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:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	17 April 2024
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0043165

About the designated centre

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

Bridhaven Nursing Home is a designated centre located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 182 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in six suites: on the lower ground floor - (1) Clyda is a dementia-specific unit with 18 bedrooms all single rooms with full en suite facilities of shower, toilet and wash-hand basin); on the ground floor - (2) Lee (33 beds – two twin and 29 single with en suite facilities), (3) Blackwater (37 beds – six twin and 25 single full en suite facilities) 4) Lavender (13 beds - all single full en suite bedrooms); on the first floor - (5) Bandon (45 beds – four twin and 37 single with en suite facilities), (6) Awbeg (36 beds – seven twin and 22 single with en suite facilities). Each suite had a day room and dining room and there are additional seating areas located at reception and throughout the centre. There is a large seating area upstairs for resident to relax with views of the enclosed bonsai garden and also the entrance plaza. Residents in Clyda have access to a well-maintained enclosed garden with walkways, garden furniture and shrubbery; there is a second enclosed garden accessible from the Blackwater day room. Bridhaven Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	131

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 17 April 2024	08:30hrs to 17:30hrs	Breeda Desmond	Lead
Wednesday 17 April 2024	08:30hrs to 17:30hrs	Ella Ferriter	Support
Wednesday 17 April 2024	08:30hrs to 17:30hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced one-day inspection. Inspectors met many residents during the inspection and spoke with 15 residents in more detail, and 6 visitors. Residents generally gave positive feedback and were complimentary about the staff and the care provided; they reported improvement in the quality of food served and that they enjoyed their meals; a number of residents said they were very happy in the centre and there was a great atmosphere there. Many said they were looking forward to the spring and summer activities of a barbecue, picnic planned, and outings. Visitors were complimentary about the care; they reported that staff contacted them with updates on the changing condition of their relative and said that staff were attentive to their relatives. A few residents reported that they were disappointed with some of the service and care received in the centre but said there were some specific staff that were excellent.

There were 131 residents residing in Bridhaven at the time of inspection. Bridhaven is a three storey facility with resident accommodation set out in six units over the three floors; Clyda (dementia specific unit) was located on the lower ground floor; Blackwater, Lee Side and Lavender Cottage (dementia specific unit) on the ground floor; Bandon and Awbeg upstairs (Bandon was currently closed for renovations). Management and HR offices, the main kitchen, maintenance and facilities, staff facilities, laundry, and storage areas were accommodated on the lower ground floor.

Initially upon arrival to the centre, inspectors visited all the units and saw that some residents were receiving personal care, others were being escorted to the different days rooms while others were still in bed. In the day room on Clyda and Lavender, residents were in the respective dining rooms having their breakfast of porridge, toast, fried eggs and tea in accordance with their choice. On other units, the inspector saw that staff brought residents' their breakfast in bed and left the tray on the bedside table; a few residents were seen to be asleep and their breakfast went cold.

Dinner time was observed on different units and while the inspectors observed some positive engagement by staff when providing assistance with meals, other observation showed staff standing over residents and not fully engaging with residents. Some residents required a textured diet and while the chef had plated up the meal that looked very appealing, staff were seen to mix it all together, so visually, the meal did not look appealing. Residents at some tables were not served together in line with normal social dining experience.

On several occasions, it was noted that call bells were not answered promptly. On one occasion, the nurse informed the inspector that the resident was sitting in the dining room so they knew the resident was OK, yet they did not turn off the alarm or go to the room to ensure nobody else required attention. Another call bell was alarming and when no one came to address the call bell the inspector knocked on the resident's door where two HCAs were attending to the resident, however,

neither of the HCAs turned off the call bell even though it was alerting for over three minutes while they were in the room. Residents told inspectors the continuous noise of the call bell system can be distressing.

Throughout the day inspectors observed staff interaction with residents. Many of these interactions were respectful and kind with positive engagement, chat and social conversation. However, the inspectors were informed by some residents that it was difficult to understand what some of the staff were saying as their standard of English did not support effective communication. Some staff understood the complex communication needs of residents, while other staff were observed not to understand this and their lack of appropriate interaction caused a resident's behaviours to escalate. A different staff saw the escalated behaviours, re-directed the resident and de-escalated the situation while at the same time maintaining the resident's dignity.

Staff on the dementia specific units of Clyda and Lavender facilitated activities there. These activities were seen to be resident-led and staff were observed to be patient and respectful towards residents in these units. On the other units, inspectors observed some very positive and person-centered interactions between residents and staff, however, other observations showed that residents spent protracted times unsupervised in day rooms with no interaction. An expansive screen was located in the day room of Blackwater where a music concert was screened; minutes of residents' meetings indicated that this artist was routinely displayed, and while residents had requested a change in the concerts, this was not facilitated. At 11am, residents were seen to watch mass on television in dayrooms. This was followed by staff offering residents beverages and snacks.

The activities boards were a colourful display with easily accessible information for residents; they were displayed on each unit as reminders for residents of the activities on each unit. Other publications and information on display included the monthly Bridhaven news letter, statement of purpose, residents' guide, complaints procedure and advocacy services. Bookshelves with a variety of books and games were seen in all dayrooms; additional reading material was provided by the local community library for residents.

The advocate was on site on a weekly basis to support residents, including seven residents under 65yrs; and was on site during the inspection. Inspectors saw that residents were familiar with the advocate and relaxed and comfortable in their presence.

Significant improvement was seen regarding the premises since the previous inspection with painting, redecorating both inside and outside the building. Residents personal storage in their bedrooms comprised a double wardrobe and bedside locker; some residents had an additional chest of drawers and an additional single wardrobe. Low low beds, crash mats, specialist mattresses and cushions, and assistive equipment such as hoists were available. Each resident had their own sling for use when being transferred.

The new hairdressers room was relocated just beyond reception and was reflective of a hair salon and looked really well; and residents reported that they were delighted with it. A new smoking shelter was installed in the garden in Blackwater. It had seating and fire blanket; while there was a fire extinguisher, it was difficult to open the protective unit to access the extinguisher. Fire retardant aprons were located in the main building and not within the smoking shelter.

There was a separate secure entrance to Clyda so that visitors could access the unit without needing to go through the centre. The reception area here had infection control precautionary facilities along with a sign-in sheet. Residents here had access to the enclosed garden via patio doors in the day room. This was a large well maintained space with walkways, shrubberies, raised flower beds and seating for residents to rest.

Alarm bells were wall mounted at the end of each corridor for easy access by staff and residents to call for help. Some residents using oxygen had signage indicating oxygen in use in their bedrooms; others did not, but additional signage to be displayed for other rooms with oxygen in use was addressed immediately by staff.

Throughout the inspection, it was noted that the premises was generally very clean. A total of 10 clinical handwash sinks were replaced to date and others were ordered to replace the existing clinical handwash sinks. There were hand-wash hubs on all units at different locations at the start and end of corridors. All had advisory signage to explain how to wash hands appropriately and other signs displayed included the 'five moments of hand hygiene' as reminders to staff to wash their hands. Paper towel dispensers, hand soap and pedal bins were alongside each hand-wash sink. Dani centres were wall-mounted throughout the centre which enabled staff to easily access personal protective equipment (PPE) such as disposable hand gloves and aprons. Wall-mounted hand gel dispensers were available throughout the centre, with the exception of the clinical room on Lavender; there was no hand gel available to staff here. Some bedroom furniture had been replaced, however, surfaces of some furniture such as bed frames, lockers, chest of drawers, doors and door frames were chipped and worn.

Laundry was segregated at source and laundry trolleys had pedal-operated function. There was a separate entry and exit to the laundry to prevent cross-over of dirty and clean laundry as well as specialist washing machines with a one-way operating system. Directional work-flow signage was seen within the laundry to mitigate the risk associated with cross infection.

Emergency evacuation plans were displayed throughout the centre with a point of reference to indicate one's location in the centre; primary evacuation routes were detailed in the floor plans. Floor plans were orientated to reflect their relative position in the centre. Stairwells were seen to be free of clutter. The fire doors to the main kitchen had been repaired following the findings of the previous inspection. Several bedroom doors and doors to communal areas were seen to be maintained open by footstools and small tables. The inspectors observed that a number of the

clinical rooms and nurses station were not securely maintained, allowing for unauthorised access.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This inspection was undertaken to monitor compliance with the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2013 (as amended) and to follow up on the findings of the previous inspection in November 2023. The findings of this inspection were that significant action was required by the registered provider to ensure that there was a robust management structure in place and effective management systems to ensure a safe service was provided for residents. Repeat findings were identified relating to staff training regarding challenging behaviours, staff supervision, complaints management, auditing, personal possessions relating to missing laundry, unsecured clinical rooms and sluice rooms with clinical waste, fire safety precautions, infection control and aspects of residents' care planning documentation. Additional areas of concern identified on this inspection included regulations relating to features of medication management and residents' access to activities in accordance with their interests, wishes and preferences. These will be detailed under the relevant regulations in this report.

The inspectors followed up on a large number of statutory notifications and unsolicited information submitted to the Chief Inspector of Social Services in relation to care in the centre, nutrition, safeguarding and lack of social activity. Some of these issues were substantiated and are detailed throughout the report.

Bridhaven Nursing Home is a designated centre for older adults and is registered to accommodate 182 residents. The provider is part of the Virtue group and the company has four directors' with one of the directors acting on behalf of the provider. The inspectors were informed on inspection that the management team was in the process of changing with the appointment of a new person representing the provider. The appropriate notification regarding this change in senior management was not submitted at the time of this inspection.

The current management structure on site comprised the person in charge, two assistant directors of nursing (ADONs), five clinical nurse managers (CNMs), and senior nurses. This service was supported by the health-care team, household, catering and administration staff. A human resources (HR) administrator, maintenance team and facilities manager supported the non clinical aspect of service. Two CNMs rotated on duty at weekends to support the governance structure; on night duty there was supernumerary CNM or Senior nurse cover. The group clinical director provided training on site.

Quality and safety monitoring systems in place included weekly collection of key performance indicators (KPIs) such as falls, restraints, infection, weights, pressure ulcers and complaints for example. While an annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents, this remained ineffective as many of the issues identified on inspection had not been recognised. For example, records relating to falls did not include the associate risk and incidents were not followed up to enable improvement and learnings. Further evidence of this is discussed throughout the report and detailed under Regulation 23, Governance and Management.

The regional director of operations facilitated weekly teams meetings with the persons in charge of the five centres associated with the registered provider; this provided good support as well as information sharing amongst the persons in charge. Regional 'Quality Safety and Risk' meetings were facilitated and chaired by the director of quality safety and risk. Monthly 'Social, Clinical and Transition' meetings were convened as part of their quality strategy.

The duty rosters were reviewed and while rosters showed adequate care staff, on the day of inspection there were a number of agency staff on site to cover the proposed roster. In addition, the number of staff with responsibility for activities on the day of inspection comprised two staff for over 100 residents spread over two floors and observation showed that this was inadequate as there were long periods, especially in the morning, where residents were unsupervised as detailed heretofore.

The complaints procedure was displayed at different locations throughout the building; it was in an accessible format for residents. The complaints log was reviewed and many issues were recorded in line with current legislation, nonetheless, other issues identified regarding complaints were further discussed under Regulation 34, Complaints.

Regulation 14: Persons in charge

The person in charge at the time of inspection was full time in post and had the necessary qualifications and experiences as required in legislation. She was involved in the operational management and the day-to-day running of the service.

Judgment: Compliant

Regulation 15: Staffing

Action was required regarding staffing to ensure adequate resources for the size and layout of the centre, as follows:

- there was inadequate staff allocated to the provision of social activities, as on the day of inspection, residents were observed to spend long periods of the day unsupervised in the day room with little activity except for the TV.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Action was required as some staff were not appropriately supervised in the centre:

- supervision of staff required action as there were many examples detailed throughout the report where the lack of supervision resulted in poorer outcomes for residents, for example, a resident's care plan detailed the requirement for one-to-one supervision by staff, however, this was not provided consistently in practice
- further supervision was required of staff assisting residents with food and drink to ensure residents received food in a timely and dignified manner and at an optimum temperature
- inspectors observed several occasions where residents were not being responded to in a timely manner, particularly in relation to delays in answering call bells.

Judgment: Substantially compliant

Regulation 21: Records

Action was required to ensure all records were stored in a safe manner.

- the inspectors saw that boxes of resident records were stored unsecured in a bedroom used for storage; this room was not locked and therefore these records were not maintained in a manner to be ensure the confidentiality of the information, as required by the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was acknowledged the additional efforts made by the registered provider to strengthen the management team in the centre, nonetheless, action was required to

ensure that managerial systems were in place to ensure the service was safe, appropriate, consistent and effectively monitored as follows:

- a review of the duty roster demonstrated that there was a dependency on agency staff, especially on night duty. In addition, there were insufficient staff allocated to the provision of social stimulation for residents,
- the auditing process was not sufficiently robust to ensure and enable learning to inform quality improvement, for example, concerns relating to falls, complaints and activities had not been either identified, or in the case of residents' meetings, feedback had not been actioned in line with residents' requests; in addition, many of the issues identified on inspection had not been recognised as part of their auditing process,
- there was ineffective oversight of infection control as detailed under Regulation 27
- there was ineffective oversight of residents' care documentation as detailed in Regulation 5, Individual Assessment and care plan
- regarding risk management, many rooms were not securely maintained to prevent unauthorised access, for example, clinical treatment rooms (with open sharps containers, specialist dressings, cleaning solutions for wounds and blood testing equipment), nurses stations and sluice room with clinical waste; this was a repeat finding.

Judgment: Not compliant

Regulation 31: Notification of incidents

Improvement was noted regarding submission of notifications in line with regulatory time-lines and requirements. Notifications submitted to the regulator correlated with the incidents logged as part of risk management in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

Action was necessary to ensure complaints were responded to in line with legislation, as follows:

- a few residents reported that they informed issues of complaint to management, however, these were not recorded in the complaints records seen, or followed up to enable learning and improvement to the service delivered.

Judgment: Not compliant

Quality and safety

While most feedback from residents and relatives was positive regarding care and welfare in the centre, the inspection findings demonstrated that improvement was necessary to ensure residents had a good quality of life and that they had access to meaningful activities in accordance with their stated wishes and preferences.

The newly appointed relationship manager was responsible for completing the pre-admission assessment of residents to ensure the service could care for the resident in accordance with their assessed needs. A sample of residents' care planning documentation was reviewed. The daily narrative for both day and night duty was maintained on the resident's status and progress. Touch-screen devises were displayed on corridors to enable staff record care delivered to residents. A one-page resident's summary was available which provided information about each resident and their care needs. Monthly weights were completed and information trended to ensure appropriate interventions such as referral to speech and language therapy with associated care plans. While validated risk assessments were in place to enable staff to assess residents care needs, these were not comprehensively completed to adequately inform the care planning process. This was further discussed under Regulation 5, Individual assessment and care planning. Some residents' assessments and care planning relating to challenging behaviours were excellent and detailed effective non-pharmacological interventions for the resident as well as those that did not work for the resident, however, other assessments and care plans did not have this detail. While the service actively monitored restrictive practices, the associated risk assessment for restraint did not support decision-making or could not effectively assess the related risk.

The GP was on-site Monday – Friday, and out-of-hours GP cover was provided by South Doc. Residents were seen to have good access to health and social care professionals such as a dietician, dental, occupational therapist (OT), speech and language therapist (SALT) to enable better outcomes for residents. Access to the mobile diagnostic unit enabled residents to have x rays within the centre and negated the requirement to go to an accident and emergency department with the associated anxiety and upset. Residents notes demonstrated that they had access to tissue viability nurse specialist to support wound care. Residents had access to palliative care services. Exercise programmes were held on a weekly basis as part of their positive aging programme to help residents maintain their level of muscle tone and mobility.

A sample of controlled drugs records were examined and these were maintained in line with professional guidelines. Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. As part of the medication oversight, additional information was included such as the requirement for blood profile or heart monitoring (ECG) to

be completed to enable the GP to monitor residents' response and suitability of certain medications, to ensure best outcomes for them. A record of 'as required' (PRNs) psychotropic medications were maintained as part of medication management; these records showed the rationale for administration of PRNs. Controlled drugs were examined on two units and records were in line with professional guidelines and regulatory requirements. Inspectors joined two separate medication rounds where a sample of medication management administration records were examined. Residents had photographic identification and allergy status details. While some medications requiring crushing were individually prescribed in line with best practice, others were not, rather; this is further discussed under Regulation 29, Medicines and pharmaceutical services.

While behavioural support charts were in place to support the relevant residents which included narrative of the residents normal behaviour, examples of behavioural disturbances and potential triggers, the possible non-pharmacological interventions to support the resident along with the pharmacological interventions, these were not seen to be implemented into practice consistently, as described heretofore.

Legionella precautions were in place regarding infrequently used water outlets; records showed that these were flushed on a weekly basis in line with current guidelines. An up to date record of residents with previously identified multi-drug resistant organism (MDRO) colonisation (surveillance) was not maintained. This meant that the provider was unable to monitor the trends in development of antimicrobial resistance within the centre. Findings regarding this were presented under Regulation 27.

A review of the dining experience required review to ensure dining was in line with a social model of care delivery. This is further discussed under Regulation 18, Food and Nutrition.

The advocate was on site on a weekly basis and was on site on the day of inspection. Residents availed of this service including residents under 65yrs. While residents' meetings were facilitated and were well attended, minutes of these meetings did not provide assurance that these meetings were interactive; issues raised were not followed up on subsequent meetings to assure residents that their voice was heard and their request or suggestions were taken on board.

Regulation 11: Visits

Visiting was facilitated in line with the requirements of the regulations. Visitors were welcomed into the centre and inspectors saw that visitors were familiar with the risk management procedures upon entering the centre of signing in and hand hygiene. There was ample room for residents to meet their relative in private if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Action was necessary regarding residents' personal possessions as many complaints related to laundry services and the poor condition in which personal laundry was returned to residents.

Judgment: Substantially compliant

Regulation 17: Premises

Notwithstanding the three-phase programme of works underway to upgrade the premises the following required action:

- there was no bath in the centre to facilitate resident choice and to ensure compliance with Schedule 6 of the regulations.
- numerous bedrooms were being used as store rooms which would indicate a lack of appropriate storage facilities in the centre.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Action was required regarding oversight of food and nutrition and the manner in which it was served to residents as follows:

- inspectors saw that staff brought residents' their breakfast in bed and left the tray on the bedside table; some residents were seen to be asleep and their breakfast went cold
- other observation showed staff standing over residents while assisting with their meal and not engaging with residents which was not conducive to a relaxed dining experience
- some residents required a textured diet and while the chef had plated up the meal that looked appealing with the semblance of a normal diet, staff mixed it all together, so visually, the meal did not look appealing,
- residents at some tables were not served together in line with normal social dining experience.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did not comply with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services (2018). Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example:

- an up to date record of residents with previously identified multi-drug resistant organism (MDRO) colonisation (surveillance) was not maintained; there were no MDROs recorded for 2024, and for 2023, the only records available regarding MDROs was for Leeside which reported three residents with MRSA, consequently, management and staff were unaware of which residents were colonised with MDROs. Lack of awareness meant that the provider was unable to monitor the trends in development of antimicrobial resistance within the centre or that appropriate precautions may not have been in place to prevent the spread of the MDROs within the centre,
- one CNM was appointed IPC lead for the service, however, that CNM was on extended leave and her responsibilities had not been re-assigned to ensure up to date antimicrobial stewardship records to enable oversight, as detailed above
- known infections were not detailed in care planning to ensure appropriate care
- notwithstanding the capital project plan in place to address the environment and equipment concerns, the following issues remained outstanding which had the potential to impact the effectiveness of infection prevention and control with the associated risk of transmitting a healthcare-associated infection within the centre: surfaces to furniture such as hand rails, bed frames, lockers, and bed tables were worn so effective cleaning could not be assured
- some hand-wash sinks did not comply with the document HBN-09 infection control in the built environment (DoH 2013) clinical wash-hand basin guidance
- the mattress in one twin bedroom was uncovered and the surface was badly worn so effective cleaning could not be assured
- there was no clinical hand wash sink in the clinical room on Lavender, and while it was reported to the inspector that nurses performed hand hygiene before medication management or accessing clinical supplies for example, there was no hand hygiene gel available in the clinical room to facilitate this.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was necessary to ensure fire safety precautions as follows:

- many doors were seen to be held open with chairs, a table and a foot stool
- full compartment simulated evacuations had not been completed to be assured that a full compartment evacuation could be completed in a timely and safe manner by all staff
- a new smoking shelter was installed into the garden in Blackwater. It had seating and fire blanket; while there was a fire extinguisher, it was difficult to open the protective unit to access the extinguisher. Fire retardant aprons were located in the main building and not within the smoking shelter and so were not easily accessible.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were examined and these showed mixed findings. Some had personalised information to inform individualised care while many others did not have this detail and required action to enable staff provide individualised care. For example:

- one resident's behavioural assessment did not acknowledge the resident's significant behavioural risks,
- while a resident was deemed a high absconsion risk, this was not detailed in their 'safe environment' risk assessment
- a rest and sleep assessment stated the resident required aids to sleep, but the care plan did not detail what these aids were
- a spirituality and end of life assessment did not have any information to inform care planning,
- medical histories such as epilepsy did not inform either the assessment or care planning process to ensure staff were aware of the resident's condition
- resident's on oxygen therapy and antibiotic treatment for a chest infection did not have this detailed in either their assessment or care planning records
- assessments and care plans were not updated in line with specified regulatory requirements or in accordance with the changing needs of residents; for example, one resident's care plan was last updated 23/07/23.

Judgment: Not compliant

Regulation 6: Health care

Action was necessary to ensure residents' healthcare needs were met in accordance with a high standard of evidenced based nursing care as follows:

- wound care management was not in line with professional guidelines to enable and ensure best outcomes for residents, as one resident required specialist dressings, however, staff were not appropriately trained to undertake this procedure, and records relating to wound care management did not detail precautionary actions relating to skin frailty to prevent further trauma to the resident's skin integrity
- action was required to ensure residents pain levels were monitored to inform the administration of analgesia
- a resident requiring regular repositioning and oral hygiene care did not have effective oversight of this care delivery.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The use of restraint in the centre was not always in accordance with the national policy as published on the website of the Department of Health as required by the regulations:

- although there was a comprehension training matrix in place for all staff, there were several staff who did not have up-to date training in responsive behaviour as per the centers' policy; this was a repeat finding,
- behavioural associated care plans were not sufficiently detailed to direct and support individualised care
- the assessment for the use of bedrails was not sufficiently robust as decisions made regarding bedrails remained subjective; there continued to be a high level in use with 24 residents with bedrails
- some staff were observed not to understand the complex communication needs of residents and their lack of appropriate interaction cause residents' behaviours to escalate
- assessment and behavioural templates (ABC charts) relating to challenging behaviours were not comprehensively detailed to enable best outcomes for residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required to ensure residents rights were upheld, as follows:

- residents' meetings were facilitated and well attended, however, the minutes did not assure that residents' voices were heard, or that issues raised were followed up in subsequent meetings, for example, residents feedback requesting change to concerts being shown on the TV's as the same artist was being continuously played. However, inspectors saw this artist was still played on two units during the inspection and the concert appeared to be on repeat,
- although an advocate visited the centre on a weekly basis there was evidence that residents' were not always referred to advocacy services in a timely manner
- on the day of inspection, residents were observed to spend long periods of the day unsupervised in the day room with little activity except for the TV; assurances were not provided that residents would have access to occupation and recreation in accordance with their interests and capacities,
- there were long delays noted regarding answering call bells, so safety and choice of residents could not be assured,
- the inspectors were informed by residents that it was difficult to understand what some of the staff were saying as their standard of English did not support effective communication to take place; residents also reported that some staff did not speak in English when in the presence of residents.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The following records required action to ensure residents' medication records were maintained in line with professional guidelines and regulatory requirements:

- while some medications requiring crushing were individually prescribed in line with best practice, others were not. Inappropriate crushing of some medications could result in residents receiving sub-optimal effective dosages of medications, and in contravention of manufacturer's guidelines.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not 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 9: Residents' rights	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0043165

Date of inspection: 17/04/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of the staffing levels allocated to the provision of social activities is now completed. A whole home approach has been adapted – An education program has been established where staff are currently being trained regarding their role in activities and activity champions have been nominated per unit. Staff are now allocated to supervise each day room and assist the residents in meaningful activities. The Social Care Manager is currently reviewing all residents social care plans and a meaningful activity program planned around same.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Bridhaven will identify and train the training leads for both day and night, to ensure all staff are trained appropriately and have the skills to supervise and support staff where appropriate. Champion Quality Circles are established in activities, nutrition, safeguarding, dementia care and palliative care. Workshops in communication and managing residents with behaviors that challenge will commence in June and continue until all staff are proficient	

in identifying the needs of residents and addressing same.
Bridhaven will be independent and will have its own set of trainers in different areas, including the training covered during the induction. Staff will be supported by HR, RPR, PIC and Management team to facilitate this.

The Induction program is currently being reviewed by the QRS Director and the CTDM and the development of a role of Clinical preceptor for the home is being established.

The dining experience is monitored daily by CNMs, Senior Nurses, Nutritional Champions, and care leads.

CNM, Senior Nurses and Care leads will monitor the call bells on each unit daily and weekly call bell audits will be conducted and QIPs actioned. Complaints regarding delayed answering of call bells will be investigated, actions taken and resolved in a timely manner.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A clear protocol for archiving, storing, retriving and destruction of documentaton is in place.
All documentation is scanned to the cloud before it is archived and all paper documentation is stored in a secure location with restricted access.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
After Inspection the recruitment process and rota were reviewed.

A robust plan was put in place to ensure all measures were taken to recruit, train and support new staff, the outcome of which was and is very positive. As of the 2nd of June 2024, no agency staff are required. Bridhaven will continue this process to minimize the risk of a dependency on agency staff in the future.

A review of the staffing levels allocated to the provision of social activities is now completed. A whole home approach has been adapted – An education program has been established where staff are currently being trained regarding their role in activities and

activity champions have been nominated per unit. (Regulation 15)

Further training in auditing & complaints management has been completed. Weekly check-in with all residents by the senior management team is underway to ensure all complaints are captured, documented, and resolved which will enable learning to inform quality improvement. Clinical & non-clinical meetings will be scheduled monthly, audits, QIP will be discussed and shared with the whole team. Residents Meetings feedback will be actioned and feedback to all concerned. (Regulation 9)

Prior to admission, potential residents will be assessed by the relationship manager as per the pre-admission policy. The PIC will then assess the suitability of the center to the resident's care needs. On admission the Resident will have all mandatory assessment care needs completed within 24 hours and this will inform their care plan which be person centered and completed in 48 hours post op. A post admission audit will be completed by the senior nurses and actions taken if required. This will then be reviewed by the ADONs responsible for their units. The daily review by the management team will monitor any changes in Residents conditions and guide the Nursing staff on appropriate updating of the resident's care plan. All new nursing staff have in-house care plan training with the Clinical Training and Development Manager, and each staff member has received a guidebook on the same. (Regulation 5)

All Infection Prevention and Control measures are being addressed as per timeline specified in regulation 27 below.

A review of the security of the Sluice rooms, Clinical Rooms and Nurses Stations has been completed – where necessary new locks and signage in these rooms have been replaced and all staff updated regarding this. CNMs & Senior Nurses are responsible for rounds/spot-checking using the daily Infection Control Checklist

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Following the inspection all complaints are investigated in line with Bridhaven Complaints policy. Since the Inspection, in-house training has commenced on complaints management and documentation with the senior team and nurses by the Quality Safety and Risk Director, this is ongoing and mandatory for all staff.

Weekly check-in with all residents by the senior management team to ensure all complaints are captured, documented, and resolved to satisfaction.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
A full review of the laundry services provided in-house has been completed.
Expert advice sought regarding same.

Quality Improvement Plan in place – which included a designated laundry staff supervisor being appointed, increase in staffing daily to facilitate ownership of the service and to create a robust communication pathway between laundry staff, residents, and families.

Survey with Residents and families currently being carried out as to improvements required.

All complaints regarding laundry being followed up in a timely manner as per our complaints policy.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All Residents are informed at the pre-admission assessment stage that Bridhaven does not have a bath. The Residents make an informed decision regarding their choice of home based on their preference prior to admission.

A review of the current storage facilities in each unit is currently being carried out and will be completed by the 15th of June. Any action required will be taken and addressed to ensure adequate storage of all equipment and storage needs are met.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Following the inspection the Dining Experience was reviewed at all mealtimes.

Quality Improvement plans were put in place to ensure that Residents rights and preferences are being adhered to. This is to ensure that nutritional food is served at optimum temperature in a relaxed and conducive manner.

The dining experience is monitored daily by CNMs, senior nurses, nutritional champions, and care leads.

Further dining experience training is scheduled onsite.

Nutritional meetings with Residents and staff are scheduled, this will facilitate a forum for both residents and staff to engage and share learnings.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following Inspection a review of the Infection & MDRO tracker was completed and updated. This is reviewed weekly and updated as necessary. Trends are analyzed and learnings shared with the GP, Staff and Residents.

2 CNMs are trained as IPC leads and 2 more training places have been reserved for Summer 2024. IPC leads are actively involved in the induction process of all new staff and at the point of care. A robust auditing system is in place to monitor same.

Residents care plans will reflect the care needs of residents with infections – CNMs & senior nurses will actively monitor this.

An audit on all furniture in the home has now been completed - to date 114 overbed tables and 61 lockers have been replaced, 5 new beds replaced on the 22/05/2024, a further consignment of lockers and over bed tables has been ordered as part of the continued upgrade project. The replacement of chipped handrails is currently being replaced with a completion date of 31st July 2024.

10 Hand wash sinks that comply with HBN -09 have been installed with a further 9 identified. These will be completed by 31st of August 2024.

An audit of mattresses was completed in May by Facilities, mattresses identified as requiring replacement are currently being replaced.

An IPC Audit conducted by the IPC lead in May identified areas where hand hygiene gel was required, and actions taken.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
No doors will be held open by any means. Spot checks will be conducted to ensure this and all staff have been informed of same.
Full – compartment simulated evacuations are completed every 2 weeks as per the schedule on the training calender, these are reviewed by the ADONs over their units.
All Residents who wish to smoke are assessed for the need /wish to have a smoking apron. Residents are allocated an apron and same is hung in the Smoking shelter for easy access.
The Protective unit lock giving acces to the extinguisher was addressed on the day of the inspection and now is checked as part of the Fire Checks.

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:
A review of the monitoring process has been completed.

Prior to admission, potential residents will be assessed by the relationship manager as per the pre-admission policy. The PIC and the senior team will then assess the suitability of the center to the residents' care needs. This may involve further pre-assessments and interventions before the resident is admitted.

Staff will be informed prior to all new residents' arrivals and their care needs discussed at handover and at huddles. Where possible a "Key to me" is completed prior to admission and shared with staff.

On admission the Resident will have all mandatory assessment care needs completed within 24 hours plus any further assessments deemed necessary and this will inform their care plan which will be person centered and completed within 48 hours post admission.

A post admission audit will be completed by the senior nurses and actions taken if required. This will be reviewed by the ADONs responsible for their units.

The daily review by the management team will monitor any changes in Residents conditions and guide the Nursing staff on appropriate updating of the resident's care plan.

A clinical tracker to monitor clinical risks such as BPSD, dementia and use of restraint and other conditions will be established.

All new nursing staff have had in-house care plan training with the Clinical Training and

Development Manager, and each staff member has received a guidebook.

Care plans will be updated within the timeframe of the regulation following discussion with the Resident and or their nominated representative and or as changes occur.

A thorough review of all Residents care plans is underway same will be adapted and simplified to address the care needs of all residents. Expected date of completion is 30/06/2024.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
2 Nurses have attended the Royal College of Surgeons wound care course – both will facilitate training in–house on induction and at point of care regarding wound care prevention, treatment, and care planning.

A further 7 nurses attended onsite training with the Tissue Viability Nurse on the 29.05.2024 with more scheduled in-house during June.

All Residents receiving analgesia will have their pain score documented prior to administering analgesia and after to monitor effect, this will inform further intervention if required.

Daily review of all residents by the management team will ensure that there is effective oversight of care delivery and any further resources or interventions required put in place.

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:
Following the inspection the Clinical Training and Development Manager attended the centre and commenced in-house Dementia and Behaviours that challenge training. Going forward a commitment has been given to attend the centre 2 days per month to continue training.

Inhouse workshops will commence in June – led by the Regional Director and specific to each Unit needs. As part of these workshops behavioural associated care plans will be

discussed, triggers & escalations factors (such as lack of appropriate interactions) will be identified and de-escalation techniques shared, these will underpin the knowledge and understanding of the care plan for each resident.

All residents with behaviours that challenge will have a specific person-centred care plan that will be shared with all staff as necessary.

The assessment for the use of bedrails is currently under review by the Quality, Risk and Safety Manager – this will be completed by the 4th of June, all recommendations will be actioned.

All nursing staff will be trained in appropriate documentation relating to challenging behaviours, and same will be reviewed by the CNMs and the senior management team as part of the weekly KPIs

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Social Care Manager is currently reviewing all Residents social care plans and a meaningful Activity program planned around same for each resident.
The Residents Meeting minutes will reflect all residents' feedback and actions will be taken to accommodate all Residents wishes. Learnings will be shared with all staff and residents within the home.

Residents will be informed when the Advocate is in the center and provided with an opportunity to speak to her. Where necessary Residents will be referred to SAGE/PAS in a timely manner and be kept fully informed of the communication pathway.

A whole home approach has been adapted – An education program has been established where staff are currently being trained regarding their role in activities and activity champions have been nominated per unit.

Staff are now allocated to supervise each day room and assist the residents in meaningful activities.

CNMs, Senior Nurses and Care leads will monitor the call bells on each unit daily and weekly call bell audits will be conducted and QIPs actioned. Complaints regarding delayed answering of call bells will be investigated, actions taken and resolved in a timely manner.

Staff will be assisted in improving their English language skills by holding communication workshops on site and at point of care. There will be a focus on underpinning knowledge and understanding as to why they cannot speak in their native language. This will also be reinforced during the recruitment process.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A thorough review of medication management was completed.

Quality improvement plans from same were completed and actioned.

Shared learnings with all Nurses.

All Nurses will undergo yearly medication management competency assessments.

All new nurses will undergo 3 competency assessments prior to independently administering medication as part of their induction plan.

A new platform for medication management training has been established.

A new electronic system is currently being rolled out and will be in place by the 15th of July 2024.

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 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly and returned to that resident.	Substantially Compliant	Yellow	31/05/2024
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/05/2024

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/05/2024
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	31/05/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	31/05/2024

	designated centre and are available for inspection by the Chief Inspector.			
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.	Substantially Compliant	Yellow	31/05/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2024
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	31/08/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all	Substantially Compliant	Yellow	31/05/2024

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/05/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	31/05/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	31/05/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in	Substantially Compliant	Yellow	31/05/2024

	any case no later than 30 working days after the receipt of the complaint.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	31/05/2024
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.	Substantially Compliant	Yellow	31/05/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are	Substantially Compliant	Yellow	31/05/2024

	fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
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	31/05/2024
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	31/05/2024
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	Substantially Compliant	Yellow	30/06/2024

	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 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/06/2024
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	10/06/2024
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	31/05/2024

Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/05/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/05/2024