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

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| Name of designated centre: | Duleek Nursing Home |
| Name of provider: | Arnotree Limited |
| Address of centre: | Duleek Nursing Home, Downestown, Co Meath, Meath |
| Type of inspection: | Unannounced |
| Date of inspection: | 12 October 2022 |
| Centre ID: | OSV-0008238 |
| Fieldwork ID: | MON-0037229 |

## About the designated centre

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

Duleek Nursing Home is located in a rural setting just outside the village of Duleek which is in the east of County Meath. Duleek is just 7.5kms from Drogheda and 17kms from Navan. The aim of the nursing home is to deliver high standards of quality care to a maximum of 121 residents. The centre offers an extensive range of short stay, long stay and focused care options. Each of the 121 bedrooms are single ensuite bedrooms and residents have access to a number of communal rooms spread over two floors. Residents have access to a number of landscaped garden areas which are safe and secure for residents to use.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 35 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Wednesday 12 October 2022 | 09:00hrs to 16:50hrs | Sheila McKevitt | Lead |

## What residents told us and what inspectors observed

The inspector observed that a number of residents were actively mobile due to their dementia. These residents had access to an enclosed courtyard which enabled them to mobilise outside in a secure environment.

Staff were available to supervise residents. The inspector observed staff supervising residents while mobilising throughout the corridors, ensuring their independence was maintained. The inspector observed good staffing levels on the day of inspection.

The inspector observed that some clinical care practices delivered did not reflect a high standard of nursing care. The oversight of these practices, particularly nursing records and medication management required strengthening.

Residents' rights were upheld. Residents spoken with said they were given choices in relation to food offered at each mealtime, the time they got up and went to bed at and also what activities they attended. Throughout the course of the day the inspector observed staff offering residents the choice to attend activities. Residents said staff respected the choices they made.

The inspector saw that a residents meeting was taking place on the day of inspection and staff were heard reminding residents of the scheduled time of the meeting. A number were seen walking towards the meeting independently others choose not to attend.

The inspector observed that residents' were well-groomed. Residents said there were enough staff on duty to assist them when they required assistance. They said their call bell was answered in a timely manner.

Some staff spoken with confirmed they had not received mandatory training prior to commencing work such as, safeguarding vulnerable resident training.

Residents' right to privacy was maintained. There were privacy locks on each bedroom, en-suite, communal bathroom and toilet door.

Laundry facilities were available on site. Residents informed the inspector that they sent their laundry for washing and received it back clean and fresh. Clothing was labelled with the resident's name to prevent loss.

The premises was clean and tidy with corridors free from clutter. Fire exits and escape pathways were noted to be clear from obstruction.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as

requiring improvement are discussed in the report under the relevant regulations.

## Capacity and capability

Overall, this was not a well-managed centre. There was an absence of effective management systems. The oversight of clinical care was poor and staff supervision was inadequate to ensure staff were trained and that policies were implemented in practice.

This was the first risk inspection carried out in Duleek Nursing Home since it opened on 20 June 2022. Arnotree Limited is the registered provider of Duleek Nursing Home. The senior management team included the provider representative, person-in-charge, and and assistant director of nursing. This team was supported by a director of clinical governance and quality, a chief operating officer, a group facilities manager, human resource staff, and administrative supports.

The inspector found that adequate resources were not available to ensure the service provided was safe, appropriate , consistent and effectively monitored. There was no established management system in place to proactively oversee practices. In the absence of an established system, the areas of non-compliance identified on this inspection had not been identified by the management team and had led to a less then satisfactory quality of care being delivered to residents. Following the inspection, a cautionary meeting was held with the governance and management team where assurance was sought and received from the provider that they would take immediate action to bring the centre into compliance.

Training was not adequately resourced. Staff had not completed mandatory training prior to commencing work in the centre or on induction. Therefore, staff were working with residents without having their mandatory training in place. This was not in-line with the centre's own policy and had the potential to negatively impact the standard of care delivered to residents.

Incidents where residents had been transferred out of the centre following an accident had been notified to the Chief Inspector, however a loss of power on two known occasions had not been notified as required.

Records reviewed including the statement of purpose, contracts of care and records of complaints met the legislative requirements.

## Regulation 15: Staffing

The staffing numbers and skill-mix were good. Staff were attentive towards

residents and were available to supervise residents in communal areas.

There was a minimum of one qualified nursing staff on at all times.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspector was not assured that staff had access to appropriate training. A high number of staff had not completed training in a number of areas, for example;19/51 staff had not completed manual handling theory training and 25/51 had not completed manual handling practical training. 23/51 staff had not completed fire training. 38/51 had not completed hand hygiene training, however staff were receiving hand hygiene training on the day of this inspection. 38/51 had not received infection prevention and control training.

The supervision of care practices was not adequate together with the implementation of more robust systems in areas such as, admissions and record keeping was required.

Judgment: Not compliant

## Regulation 19: Directory of residents

The directory of residents was reviewed. It contained most of the required information. The name, address and telephone number of the General Practitioner (GP) had not been entered for one of the three residents cross referenced with the computerised directory of residents.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The inspector was not assured that the service was adequately monitored. Management systems were not in place, to ensure that the entire service provided to residents was safe, appropriate, consistent or effectively monitored. While key performance indicators (KPIs) were measured there were no meaningful audit systems to monitor service and various areas of practice, identify deficits and drive improvement.

Evidence where further clinical oversight was required included;

- the standard of nursing documentation required improvement to ensure an overall picture of a resident's health and well-being such that any clinician could identify indicators of deterioration and implement preventative measures.
- access to and completion of mandatory and relevant training by staff employed and currently working in the centre.
- effective supervision of staff to ensure that clinical practices were safe and in line with best available evidence
- the procedure for administration of medications from a tray where all residents pouches of medications were collectively placed was not in line with medication management policy.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

The contracts of care met the legislative requirements. The sample of contracts reviewed had been signed by the resident or their appointed representative and the registered provider representative. They also included the fees to be charged and the room occupied by the resident.

Judgment: Compliant

## Regulation 3: Statement of purpose

The statement of purpose was unchanged since the registration of the centre in June 2022. The contents met the regulatory requirements and reflected the number and make-up of the beds in the centre.

Judgment: Compliant

## Regulation 34: Complaints procedure

The complaint procedure was available and displayed in the centre. It included the designated complaints officer, the right of appeal and the nominated person to oversee the complaints process.

The complaints received to date were all closed. Records reviewed in respect of

these complaints, showed that the complaints process had been followed. Complaints made had been investigated promptly, either upheld or not upheld, with the complainant being informed of the outcome of the complaint and written evidence of whether they were satisfied or not with the outcome.

Judgment: Compliant

## Regulation 4: Written policies and procedures

Some of the Schedule 5 policies did not reflect practices. For example:

- The Staff training and Development Policy, section 5.3 stated that the Clinical Governance Team would report monthly on manual training. There was no written evidence of this.
- The Resident Introduction and Care Assessment Policy, section 7.7 stated that all residents would have a comprehensive assessment completed on admission.This was not consistently implemented in practice.
- The medication administration practices were not reflective of the medication management policy.

Judgment: Not compliant

## Regulation 31: Notification of incidents

The Chief Inspector was not notified of the loss of power within three days of the occurrence of the event. The inspector was aware of two occasions where the centre had experienced a loss of power. These were both submitted retrospectively, post the cautionary meeting held with the provider.

Judgment: Substantially compliant

## Quality and safety

Significant improvements to the quality and safety of care provided to residents was required to ensure residents received a high standard of quality care as stated in the registered provider's statement of purpose and were safeguarded by staff who had the required training and knowledge to effectively identify and meet residents' needs.

The inspector found that residents were not appropriately assessed on admission to

the centre. A comprehensive assessment and other relevant clinical risk assessments were not in place for residents who had been admitted to the centre. In addition, a number of residents did not have care plans in place to reflect their identified care needs and guide staff in the provision of care in line with multidisciplinary assessment. The failure to comprehensively assess a resident on admission and outline the care they required in a person-centred care plan had the potential to negatively impact the quality of care delivered to residents.

Premises were clean and uncluttered, all entrances and exits were clear. Residents were receiving visits as and when required and they assured the inspector their right to visitors was being upheld.

There was a safeguarding policy in place, however all staff had not received the required appropriate training in the protection of vulnerable residents prior to starting work in the centre. An Garda Siochana (police) vetting disclosures were secured prior to staff commencing employment, for the protection of residents. The provider was not a pension-agent for any residents. There was a safe system in place to hold petty cash on behalf of the resident.

Residents had a medical review completed on admission and within a four month time period, or sooner, if required. There was evidence that residents had access to all required allied health professionals services and the inspector saw evidence that a variety of these practitioners were involved in assessing and caring for the residents. However, the poor standard of clinical documentation observed on the day, showed that specialist's recommendations were not always recorded and implemented in practice.The overall standard of nursing care was not high. This is reflected in the evidence outlined below under the respective regulations.

## Regulation 11: Visits

There were no restrictions on visitors. There was space for residents to meet their visitors in areas including and other than their bedrooms. There was a visitors book which visitors were requested to sign prior to entering and on departing the centre.

Judgment: Compliant

## Regulation 17: Premises

The centre was found to be clean and tidy. The premises met the need of the 35 residents currently living in the centre. The two corridors occupied by residents were both on the ground floor where residents had access to an enclosed garden, and

several communal rooms.

Judgment: Compliant

## Regulation 25: Temporary absence or discharge of residents

The documentation completed for the temporary discharge of a resident to hospital was reviewed. All relevant information about the resident was sent to the receiving hospital. On return from the hospital medical and nursing discharge letters together with other relevant documentation was received and available for review in individual record files.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

Medications and pharmacy records were stored securely in a locked medications room. Processes were in place to receive and check medications and unused medications were returned to the pharmacy in line with the centres own processes. Nevertheless some discrepancies were observed between local policies and practice as mentioned under Reg 23.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Following the review of three residents' records the inspector found that residents were not fully assessed and did not have appropriate care plans in place to reflect their assessed needs within 48 hours of admission to the centre. For example:

- One resident admitted a week prior to this inspection had no comprehensive assessment completed and another resident had one on file but it had not been completed and was found to be blank.
- Another resident admitted post fracture resulting from a fall at home, did not have a falls risk assessment completed on admission or since admission.
- One resident had no care plans in place.

Judgment: Not compliant

## Regulation 6: Health care

The registered provider did not ensure that appropriate medical and health care, including a high standard of evidence-based nursing care was provided to all residents. For example;

- The assessment of those residents who were on a fluid and food intake chart was poor. There was no evidence that these records were reviewed by a nurse at the end of each day. This had resulted in one resident not receiving the treatment prescribed by their general practitioner. For example, the food chart stated "porridge minimal", and "lunch minimal" so one could not determine what volume of food was consumed by the resident. Also, the residents' GP had prescribed sub-cutaneous fluids if the resident drank less then 500mls in a day. The inspector reviewed fluid balance charts from the previous weeks and noted that there was four days out of seven where the residents' fluid intake was less then 500mls, noting one day it was 75mls. The resident had not received any sub-cutanous fluids to date.
- Inter-disciplinary team recommendations and treatment plans were not always incorporated into the resident's care plans. For example, one resident who had been seen in the orthopaedic outpatients and prescribed a schedule of exercises to be completed daily did not have a care plan in place to reflect this aspect of their care needs. The schedule of exercises prescribed could not be found and there was no evidence that staff had completed them with the resident since they had been seen in the orthopaedic clinic.
- One resident who had been assessed by a speech and language therapist prior to admission from the acute sector did not have all the detailed recommendations reflected in their care plan.

Judgment: Not compliant

## Regulation 8: Protection

The provider had not taken all reasonable measures to protect residents from abuse, including staff training. This was evidenced by a review of the training records for the 51 employees. The inspector noted that there was no evidence that 75% of staff (38 of the 51 staff) working in the centre had completed training in relation to the detection and prevention of and responses to abuse.

Judgment: Not compliant

## Regulation 9: Residents' rights

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| Residents' rights were upheld in the designated centre and all interactions observed during the day were person-centred and courteous.<br><br>Residents' privacy and dignity was respected and they had access to information using a variety of media such as newspapers, television, internet, radio. Residents said they were satisfied with the opportunities for meaningful engagement and the facilities available to them on a daily basis. |
| 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 | Not compliant |
| Regulation 19: Directory of residents | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Not compliant |
| Regulation 31: Notification of incidents | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 25: Temporary absence or discharge of residents | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Duleek Nursing Home OSV-0008238

## Inspection ID: MON-0037229

## Date of inspection: 12/10/2022

**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** |
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| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>To ensure compliance the PIC will have the following in place and implemented and actioned as required:<br>• All training files have now been uploaded on to the digital HR system. All staff are fully compliant in Manual handling training, Hand hygiene, IPC, Safeguarding and Fire training.<br>• Pre-Admission assessments are reviewed by PIC and discussed with the Director of Clinical Governance, Quality and Risk (DCGQR) and only if needs can be met within the home based on staffing levels and skill mix will they be admitted.<br>• Supervision of care is completed by the ADON and PIC. Additional staff nurses and CNMs are being hired to further support the home.<br>• A detailed staff allocation is under development to ensure staff can be guided and supported to meet the care needs of residents. | |
| Regulation 19: Directory of residents | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 19: Directory of residents:<br>To ensure compliance the registered provider will have the following in place and implemented and actioned as required:<br>• The resident's directory is fully compliant and will be reviewed weekly by the homes administrator to ensure compliance. This will then be reviewed by the compliance team on a regular basis to ensure all details as per schedule 3. | |

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance the registered provider will have the following in place and implemented and actioned as required:
• Detailed and guiding audits have been introduced to ensure the service is adequately monitored.
• Training has commenced to ensure nursing documentation reflects the overall picture of a resident's health and wellbeing. This is to ensure that it correctly identifies and guides the care required. The Nursing documentation is reviewed daily by the PIC/ADON/CNM and weekly by the Clinical Governance and Compliance team.
• All staff records with regards to their training is now evidenced in the digital HR system.
• A detailed staff allocation is under development to ensure staff can be guided and supported to meet the care needs of residents.
• A full review of our medication administration is underway with our Pharmacy/pharmacist. Once agreed our policies will be updated to reflect practice.

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| Regulation 4: Written policies and procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure compliance the registered provider will have the following in place and implemented and actioned as required:
• All training reports are reviewed monthly by the Clinical Governance Compliance team. A HR generalist administrator will be hired in the home to ensure ongoing compliance.
• An admission audit review is now in place that requires the PIC/ADON to review and sign off that all residents are admitted as per policy. This includes all assessments completed and care plan commenced.
• A full review of our medication administration is underway with our Pharmacy/pharmacist. Once agreed our policies will be updated to reflect practice.

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| Regulation 31: Notification of incidents | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance the PIC and registered provider will have the following in place and implemented and actioned as required:
• Notifiable incidents that occur will be recorded in the EPIC system and the PIC/ADON/CNM will also inform the RPR team via email that a notifiable event has occurred. This will ensure prompt reporting and follow up.
• The DCGQR reviews weekly the EPIC system all notifiable incidents are recorded and discussed with the PIC during the homes weekly reviews.

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| 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:
To ensure compliance the PIC and registered provider will have the following in place and implemented and actioned as required:
• A full review is underway and will be evidenced to ensure all residents acre plan and assessments are completed and reflect, guide and support the care required by each individual resident
• An admission audit review is now in place that requires the PIC/ADON to review and sign off that all residents are admitted as per policy. This includes all assessments completed and care plan commenced.
• Admissions will be discussed weekly with the DCGQR. This is to ensure care plan and assessments completed and guide care required.

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| Regulation 6: Health care | Not Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure compliance the registered provider will have the following in place and implemented and actioned as required:
• The home has introduced 3 handover meeting per day to ensure all relevant care needs and requirements are discussed and updated in EPIC.
• A detailed staff allocation is under development to ensure staff can be guided and supported to meet the care needs of residents.
• Meetings are taking place with care staff on the importance of describing the entries

made into EPIC correctly. Giving specifics not generalities. example describing the amount of fluids taken in mls and food in mouthfuls.
• There is a SOP in place to guide and support staff following an allied healthcare professional visit. When an allied healthcare visit or inter-disciplinary team recommendation is made the POIC/ADON/CNM will ensure the SOP has been followed and all recommendations are reflected in the residents plan of care.

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance the registered provider will have the following in place and implemented and actioned as required:
• All relevant training certificates have been uploaded to the staff digital file. All staff working in the centre have safeguarding training in place.

## 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 | 16/11/2022 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 16/11/2022 |
| Regulation 19(3) | The directory shall include the information specified in paragraph (3) of Schedule 3. | Substantially Compliant | Yellow | 16/11/2022 |
| 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 | 09/12/2022 |
| Regulation 23(c) | The registered provider shall ensure that | Not Compliant | Orange | 09/12/2022 |

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| | management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | | | |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Substantially Compliant | Yellow | 16/11/2022 |
| Regulation 04(1) | The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5. | Not Compliant | Orange | 16/11/2022 |
| 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 | 09/12/2022 |
| Regulation 5(2) | The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social | Not Compliant | Orange | 09/12/2022 |

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| | 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. | | | |
| Regulation 5(3) | The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned. | Not Compliant | Orange | 09/12/2022 |
| Regulation 6(1) | The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | Not Compliant | Orange | 09/12/2022 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Orange | 16/11/2022 |

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| Regulation 8(2) | The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse. | Not Compliant | Orange | 16/11/2022 |