has been completed on the communication needs of all residents. Care plans reflect the outcome of assessment and details all supports required by each resident. S: Training has been provided to the nursing team to ensure their understanding of the importance of identifying residents' communication needs. M: By the PIC and in house nursing team. A: Through review and training support by the regional management team R: Overview by the Regional Director in conjunction with the RPR. T: 30/8/2022	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: S: Rooms 5/6 and 7/8 have converted to single occupancy and provide for residents needs as per the regulations and standards. S: Ventilation in the assisted bathroom has been repaired. S: The toilet without a grab rail has been reconfigured into a male staff changing area and is no longer accessible to residents. S: A full review and declutter of all areas used as storage has been completed. S: Designated storage areas are now in place. M: By the PIC and the maintenance team A: Through review and monitoring of completion by the regional management team R: Overview by the Regional Director in conjunction with the RPR. T: 31/8/2022 .	

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
S: Refurbishment is ongoing in the centre which includes the upgrading of hand hygiene sinks to meet the required specifications. By 31/12/2022
S: Drying racks have been replaced in both sluice rooms.
S: Cleaning equipment and chemicals have been moved from the floor.
S:A full review of storage was undertaken. Additional storage has been provided external to the home which enables bedrooms to revert to their orginal format thereby allowing to be more easily cleaned.
S: Staff have been educated on the importance of correct disposal of medical waste.
S: A full review of equipment was undertaken and worn items have been removed or replaced as appropriate.
M: By the PIC and the maintenance team
A: Through review and monitoring of completion by the regional management team
R: Overview by the Regional Director in conjunction with the RPR.
T: 31/8/2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
S: A full review of all ski sheets has been completed to ensure all are fully secured. The identifed risk of loose ski sheets was added to the risk register on the day of inspection. Continued monitoring is in place to ensure ski sheets are secure and in place at all times.
S: The issue with the pathway was addressed on the day of inspection.
S: The two bedrooms identifed during the inspection remain unoccupied thereby ensuring fire doors remain unobstructed.
S: The current floor plan for the centre is currently under review and additional fire doors are on order and will be installed by the end of September 2022.
S: The fire blanket originally in place and removed at the direction of the fire officer has been replaced. All surfaces have been repainted with flame retardant paint.
M: By the PIC and the maintenance team
A: Through review and monitoring of completion by the regional management team
R: Overview by the Regional Director in conjunction with the RPR.
T: 30/9/2022.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
S: A new care plan template has been introduced that prompts nursing staff to more fully reference all activities of daily living including responsive behaviour, communication and resident's likes and dislikes.
S: A full review has been completed on the communication needs of all residents and training has been provided to nursing staff. Care plans reflect the outcome of assessments and detail all supports required by each resident.
S: Care plans are reviewed and discussed with the resident and their NOK on admission and during 3 monthly resident/ family meetings.
S: All wounds are reviewed on admission and a plan is in place to guide staff on the actions needed to fully support resident's needs.
M: By the PIC and the Nursing team
A: Through review and monitoring by the regional management team
R: Overview by the Regional Director in conjunction with the RPR.
T: 31/8/2022.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
S: The centre's wound care policy has been updated and training has been provided to all staff in relation to the treatment and care of a wound, the importance of involvement of the TVN and the preventative plan in place to prevent wound formation.
S: A meeting has been arranged with the TVN and their team to secure in-house visits going forward.
M: By the PIC and the Quality team
A: Through review and monitoring by the regional management team
R: Overview by the Regional Director in conjunction with the RPR.
T: 31/8/2022.

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 full review of restraints is underway that includes ensuring that risk assessments are completed and alternatives or less restrictive measures are trialed before bed rails used. Resident choice will always be respected in relation to trialing alternatives. S: The Restraint Policy has been updated. M: By the PIC and the in house management team A: Through review and monitoring by the regional management team R: Overview by the Regional Director in conjunction with the RPR. T: 31/8/2022.	

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 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Not Compliant	Orange	31/08/2022
Regulation 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Not Compliant	Orange	31/08/2022
Regulation 10(3)	The person in charge shall ensure that staff	Not Compliant	Orange	31/08/2022

	are informed of any specialist needs referred to in paragraph (2).			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	31/08/2022
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	31/08/2022
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	31/12/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	31/12/2022

	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.	Substantially Compliant	Yellow	31/08/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/09/2022
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	30/09/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2022

Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	13/08/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/08/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/08/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph	Not Compliant	Orange	31/08/2022

	(3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's 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.	Substantially Compliant	Yellow	31/08/2022
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	31/08/2022
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and	Substantially Compliant	Yellow	31/08/2022

	skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
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	31/08/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/08/2022