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:	Drumbear Lodge Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Cootehill Road, Monaghan
Type of inspection:	Unannounced
Date of inspection:	05 December 2024
Centre ID:	OSV-0005312
Fieldwork ID:	MON-0045522

About the designated centre

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

Drumbear Lodge Nursing Home is a purpose-built, single-storey centre situated close to Monaghan town. The centre provides accommodation for a maximum of 94 male and female residents aged over 18 years of age. Residents are accommodated in single, twin and one multiple occupancy bedroom with four beds. The centre provides long-term, respite and convalescence care for older residents, and residents with acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff. The provider states that their objective is to provide a high standard of evidence-based care and ensure residents live in a comfortable, clean and safe environment to meet their needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 December 2024	08:15hrs to 16:20hrs	Geraldine Flannery	Lead
Thursday 5 December 2024	08:15hrs to 16:20hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

Overall, residents spoke positively about their experience of living in Drumbear Lodge Nursing Home. The residents appeared relaxed in their surroundings and were seen to be interacting well with each other and the staff on duty.

The inspectors observed that the registered provider had made positive changes in response to the previous inspection to improve the delivery of services, however further improvement was required to meet the requirements of the regulations and will be discussed further in the report.

The premises was laid out to meet the needs of residents and to encourage and facilitate independence. Throughout the day inspectors observed residents mobilizing freely around the centre. Communal areas were seen to be well-used by residents throughout the day. However, the inspectors found that the function of two rooms within the centre required review to ensure they were used in line with the registered statement of purpose. This is further detailed in the report.

The lived-in environment was clean and met residents' needs. The inspectors saw that many areas within the home had been refurbished, including painting and flooring replacement. Many areas that had been newly decorated with attractive wallpaper, which provided a very cosy atmosphere.

Inspectors heard about an on-going programme of upholstering all cloth chairs to materials and finishes that struck a balance between being homely, whilst taking infection prevention and control into consideration.

Bedroom accommodation comprised of both single and multi-occupancy bedrooms. A vacant proposed four bedded multi-occupancy bedroom had been refurbished and inspectors observed that each space was comfortably occupied by a bed, a chair and a personal storage space for each resident.

The inspectors saw that the registered provider had refurbished and reconfigured five double-occupancy bedrooms for single occupancy use. In one single bedroom some items of furniture which were required for twin occupancy remained in the bedroom reducing the amount of floor space available to the resident, as per their wishes. In addition, the railings from double privacy screening remained in place in this room and assurances were provided that it would be removed.

On the day of inspection, one twin-occupancy bedroom was used as a single-occupancy bedroom. While there was adequate area of floor space for each resident, the inspectors observed that due to the layout of the room, should assistive equipment be required, the privacy and dignity of the residents in the room may be compromised. Also, a large wardrobe, part of which was behind the door required review. The inspectors were informed that careful assessment of residents

to occupy this double-occupancy room would be required, and the provider would review these arrangements.

Residents who spoke with the inspectors were happy with their bedrooms and said that there was plenty of storage for their clothes and personal belongings. Many residents had pictures and photographs in their rooms and other personal items which gave the room a homely feel.

The inspectors observed lunch time in the centre's dining room and noted that a light lunch was served including, soup and a variety of sandwiches. The main meal would be served later in the evening, as was the residents' preference. Residents said that the food was good, they got a choice at each meal time and 'always had plenty on their plate'.

Residents had been informed of the complaints process and knew they could complain if they had an issue of concern.

Inspectors observed visitors coming and going throughout the inspection. However, there were restrictions on visitors and these restrictions infringed on the rights of residents.

The following two sections, capacity and capability and quality and safety will outline the quality of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that the management team were striving to improve practices and services.

Inspectors followed up on the compliance plan from the previous inspection and acknowledged the improvements and positive changes. However, this inspection found that there was opportunity for further improvement in relation to managing behaviour that is challenging, infection prevention and control, premises and residents' rights, and will be detailed further under the relevant regulation.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended), and inform the application to renew the registration.

The registered provider is Newbrook Nursing Home Unlimited Company. A senior management team was in place to provide managerial support. The person in charge was responsible for the day-to-day operations in the centre and was supported in the role by the assistant director of nursing (ADON).

The annual review of the quality and safety of the service and quality improvement plan was available for review. There was evidence that it was prepared in consultation with residents and their families.

Throughout the day of inspection staff were visible within the nursing home tending to residents' needs in a caring and respectful manner. Call bells were answered without delay and residents informed inspectors that they did not have to wait long for staff to come to them.

Staff were provided with appropriate training to meet the needs of their role. Staff training was closely monitored to ensure all staff completed training requirements, which proved effective in improving staff knowledge and practices.

Regulation 15: Staffing

There was sufficient staff on duty to meet the needs of the residents taking into account the size and layout of the designated centre. There was at least one registered nurse on duty at all times. All nurses held a valid Nursing and Midwifery Board of Ireland (NMBI) registration.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training. All staff had attended the required mandatory training to enable them to care for residents safely. There was an on-going schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. There was good supervision of staff on the day of the inspection.

Judgment: Compliant

Regulation 23: Governance and management

Management systems in place required greater oversight to ensure that the service provided was appropriate, consistent and effectively monitored. Evidence of where further oversight was required included:

- Management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) was not effective to

ensure standards of care and services were consistent and required greater oversight.

- Improved management systems for the oversight of cleaning of equipment was required, as discussed under Regulation 27; Infection, prevention and control.
- There continued to be a lack of clarity in respect of ensuring premises were used in line with the registered statement of purpose and floor plan. On this inspection, inspectors noted that the hairdressing sink was removed from room 27, which was registered as an assisted shower/toilet. The proposed re-location of the hairdressing room was room 64, however, this was currently registered as an assisted toilet. Management gave assurances that this room had always been used as a store room and never had a toilet or sink in-situ. Another room registered as an assisted toilet, room 67 was being proposed as a store room.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors were assured that residents were supported and encouraged to have a good quality of life in the centre. The inspectors found that although improvements had been made across most regulatory requirements further actions were required.

There was good general practitioner (GP) service supporting the residents living in the centre. There was a record showing when all residents were reviewed by their GP. The GP was available on the phone and also visited the centre. Where the GP referred residents to other services there was a clear and transparent referral and follow-up service. Residents had prompt access to all multi-disciplinary team members, which had a positive impact on the quality of care received by residents.

The inspectors reviewed a sample of care plans and found that residents' assessed needs were on the whole informed by person-centred care plans. The information in residents' care plans had improved since the last inspection and overall reflected residents' preferences and individual routines. This assured inspectors that each resident's care supports were tailored to meet their needs and reflected a move towards a person-centred approach to care planning. However, further improvements were required to ensure the use of restraint was aligned with national policy as published on the website of the Department of Health, as outlined under Regulation 7.

Residents had access to radio, television and newspapers. The registered provider had information displayed relating to advocacy services available to residents. Residents had access to activities Monday to Sunday within the designated centre. However, some routine practices restricted the residents' rights. These included

restricted visiting at all mealtimes for all and restricted access to the day room at all times.

There were arrangements in place to safeguard residents from abuse. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a concern arise. All staff spoken with were clear about their role in protecting residents from abuse.

Overall, the premises was of suitable size to support the numbers and needs of residents living in the designated centre. Progress in relation to actions from the previous inspection was evident on this inspection. For example, occupancy of five twin rooms were reduced to single occupancy and the proposed multi-occupancy bedroom number 17, was refurbished. The size of floor space surrounding each of the four bed was seen to be sufficient for each resident and each bed space contained the required fixtures and fittings. Each of the four bed spaces had privacy screening in place which ensured the privacy and dignity of each resident could be maintained.

Notwithstanding the ongoing refurbishment works in respect of premises, further improvements were required as detailed under Regulation 17: Premises.

The inspectors noted that following the last inspection, the registered provider had put in place an improvement plan to enhance infection, prevention and control to address areas of concern. However, there were still some outstanding issues and will be discussed further under Regulation 27; Infection, prevention and control.

Regulation 12: Personal possessions

Five twin bedrooms, numbers 24, 25, 26, 29 and 31 had been reduced from twin to single occupancy. These bedrooms now met the needs of residents living there and they had enough storage space for their personal possessions.

Judgment: Compliant

Regulation 17: Premises

The provider generally met the requirements of Regulation 17, however further action was required to be fully compliant. For example;

- The purpose of two registered assisted toilets required clarity. Room 64 was planned to be proposed as new hairdressing room, while room 67 was due to be proposed as a store room. Management provided assurances that they would provide rationale on current application to renew registration.

- Bedroom 29 had been reduced from twin to single occupancy, however the railings from privacy screening remained in place.

Judgment: Substantially compliant

Regulation 27: Infection control

Overall, the centre was clean and there was good adherence to the *National Standards for infection prevention and control (IPC) in community services (2018),* with the exception of the following issues identified:

- The equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. The process in place for the identification of clean equipment required review. For example, resident equipment including wheelchairs and hoists were not identifiable as clean to inform staff and thus posing risk of cross-contamination.
- A hand washing sink was awaiting installation in the cleaner's room that was due to be installed by end of November 2024 as per the previous inspection compliance plan. Inspectors were informed that the sink was on order and picture evidence would be provided once complete.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of residents' assessments and care plans reviewed were person-centered and reflected the residents whom the inspectors had met on the day. Each resident reviewed had a comprehensive assessment in place and overall the care plans reflected the residents' care needs. However, as outlined under Regulation 7 restraint risk assessments and care plans required review. There was evidence of resident and family involvement where appropriate.

Judgment: Compliant

Regulation 6: Health care

There was evidence of access to medical practitioners, through residents own GP's and out of hours services when required. Systems were in place for residents to access other healthcare care professionals as required, including tissue viability nurses, dietitian, occupational therapists and physiotherapists.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restrictive practices was not found to be in line with national policy as published on the website of the Department of Health. For example;

- Some residents with restraint in use did not always have a restraint risk assessment in place. Therefore, it was not clear what alternatives to restraint were trialled prior to restraint being used. For example, one resident with a floor alarm in place had no assessment in place. The care plan stated the resident was at high risk of falling. The resident's comprehensive and occupational therapy assessment stated they were not mobile, the falls risk assessment stated they were at medium risk of falling and the records of falls stated the resident's last fall was in 2020.
- The rationale for the use of some restraints was inconsistent in the assessments and care plans. For example, one resident with a security bracelet insitu had an assessment in place which stated that they were at moderate risk of absconsion, the resident's care plan said they were a high risk of absconsion and the Chief Inspector had been notified that they had recently absconded from the centre.
- For those residents with lap belts insitu, their care plan stated that they should have the lap belt released every two hours, however there was no evidence or records held of two hourly release.

Judgment: Not compliant

Regulation 8: Protection

All reasonable measures were in place to protect residents from abuse including staff training and an up-to-date safeguarding policy. Training records indicated that all staff had completed safeguarding training. Inspectors reviewed a sample of staff files and all files reviewed showed that staff had obtained Garda vetting prior to commencing employment. The nursing home was pension-agent for seven residents and there was a system in place to safeguard residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

The following two issues negatively impacted on residents' rights;

- One double-occupancy bedroom number 20, had adequate area of floor space for each resident allowing enough space for a bed, bedside locker and chair, however, should assistive equipment be required, the privacy and dignity of the residents in the double-occupancy may be compromised. In addition, the wardrobe of one occupant was behind the bedroom door impeding access to one of the two wardrobes. This did not negatively impact the one resident living in this bedroom on the day of inspection. However, it would be an issue if there were two residents living in the bedroom. The inspectors was informed that careful assessment of residents to occupy double-occupancy would be required and the provider gave assurances that they were reviewing these arrangements.
- There was restrictions on visitors. This infringed on the rights of residents to have visitors whenever they wished.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Drumbear Lodge Nursing Home OSV-0005312

Inspection ID: MON-0045522

Date of inspection: 05/12/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. Monthly restrictive practice committee meetings to commence for 2025. All currently assigned restrictive practices to be reviewed to see if they are still required. CNMs and Nursing Staff involved in this committee to then cross check with Assessments and Care Plans to ensure all are in line with updated information. Physio and GP input to be included in this review. The list of current restrictive practices was updated on the 28/01/25.

2. ADON has created a tick sheet as prompts for Nursing Staff / CNMs (and for management when auditing): **** Tick Sheet contains: name of resident, Assessment (Restrictive Practice and Restraint Assessment), Physio therapy Assessment / input, GP input (ie: medication management, behaviours), Care plan with trials and alternatives used and steps for responsive behaviour if needed, consent (to be logged in EPICARE) and update NOK (to be included in care plan) . During the monthly meetings this tick sheet will be used to audit/ensure that assessments are in place with evidence of alternatives trialled. Date to be completed and rolled out: 05/02/25. Restrictive practice audits completed once per quarter in Xyea management system. Actions of discrepancies noted and highlighted to each named nurse via Epicare Emails. Care plan audits are done once per month and this will pick up discrepancies in details (such as where assessments and care plans do not match up) – discrepancies highlighted to named nurses via Epicare Emails with dates to have updates completed by.

3. Care plans – Action plan to ensure Holistic care plans are being reviewed frequently: One care plan picked at random and read out at AM handover by DON every Friday to ensure the continuity of details of care between assessments and care plans. Date to be commenced: 31/01/25 . If a care plan needs to be updated following this review, it is to be done by the nurse on duty that day.

4. List of restrictive practices reviewed weekly for KPIs to Support Office COO. Due on

the Tuesday each week.

5. Restrictive practice training will be provided for all staff. The next assigned course is the 30th January 2025 by the Newbrook Trainer. Restrictive practice training and falls prevention training once per quarter to held in-house to ensure all staff up to date with training.

6. Restrictive practice is on the agenda for nursing and care staff meetings to highlight the whole process as per policy – admission, assessment, consent, care plan, MDT involvement and trials of alternatives, and then monthly reviews with the restrictive practice committee. Next restrictive practice committee meeting 25/2/25. Use of tick sheet for good follow through to be initiated from 5/2/25 onwards.

7. Consent on Epicare – previously verbal consents obtained for restrictive practices and documented in holistic care plans. Consent to be documented in Epicare as a separate entry. Highlighted for learning at the monthly nursing meeting on 5th February 2025. This is to be completed by 07/03/25 for all relevant residents.

8. CNMs are now doing a weekly audit of Epicare touchcare for the residents with currently assigned restrictive practices to see if there is evidence of assigned lap belts, checks and releasing the lap belts/ bed rails. Deficits are printed up and highlighted for daily handovers and monthly team meetings until we have full compliance. Touchcare checks are commencing on 29/01/25.

9. Lap Belts – to ensure compliance with policies and recording of lap belts, daily handover sheets are to have assigned team leaders in each area to monitor and supervise restrictive practice protocols. Daily handover sheets to reflect who is on sensor alarms, lap belts and bed rails so all staff up to date with current information. To roll out 06/02/25 after both the nurses' and HCAs' monthly meetings. We plan to have full compliance by 07/03/25.

A green tag system has been introduced to record when an item of equipment has been cleaned. A handwashing sink will be installed in the cleaner's room shortly.

The SOP has been reviewed along with the floor plans. Updated dated copies of both documents will be submitted to the Chief Inspector shortly.

All rooms in the Centre will be used in line with the SOP. Previously room 67 was registered as an assisted toilet and we are now seeking to have it registered as a storeroom. Room 64 had been registered inadvertently as a toilet and shower from when the extension was originally registered in 2019. This was an error which may have occurred at some point in the building process when it was decided not to install either a shower or a toilet in that room because it was not required. The floor plans were not updated to reflect this error.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The SOP has been reviewed along with the floor plans. Updated dated copies of both documents will be submitted to the Chief Inspector shortly.

All rooms in the Centre will be used in line with the SOP. Previously room 67 was registered as an assisted toilet and we are now seeking to have it registered as a storeroom. Room 64 had been registered inadvertently as a toilet and shower from when the extension was originally registered in 2019. This was an error which may have occurred at some point in the building process when it was decided not to install either a shower or a toilet in that room because it was not required. The floor plans were not updated to reflect this error.

The railings in bedroom 29 have been removed.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

A green tag system has been introduced to record when an item of equipment has been cleaned.

A handwashing sink will be installed in the cleaner's room shortly.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

1. Monthly restrictive practice committee meetings to commence for 2025. All currently assigned restrictive practices to be reviewed to see if they are still required. CNMs and Nursing Staff involved in this committee to then cross check with Assessments and Care Plans to ensure all are in line with updated information. Physio and GP input to be included in this review. The list of current restrictive practices was updated on the 28/01/25.

2. ADON has created a tick sheet as prompts for Nursing Staff / CNMs (and for management when auditing): **** Tick Sheet contains: name of resident, Assessment (Restrictive Practice and Restraint Assessment), Physio therapy Assessment / input, GP input (ie: medication management, behaviours), Care plan with trials and alternatives used and steps for responsive behaviour if needed, consent (to be logged in EPICARE) and update NOK (to be included in care plan) . During the monthly meetings this tick sheet will be used to audit/ensure that assessments are in place with evidence of alternatives trialled. Date to be completed and rolled out: 05/02/25. Restrictive practice audits completed once per quarter in Xyea management system. Actions of discrepancies noted and highlighted to each named nurse via Epicare Emails. Care plan audits are done once per month and this will pick up discrepancies in details (such as where assessments and care plans do not match up) – discrepancies highlighted to named nurses via Epicare Emails with dates to have updates completed by.

3. Care plans – Action plan to ensure Holistic care plans are being reviewed frequently: One care plan picked at random and read out at AM handover by DON every Friday to ensure the continuity of details of care between assessments and care plans. Date to be commenced: 31/01/25 . If a care plan needs to be updated following this review, it is to be done by the nurse on duty that day.

4. List of restrictive practices reviewed weekly for KPIs to Support Office COO. Due on the Tuesday each week.

5. Restrictive practice training will be provided for all staff. The next assigned course is the 30th January 2025 by the Newbrook Trainer. Restrictive practice training and falls prevention training once per quarter to held in-house to ensure all staff up to date with training.

6. Restrictive practice is on the agenda for nursing and care staff meetings to highlight the whole process as per policy – admission, assessment, consent, care plan, MDT involvement and trials of alternatives, and then monthly reviews with the restrictive practice committee. Next restrictive practice committee meeting 25/2/25. Use of tick sheet for good follow through to be initiated from 5/2/25 onwards.

7. Consent on Epicare – previously verbal consents obtained for restrictive practices and documented in holistic care plans. Consent to be documented in Epicare as a separate entry. Highlighted for learning at the monthly nursing meeting on 5th February 2025. This is to be completed by 07/03/25 for all relevant residents.

8. CNMs are now doing a weekly audit of Epicare touchcare for the residents with currently assigned restrictive practices to see if there is evidence of assigned lap belts, checks and releasing the lap belts/ bed rails. Deficits are printed up and highlighted for daily handovers and monthly team meetings until we have full compliance. Touchcare checks are commencing on 29/01/25.

9. Lap Belts – to ensure compliance with policies and recording of lap belts, daily handover sheets are to have assigned team leaders in each area to monitor and

supervise restrictive practice protocols. Daily handover sheets to reflect who is on sensor alarms, lap belts and bed rails so all staff up to date with current information. To roll out 06/02/25 after both the nurses' and HCAs' monthly meetings. We plan to have full compliance by 07/03/25.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The layout of bedroom 20 is being reviewed. Twin bedroom 20 will only cater for ambulatory residents who are admitted for short-term respite or convalesce. This will be included in the revised SOP which will be submitted to the Chief Inspector shortly.

We are also reviewing the types of residents that would be admitted into this room and whether they would have significant assistive equipment.

The Centre has protected mealtimes for residents. However, the implementation of this policy has been reviewed along with signage displayed in the Centre. Residents are free to receive visitors whenever they choose.

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 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	28/02/2025
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.	Substantially Compliant	Yellow	15/02/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	15/02/2025

	associated infections published by the Authority are implemented by staff.			
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.	Not Compliant	Orange	07/03/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	28/01/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	28/01/2025