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:	Brentwood Manor Private Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Letterkenny Road, Convoy, Donegal
Type of inspection:	Unannounced
Date of inspection:	07 November 2022
Centre ID:	OSV-0000322
Fieldwork ID:	MON-0037481

About the designated centre

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

Brentwood Manor Nursing Home is a purpose built single storey building located in a residential area a few minutes drive from the village of Convey in County Donegal. The building is organised into five units named Oak, Ash, Elm, Birch and Rowan. The residents' accommodation, communal space that includes a dining room, sitting areas and toilet and bathroom facilities. There are 36 single and ten twin bedrooms and all have ensuite facilities that include a toilet, shower and wash hand-basin. There is extensive grounds surrounding the centre and a smaller safe garden space is accessible to residents. The centre provides care to 56 dependent persons who have problems associated with dementia or other cognitive problems due to brain injury or major illness. The statement of purpose states that the service aims to provide high quality health and social care for residents through a person centred care approach.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

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
Monday 7 November 2022	20:15hrs to 22:20hrs	Catherine Rose Connolly Gargan	Lead
Tuesday 8 November 2022	08:10hrs to 16:30hrs	Catherine Rose Connolly Gargan	Lead
Monday 7 November 2022	20:15hrs to 22:20hrs	Rachel Seoighthe	Support
Tuesday 8 November 2022	08:10hrs to 16:30hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over two days, the first day of the inspection was carried out between 20:15hrs and 22:20hrs. On the first evening of the inspection there were two nurses and four care staff on duty to care for 52 residents. Three other residents were in hospital and a fourth resident was on home leave with their family. One resident was re-admitted to the centre from hospital on the first evening of the inspection. The second day of the inspection was facilitated by the person in charge.

An introductory meeting was commenced, followed by a walkabout of the premises. This gave inspectors the opportunity to meet with residents and staff, to observe the lived experience of residents in their home environment and to observe staff practices and interactions. During this time, many residents were observed in the communal sitting rooms and walking on the corridors. Residents appeared to be well-dressed and were neat and tidy in their appearance. Inspectors found that residents' accommodation in the centre was divided into two separate areas by means of electronic key code locked doors. One area had 30 male residents and the other area had 22 male and female residents and the inspectors observed that the residents in either area did not interact or mix with each other at any time. Later in the evening the male only area of the centre was divided further into three separate areas. Inspectors were told by the centre's management that these arrangements were in place to protect residents from COVID-19 infection. However, there was no evidence of COVID-19 infection in the centre at the time of this inspection.

Inspectors spoke with staff and met a number of residents who were still up and about in both units. Inspectors found that staff on both units were working hard to provide care and support for the residents but were unable to meet their needs in a timely manner. Some staff interactions with residents demonstrated kindness but the majority of staff interactions with residents involved completing tasks of care. Inspectors observed that there were not sufficient staff on duty to provide safe care, taking into account the resident profile and the layout of the designated centre. Staffing available was split between the two areas with one nurse and two carers allocated to each area. Inspectors observed that many of these residents were at risk of falling and required supervision, other residents needed two staff to attend to their care needs and a number of residents were known to display varying levels of responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors found that the staffing resources in place did not ensure that residents could be adequately supervised. Concerns were validated by a near miss peer-to-peer incident that occurred in a communal room on the evening of the inspection, no member of staff was present in the communal room with the residents at the time of the incident. Inspectors observed one resident had wandered into an unsecured storage room, which was a particular risk as the room contained chemicals and medication which had been inappropriately stored in this room. This was immediately addressed by the staff nurse on duty in

response to inspectors bringing this finding to their attention. Inspectors found that there were not sufficient staff available to supervise the resident as they wandered around the unit. Inspectors also found that staff from both units were required to complete laundry at night which staff reported took up to an hour to complete. The laundry facility was located in a separate external building and staff were required to leave the residents regularly during the night to attend to laundry tasks. This posed a risk to residents as it further reduced the number of staff who were available to provide care and support for residents in the centre.

Inspectors found that residents' in the both areas did not have equal access to the facilities available. For example, a female resident who requested a cigarette was required to smoke outside on the first evening of the inspection, as they were restricted from accessing the designated smoking room which was located in the area of the centre accommodating male residents only. The resident , who was assisted to a courtyard by a member of staff, informed inspectors that they have to smoke outside every night as there is no other facility available. Additionally, residents accommodated in the male wing were unable to access the sensory room, as this was located in the unit designated for female residents.

Inspectors observed residents' dining experience in the centre and saw that the dining rooms had accommodation for nine residents in each. As the there was insufficient space in the dining rooms, the remaining residents ate their meals in the sitting rooms. Staff told the inspectors that residents' meals were served in one sitting. The inspectors observed that there was enough staff available to assist residents with eating and while some person centered interactions were observed, some staff interactions were task focused.

On the second day of the inspection, care staff were observed trying to respond to residents' requests for assistance but were unable to meet them in a timely manner and residents became frustrated. Inspectors again observed that there staff were unavailable to remain with residents in the communal sitting rooms as staff were needed to support other residents with personal care in their bedrooms. On one occasion, inspectors observed that a care staff who was supervising a number of residents who were at high risk of fall, had to leave the room unattended as a resident in another area required urgent assistance with their personal care. The inspector observed this resident was trying to find their bedroom and was wandering into another resident's bedroom. There were no staff available to assist this resident as they wandered without purpose around the unit. Inspectors also observed that care staff were often waiting for another staff member to become free to help them to provide safe care for residents who needed two staff to meet their needs. Inspectors also observed that floors in the unit were being washed mid morning. Although, staff were aware of the risk of residents falling and endeavoured to ensure they remained in the communal room, inspectors observed that a number of other residents were were at risk of slipping as they were walking on the wet floor. Inspectors also noted that the electronic resident record system could only be accessed by staff in the centre's reception. This meant that nursing staff were required to leave the resident areas each time residents care records needed to be accessed and were unavailable to supervise care and meet residents needs.

There was one member of staff with overall responsibility for coordinating social activities for all residents in the centre. On the second day of the inspection, social activities were observed being carried out in a communal room in only one area of the centre which the residents in the other area of the centre could not access and these residents were not provided with any opportunities to participate in any social activities to meet their needs during this inspection. Outside of mealtimes and visits by relatives, most of the residents were observed to spend their day in the sitting rooms with the television on. Inspectors observed that most of the residents were not watching the television or engaging with each other. Some residents slept in their chairs. One resident was observed to care for toy animals. Other residents who did not attend the sitting rooms were observed to spend much of their time pacing the corridors for long periods. Few of the residents engaged but those who did expressed satisfaction with the service and staff caring for them.

The inspectors observed that staff did not identify that some residents were experiencing responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff appeared to accept that the behaviours residents were exhibiting were 'usual behaviours' for these residents. As a result, these residents were not adequately supported by staff . For example, the inspectors observed that one resident was trying repeatedly, to open a locked corridor door which led out of the the male only area of the centre. When the door was opened from the other side by a member of staff entering the area, the resident sought to enter the main reception area, however staff were seen to immediately redirect the resident back into the male only area, without explanation. No further intervention was observed to take place to support this resident and to address this resident's anxieties. Inspectors also observed the same resident attempting to open a locked door into an enclosed courtyard area, staff were seen waving at the resident to redirect them away from the door, however no further interaction took place to support this resident.

Inspectors observed that the residents were not supported to leave the two separated areas of the centre unless they were receiving visitors. Residents were then assisted out of the secure area by a staff member, to a visitors room located near the main reception area. The extent of the segregation was such that there were no interactions between the male and female residents. In addition, such segregation significantly reduced the opportunities for socialisation between residents.

Some residents' bedroom doors were painted in a variety of colours to assist residents with way-finding. Some residents' bedrooms were personalised with items such as their photographs and ornaments.

Corridors were wide and had handrails on both sides, however, storage of bulky equipment along some corridors posed a trip hazard to vulnerable residents and hindered their access to the handrails provided. While some walls on the corridors were decorated with murals for residents' enjoyment, a number of these murals were damaged and torn.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This inspection found that management and oversight of this service was not effective and the quality assurance processes in place did not ensure that this service was safe, appropriate and met the needs of the residents. As a result the inspectors found that there was a culture of restrictive practices and daily routines that were negatively impacting on the lives of the residents. Unsolicited information received prior to this inspection by the Health Information and Quality Authority (HIQA) alleging poor standards of nursing, personal and social care of residents, inadequate staffing, access to healthcare and high incidence of residents falling were substantiated on this inspection and the inspectors' findings are discussed under the relevant regulations in this report.

The provider had only completed three out of seventeen of the actions in their compliance plan from the last inspection in May 2022. The provider had reduced the floor space in a multipurpose activity room and converted the centre's oratory to provide staff changing facilities and a visitor's room during the COVID-19 pandemic. These facilities had not reverted back to the purpose they were registered for at the time of this inspection and the provider had not made an application to the Chief Inspector to vary the designated centre's registration conditions to retain these visiting and staff changing facilities up to the time of this inspection.

The provider states in their statement of purpose dated 20 October 2022 that Brentwood Manor nursing home is a dementia specific nursing home. While, the majority of residents living in the centre on the days of this inspection had dementia, some other residents were admitted for long-term care with acquired brain injuries and mental health disorders. Ten residents in the centre were aged under 65years, four of whom had additional personal assistant hours funded. Another resident had privately funded personal assistant hours and another resident attended a day service on one day each week. The findings of this inspection did not provide satisfactory assurances that there was sufficient oversight of the quality and safety of this service by the provider and that adequate resources were provided by the provider to meet residents' needs and ensure their safety and quality of life in the centre.

The registered provider of this designated centre is the The Brindley Manor Federation of Nursing Homes Limited. The provider company's chief operating officer (COO) was assigned to represent them. As the provider is involved in operating several residential services for older people, Brentwood Manor nursing home benefits from access to and support from centralised human resources, information technology, staff training and finance departments. The person in

charge has been in the role since February 2016 and meets regulatory requirements. The person in charge had senior clinical support from a regional manager and an assistant director of nursing locally who assisted with auditing and staff supervision. The assistant director of nursing deputises during leave by the person in charge.

The number and skill mix of staff working in the centre on a daily basis was not adequate to meet the increased needs of residents in the centre. Effectiveness of the already inadequate staffing resources available were further impacted as a result of dividing the centre into two separate units with a separate allocation of staff during each day and with dividing the centre into five separate areas at night. Inspectors found that staff were unable to meet the increased and complex needs of residents and residents' safety, the quality of the care they received and their quality of life in the centre was negatively impacted. For example, staff were not available to ensure vulnerable residents' risk of falling was managed, residents were safeguarded, residents had opportunities to participate in meaningful social activities in line with their capacities and choices. The majority of staff-resident interactions were related to care interventions and were not person centred and residents' opportunities and support for positive risk taking and a good quality of life in the centre were not optimised.

Staff training records, inspectors' observations and discussions with staff showed that not all staff had access to mandatory training in fire safety and safeguarding residents from abuse. In addition, staff did not have access to training and support to develop their skills and competencies with providing person centred care for residents. In addition, there were no staff available who had training in the provision of suitable social activities for residents with dementia, acquired brain injury and mental health disorders. Standards of residents' clinical and social care, documentation, supervision of vulnerable residents and cleaning in the centre did not give assurances that staff were appropriately supervised according to their roles. Consequently, necessary improvements were not identified through the centre's staff supervision processes and comprehensively addressed.

Not all required incidents as specified by the regulations were notified to the Chief inspector as required. Notification of a safeguarding incident that occurred in August 2022 was received following this inspection. Notification of the restrictions on residents in their environment was not received.

An up-to-date centre specific complaints policy was available in the centre to inform management of complaints by residents or others regarding the service provided. While, inspectors were assured that all complaints were investigated and the outcome of investigations were communicated with complainants, the documentation supporting this process required improvement.

Regulation 15: Staffing

There was insufficient numbers of staff with appropriate skills to meet the needs of

residents in the designated centre. This was evidenced by the following;

- Staff were not present in the sitting rooms where vulnerable residents with assessed risk of falling and residents with increased risk of experiencing responsive behaviours spent much of their day. This meant that staff were not present to mitigate residents' risk of falling and to de-escalate responsive behaviours including behaviours that posed a risk of harm to other residents.
- There was a high incidence of residents falling in the centre. The inspectors found that residents fell on 90 occasions from 01 January to 30 November 2022. Twenty three (approximately 26%) of these fall incidents by residents occurred in the sitting rooms, the majority of which were not witnessed by staff. Inspectors observed on the first day of the inspection that staff were not present in one of the sitting rooms when a peer-to-peer incident occurred.
- Inspectors found that two staff nurses and four care staff rostered each night was not adequate staffing resources to ensure residents' needs were met at night. For example, nearly 50% of falls by residents occurred between 20:00hrs and 08:00hrs and most were not witnessed by staff.
- Care staff had responsibility for doing laundry duties at night. Staff informed the inspectors that this role necessitated them spending up to an hour at a time in the laundry located in a separate building. This meant that staff available to meet residents' needs was reduced for long periods during the night.
- There was not enough staff available to ensure residents had reasonable opportunity to engage in meaningful social activities to meet their interests and capacities.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found from observing staff practices, speaking to staff and from review of residents' care documentation and staff training records that staff available that had not all staff had been facilitated to attend mandatory training as follows;

- Refresher fire safety training had not been completed by 27 staff
- One staff nurse had not completed training in safeguarding residents from abuse.

Training records also identified the need for staff training in the management of restrictive practices in line with the national policy, in order to bring about improved outcomes for residents as discussed under Regulation 7. The findings of this inspection also identified staff training needs in care and support of residents with dementia and person-centred care.

Staff were not appropriately supervised to ensure that they carried out their work to

the required standards. This was evidenced by the following findings;

- Staff did not recognise that the overly restrictive practices and routines infringed the rights of many of the residents living in the centre. For example, it was accepted practice among staff that access for a cohort of male residents was restricted to one side of the nursing home. This practice meant that they were unable to integrate with the other male and female residents in the centre.
- Residents' were not adequately supervised in the communal sitting room.
- Residents' care documentation was poorly maintained.

Judgment: Not compliant

Regulation 23: Governance and management

The management and oversight systems in place to ensure compliance with the Health Act 2007 (Care and Welfare of resident in Designated centers for Older People) Regulations 2013 were not effective. This was evidenced by the following findings;

- The management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not effective as evidenced by the findings of this report regarding restrictive practices; healthcare, care planning, residents rights, fire safety, infection control and premises.
- Systems to ensure adequate staffing resources were provided were not in place and did not ensure the effective delivery of care in accordance with the centre's statement of purpose.
- Risk was not appropriately managed in the centre and resulted in a culture of over restrictive and institutional practices which were negatively impacting on residents' quality of life, positive risk taking, rights and well being as evidenced by the findings in this report regarding restrictive practices in place and failure to ensure residents' rights were respected.
- Risk posed by insufficient arrangements for clinical oversight of residents' care had not been identified and addressed by the provider as evidenced by deficits in , inappropriate supervision of staff, care-planning, health care and infection prevention and control.
- The quality assurance systems that were in place did not ensure the quality and safety of the service was effectively monitored. This was impacting on clinical effectiveness and residents' quality of life. For example, disparities between the consistently high levels of compliance reported in the centre's own audits did not reflect the inspectors' observations during the inspection.
- The service did not have effective leadership, governance and management systems in place to reduce risk of harm and to promote the rights of each resident. As a result, safeguarding concerns such as institutional practices

were not effectively identified and managed in the centre.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of four residents' contracts of care agreed between the residents and the provider and saw that they accurately set out the terms and conditions of their residency including the proportion of the overall fee charged to each resident in receipt of Fair Deal scheme support and the bed they occupied. Inspectors confirmed in the sample of residents' contracts reviewed that residents were not charged for any additional services they had not received.

Judgment: Compliant

Regulation 31: Notification of incidents

Whilst the majority of notifications were submitted within the time-frames, the centre had not notified the Chief Inspector of a safe-guarding incident as required by the regulations. This notification was submitted in the days following the inspection.

Additionally, notification of use of restrictive medicines that had been used on several occasions and restrictions on residents' access within the centre had not been notified in quarterly notifications as required by Regulation 31. Notification of incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were two complaints recorded in the complaints record for 2022 and both were closed to the satisfaction of the complainants. However, the inspectors were told by a member of the management staff that another complaint was received and was in progress. While inspectors were given assurances that this complaint was being managed in line with the centre's policy, there was no information recorded in the records made available to the inspectors regarding this complaint, the investigation process, response to the complainant and the actions taken .

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that most residents' clinical and nursing care needs were generally met. However, actions were necessary to address suboptimal standards of care provided for residents' at risk of,or with wounds caused by pressure to areas of their skin. Inspectors observed an unacceptable institutional approach to care and found that interactions by staff with residents were predominantly limited to providing care interventions with limited evidence of quality person-centred interactions. .

Overly restrictive and institutional practices were found on this inspection that prevented residents from accessing communal accommodation in the centre during the day and going outside the unit their bedroom was in at night. This practice limited residents' opportunities to engage in meaningful social interactions with each other and with staff, was having a negative impact on residents' quality of life and wellbeing and did not uphold their rights to determine how and where they spent their day.

While residents had timely access to their general practitioners (GPs), there was evidence of delay in accessing physiotherapy and occupational therapy services. There was a high incidence of residents falling in the centre and while some actions were described to mitigate risk of recurrence, these actions were not implemented. For example, increased supervision by staff was referenced as a measure to reduce the risk of residents falling but was not implemented.

Several residents' nursing and social care needs were not comprehensively assessed to a satisfactory standard and consequently care plans were not developed to direct staff on the care and supports these residents required. For example, residents social activity needs were not comprehensively assessed and resulted in residents not having access to suitable and meaningful social activities that met their capacities and choices to ensure their quality of life in the centre was optimised. The inspectors found that residents' wound care required improvement to ensure they were managed in line with evidence based wound care procedures. Records showed that effective arrangements were not in place to ensure treatment and care recommendations made by members of the multidisciplinary team were implemented and monitored. Inspectors' findings are discussed further under regulations 5; Assessment and Care Planning and 6, Healthcare.

While, residents had access to psychiatric services. the inspectors found that the current care practices did not ensure that staff provided appropriate support and care for those residents who may display responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment.) Staff

practices in relation to restraints were not in line with the national restraint policy.

The provider had made improvements to some parts of the residents' lived environment by replacing carpet floor covering with a surface that supported effective cleaning. However, remaining carpets were visibly soiled and created a significant malodour. Carpet floor covering was deep cleaned on the second day of this inspection in response to inspectors identifying their findings to the management team. Notwithstanding the improvements made, inspectors found that ongoing maintenance of the premises did not ensure all areas were in a good state of repair and were adequately maintained for the comfort and safety of the residents. This was a particular concern as the provider had failed to develop the environment to become a dementia friendly space which was familiar and therapeutic for the many residents with dementia.

Residents accommodation in the centre was arranged on ground floor level in five units known as Ash, Oak, Elm, Birch and Rowan Avenues. Residents' bedroom accommodation was provided in 46 single and ten twin bedrooms. One single bedroom did not have en-suite shower facilities and it was necessary for the resident in this bedroom to travel a distance to the nearest communal shower in another unit. There were four sitting rooms and four day rooms, a sensory room, smoking room, hair salon and a multi-purpose activity room and visitor's off the reception area provided. Due to the environmental restrictions in place, each resident had access to some of these areas only. None of the residents could access the multipurpose activity room and visitor's room or reception area of the centre as they wished. Two enclosed outdoor areas were provided but were not accessed by any residents on the days of this inspection.

Notwithstanding improvements made by the provider since the last inspection to protect residents from risk of fire, the inspectors found that action was required to bring the centre into compliance with the regulations and to ensure effective containment of fire and smoke, staff training and documentation of fire safety equipment checking to ensure this equipment is operational at all times. The inspectors' findings are discussed in further detail under regulation 28, Fire precautions.

The designated centre were free of COVID-19 infection at the time of this inspection. Staff took infection prevention and control precautions as recommended in public health guidance, were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns regarding a resident. However, the environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection and ensured compliance with regulation 27, Infection control.

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors in a designated visitors room. Visits were encouraged with precautions to manage and mitigate the risk of introduction of COVID-19 infection.

Residents had access to local and national newspapers and radios. While televisions

were available in the communal sitting rooms, some residents did not have a television in their bedroom and residents in twin bedrooms did not have individual choice of television viewing and listening as only one television was provided in these bedrooms.

Regulation 11: Visits

Visits by residents' families were encouraged and practical precautions were in place to manage any associated risks. Residents access to their visitors was not restricted and facilities were available to ensure residents were protected from risk of infection.

Judgment: Compliant

Regulation 17: Premises

Although the provider had made improvements to the premises since the last inspection, such as replacing some flooring and installing additional clinical hand hygiene sinks along corridors, further actions by the provider were necessary to ensure that the layout and design of the premises is appropriate to the number and needs of residents in the centre and in accordance with centre's statement of purpose. This was evidenced by the following findings;

- The layout and design of the residents' dining rooms were not of a sufficient size to facilitate all residents to eat their meals in the dining rooms available. For example, the centre provided accommodation for 56 residents and there were four dining rooms in the centre that provided dining facilities for nine residents in each. A second sitting arrangement was not in place at the time of this inspection to ensure all residents could dine in a dining room environment.
- The seating provided in the residents' sensory room was of a very low level and did not promote residents' independence or meet many of the residents' needs for seating at a higher level.
- There was insufficient storage space for residents' equipment and house keeping equipment. Items of residents' equipment such hoists and laundry trolleys were inappropriately stored on corridors.This posed a risk of falls, as it was a trip hazard to vulnerable residents and it impeded residents' access to the handrails.
- A large cleaning device used to clean floor surfaces in the designated centre was stored in the residents' communal room off the centre's reception area. This posed a risk of cross infection and risk of injury to vulnerable residents.
- One resident had to travel an unacceptable distance from their bedroom to access a shower.

- The layout of one twin bedroom did not provide sufficient circulation space for one resident to access the en suite toilet and shower facility attached to that room.
- The layout of some twin bedrooms did not ensure that residents had access to lockable storage to secure their valuables within their bed space.

The provider had not ensured that the premises was in compliance with Schedule 6 of the regulations. This was evidenced by;

- Floor covering that was continued to form skirting at the base of the walls in one sluice room were peeling away from wall surfaces.
- Wall surfaces in the reception area, in some residents' bedrooms, along some corridors and on wooden doorframes and bedroom doors were scuffed and had paint missing and required repair and painting.
- A number of feature wallpaper murals displayed along corridors for residents' enjoyment were torn and damaged.
- Arm rest surfaces on a number of fabric covered chairs used by residents were torn and damaged. Loose arm rest covers fitted to cover the torn areas were removed by residents exposing the torn arm rests which could not be effectively cleaned.
- One area of a ceiling surface showed signs of water leakage damage and required repainting.
- A handle had been broken off a window in the designated smoking room and made opening and closing this window difficult.

Judgment: Not compliant

Regulation 27: Infection control

The infection prevention and control processes that were in place did not adequately address risks associated with the transmission of health care-associated infections and the environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by the following findings;

- The system in place to provide assurances that equipment was cleaned after each use was not robust. For example, inspectors found that the footrests of hoists were visibly unclean.
- A communal bath was visibly stained and it was unclear if it had been cleaned after use.
- Hoist slings used to support residents' mobility needs were being stored on a hoist when not in use and were not assigned for individual resident's use, this posed a risk of cross infection.
- A hazardous waste disposal bin was not available in one sluice room. Appropriate hazardous waste bags were not available in the hazardous waste bins in a second sluice room. This meant that the waste management

procedures in place did not support the safe disposal of hazardous waste.

- Storage racks for the purpose for storing continence equipment to dry following decontamination was positioned directly over the hand washing sink in the sluice room and posed a risk of cross contamination from drip of residual liquids.
- Personal protective apron equipment was observed hanging over a rail in a communal bathroom and posed a risk of cross infection.
- Open top refuse bins were observed in the sluice rooms, increasing the risk of cross contamination.
- The layout of the centre's laundry was cluttered and untidy and did not support a unidirectional soiled to clean laundering process.
- The hand wash sink located in the laundry room was visibly unclean and did not support effective hand hygiene procedures.
- While, a programme of replacing carpet floor covering was in progress, remaining carpets on some corridors and in some residents' bedrooms were visibly stained and caused a significant malodour in these areas. Although, cleaned on the second day of this inspection, a cleaning schedule was not in place to ensure that carpets were maintained in a clean state at all times.
- A hand hygiene sink and lockable storage for potentially hazardous cleaning solutions were not available in the house-keeping room.
- The floor surface of one of the housekeeping stores was visibly unclean and items of equipment and boxes of supplies were inappropriately stored on floor. This hindered effective floor cleaning and posed a risk that items stored on the floor would become contaminated.
- The floor surface in the centre's laundry was visibly unclean. Items of equipment were stored on the floor and hindered effective cleaning. Inspectors also observed a cleaning bucket containing discoloured water was stored in a corner of the laundry. A laundry staff member informed inspectors that they used this equipment to clean the floor during the day.
- Although, hand hygiene sinks that met recommended standards were available for staff use in the centre, the hand hygiene sink in a clinical room was of a domestic sink design and did not meet recommended clinical hand hygiene sink recommendations or support effective clinical hand hygiene procedures.
- A bedpan disinfection machine was not functioning as required at the time of this inspection. Further to maintenance on the days of inspection, the inspectors were given assurances that this equipment was operating as required. A service record dated August 2022 recommended replacement with a new machine. This recommendation had not been progressed up to the time of this inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure adequate precautions were in place to

protect residents and others from the risk of fire and that the centre was in compliance with regulation 28, Fire precautions as follows;

- Although, action was taken by the provider since the last inspection in May 2022 to address large gaps between the floor and several doors including residents' bedroom doors, inspectors found that a large gap between the floor and the bottom of one resident's bedroom door and a storeroom were not addressed. Therefore, containment of fire/smoke/fumes was not assured in these areas in the event of a fire in the centre.
- Refresher fire safety training had not been completed by 27 staff. As only one simulated evacuation drill was completed in 2022, not all staff were facilitated with an opportunity to participate in an evacuation drill procedure. Some staff who spoke with inspectors were not aware that fire exits opened on activation of the fire alarm and understood that they needed a key to open them. This posed a risk of delay in evacuation to the outside of the building if required.
- While, a record of a simulated night-time emergency evacuation drill completed in May 2022 given to inspectors gave assurances regarding residents' timely evacuation, the staffing resources referenced did not reflect the actual number of staff rostered and did not account for the role of night staff not included in the simulated procedure.
- Annual certification of the emergency lighting system in the centre was not available for review on the days of this inspection.
- While, some records of fire safety equipment checks were available, these records were incomplete and did not give assurances that some items of equipment such as the fire alarm panel and fire doors were adequately checked and any action to remedy any defects found had been addressed. For example;
    - Inspectors were told that the fire alarm system was tested weekly. However, no records were available to confirm completion of this procedure to ensure this emergency system was operational at all times.
    - Inspectors were told that the fire alarm panel was checked for faults each day however, records were not available to confirm this.
    - Records of fire door checks confirmed with a tick that emergency exit and fire doors were operated as required, however the records were not adequate as they did not reference the condition of the individual doors and whether any defects had been identified and addressed.
- An exit designated as an emergency fire exit was obstructed by a clothes hanging rail in a room registered as the residents' oratory and in use at the time of this inspection as a staff changing room.
- An ash tray and protective smoking apron was not provided in the centre's smoking room. This posed a risk of burn injury to vulnerable residents.
- The personal emergency evacuation procedures (PEEPs) were not updated for two residents to ensure their needs were assessed regarding the staffing resources and equipment they needed to ensure their safe evacuation.
- A heat/smoke sensor was not fitted in the male changing room.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a number of residents' assessment and care plan documentation and found that significant actions by the provider and person in charge were necessary to ensure residents' needs were appropriately assessed and that care plans were developed and implemented to address any needs identified. This was evidenced by the following findings;

- Residents' comprehensive assessments were incomplete and therefore, not all their needs were not identified and a plan of care developed to provide direction for staff on the care and supports thy must provide to meet residents needs. For example, a resident who experienced responsive behaviours did not have this information recorded in their comprehensive assessment, consequently a behavioural support plan was not developed. This meant that staff did not have adequate information on how this resident's behaviours may present, triggers to the behaviours that should be avoided or the most effective strategies to de-escalate their responsive behaviours. In addition, comprehensive assessments completed for some residents with nutritional needs did not adequately identify their needs and preferences. Consequently a care plan was not developed to address their nutritional needs.
- Care plans were not developed for several residents to meet their needs. Inspectors found the following; For example,
    - Social Activity care plans were not developed for several residents' to inform staff on the social activity programmes they required to ensure their interests and capacity needs were met. . The inspectors found that this resulted in negative outcomes for residents' quality of life in the centre.
    - A care plan was not developed for a resident with a history of seizures prior to admission. This meant that staff were unaware of this resident's health risks and did not have up-to-date information regarding the care interventions this resident needed in the event of them having another seizure
    - A care plan had not been developed to direct staff on the care interventions they must complete for a resident with a pressure related to prevent further deterioration of the wound.
- Some residents' care plans were not reviewed and update at four monthly intervals or in response to their changing needs. For example, one resident's social care plan did not reflect current arrangements regarding their access to external support services. Additionally, inspectors found that not all staff were aware of the arrangements in place.

Judgment: Not compliant

Regulation 6: Health care

The provider and person in charge did not ensure that residents received a high standard of evidence based nursing care to meet their needs. This was evidenced by the following findings;

- Residents with pressure related skin wounds were not provided with a high standard of evidence based nursing care regarding prevention of pressure related skin damage and care to promote healing of pressure related wounds that had developed. For example;
    - A recommendation made by a tissue viability nurse that a specific secondary dressing should be applied to protect a resident's significant pressure ulcer wound from contamination and friction had not been completed for seven consecutive days.
    - Repositioning records were not available for another resident with a pressure related skin wound.
- Residents with assessed risk of falling were not adequately supervised by staff although their care plans identified that this action should be completed to mitigate their risk of falling or of sustaining repeat falls. This finding did not reflect high standards of nursing care and support for these residents.
- Several residents in the centre experienced episodes of responsive behaviours, some of whom had behaviours that posed a risk to other residents' safety. Staff did not ensure that they were available at all times in the communal sitting rooms to ensure residents residents with responsive behaviours were supported and the other residents were appropriately safeguarded.
- Residents with impaired mobility and assessed risk of falling did not have timely and regular access to physiotherapy or occupational therapy. This finding did not reflect high standards of evidenced based nursing care to meet their mobility needs.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Not all staff had been facilitated to attend training in responding to and managing residents' responsive behaviours. Consequently, not all incidents of responsive behaviours were recorded and not all residents who experienced responsive behaviours had a care plan in place to mitigate risk of their behaviours occurring or when they occurred, knowledge of the most effective strategies to de-escalate their behaviours and mitigate risk of to other residents. Not all responsive behaviours were recognised as such and records were not consistently maintained to support

monitoring and treatment pathways. For example, inspectors found that a number of peer-to-peer incidents were not appropriately investigated and managed in the centre.

Restrictions placed on residents access in the centre did not reflect national guidance and did not ensure that restraints were used in the least restrictive manner and for the minimum amount of time required.

For example;

- A cohort of 30 male residents were kept separated in one part of the centre from other male and female residents at all times. A clear rationale for this practice was not available and risk assessments were not completed for each resident to record what the risks were and what non-restrictive interventions were in place to manage the risk prior to implementing environmental restraints.
- All residents' were restricted with use of electronically locked doors from accessing the reception area unless accompanied by staff to meet their visitors in the visitors' room. This meant that residents did not have access to the reception desk or a large room that was registered as communal space for residents' use.
- Access to each of the five units was restricted by electronically locked cross corridor doors at night.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights to exercise choice in how and where they spent their day was not respected. A cohort of male residents were segregated in one area of the centre by electronically locked cross-corridor doors. This was a well established practice in the centre and did not reflect the current needs of the residents or their preferences. This practice prevented these residents from integrating with the other male and female residents in the centre. This is further discussed under regulation.

All residents in the centre had dementia and most of the residents were able to mobilise either independently or with the aid of some assistive equipment. Residents were not provided with adequate opportunities to engage in meaningful social activities that met their interests and capacities. The activity coordinator tried to meet the residents social activity needs but as many of the residents were unable to engage in group activities, one-to-one activities provided were limited. The inspectors found from review of residents' care records that they did not have any opportunity to participate in social activities for several days at a time. For example, one resident aged under 65yrs did not have opportunity to engage in a social activity from 19 Oct to 03 November 2022. Another resident also aged under 65yrs did not have opportunity to engage in social activities from 28 October to 01

November 2022. Although, the centre exclusively admitted residents with dementia, staff did not have skills to facilitate accredited sensory focused activity programmes to ensure residents had access to meaningful social activities that met their interests and capacities. .

Televisions were not provided in all bedrooms and the provision of one television set in twin bedrooms did not afford each resident personal choice regarding their television viewing and listening.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Brentwood Manor Private Nursing Home OSV-0000322

Inspection ID: MON-0037481

Date of inspection: 08/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of the staffing needs of the home including night-time staffing was completed by 31st December to ensure residents are supported and supervised at all times. From 1st January 2023, laundry staff resources have been increased to prevent the need for night staff to undertake these tasks routinely. From 1st January 2023, an additional activity staff member is in place to support residents to more fully engage in meaningful social activities.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: By the 28th February 2023, all staff will have completed mandatory training. This includes fire, moving and handling, safeguarding, responsive behaviours and restrictive practices. By 31st January 2023, all nursing staff will have received training on documentation of care records. Supervision arrangements were reviewed immediately following the inspection on 8th November 2022 and changes made to the daily and nightly allocation of staffing to maximise supervision of residents at all times of the day within the centre.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of management systems was completed by 31st December 2022. The in-house management team resource has been enhanced from 1st February 2023 to ensure safe, appropriate, consistent and effective supervision monitoring. This will be monitored monthly at the governance meeting by the regional team.
A review of clinicial risk is underway in relation to resident care. This will be completed by 15th February 2023 and will consider support of residents with responsive behaviour, restrictive practices and resident's rights. Findings will be considered and required improvements implemented. An ongoing review of clinical risk by the regional management team will be carried out through monthly governance meetings.
From 1st January 2023, a new suite of audits and an audit calendar is now in place for 2023. Oversight of these audits will be by the PIC and shall be monitored during monthly Governance Meetings with the Regional Director.

From 1st February 2023, the safeguarding care plans of residents will be reviewed weekly by the PIC and overseen by a member of the regional team at least monthly, to ensure that residents' needs continue to be met and that any new safeguarding concerns are reflected in care plans.

By 28th February 2023, all staff will have completed in-person training in Safeguarding Vulnerable Adults.

By 28th February 2023, a new Standard Operating Procedure, which has been developed with resources to guide the PIC in the investigation of safeguarding/potential safeguarding incidents, will be implemented in the centre.

From 1st March 2023, following training, the Director of Nursing will arrange in-house refresher sessions for all staff. This will comprise of a weekly learning event in the centre that will be attended by all staff. This will include looking at practices to enhance a positive and safe living environment for all residents.

By 28th February 2023, all staff will have received training in risk management and reporting to ensure a culture of positive risk taking and that openness and transparency regarding reporting is promoted in the centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
From 6th February 2023, all notifications will be submitted to the chief inspector in accordance with the timeframes identified in quarterly notifications as required by Regulation 31. This includes the use of restrictive medications. Compliance with this will be monitored by the regional team at monthly governance meetings and the Quality Team during scheduled and unannounced visits.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
From 1st January 2023, a system of documentation management is now in place to support implementation and compliance with the complaints policy and ensures all required documentation is held safely and is easily retrievable.

By 31st March 2023, all staff will have received training in complaint management to ensure a culture of learning and quality improvement is promoted in the centre.

From 1st February, compliance with the complaints policy will be monitored at the monthly governance meeting by the regional team. Trends and analysis of complaints will be considered at the meeting and feedback provided to staff to reduce the risk of recurrent complaints in the centre.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of the dining experience and mealtimes was completed in January 2023. By 15th February 2023, staff will have received training and support to improve the dining experience for all residents and all environmental changes identified in the review will be in place.

A review of the sensory room is underway to transform the space into a more enhanced sensory/snoozleen room. This work will be completed by 31st March 2023.

A review of storage space was completed by 31st December 2022 to ensure items are not stored on the corridors and that all cleaning equipment is stored appropriately. Staff have received training to ensure they are aware of the importance of appropriate storage. Audits are in place to monitor compliance with this.

A shower has been installed in room 45.

By 31st March 2023, a review and rearrangement (where required) of twin bedrooms will be complete to ensure both residents have access to the ensuite toilet and shower facility and lockable storage within their bedspace while fully promoting privacy and dignity.

An enviromental audit is ongoing and a plan for refurbishment of bedrooms is underway. This refurbishment is planned to be complete by Q3 2023.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
From 1st January 2023, the equipment cleaning schedule has been re-introduced and staff compliance with this is monitored daily by the in-house management team and monthly at the governance meeting.

By the 31st January 2023, all residents (where required) will have their own individual slings. Appropriate storage and labeling of these individual items will be in place.
New storage racking including drip trays have been ordered and will be installed in an approriate position by 15th February 2023.
From 8th February 2023, supervision of staff practices in relation to waste management, storage of PPE, adherence to cleaning schedules and storage of equipment and laundry segregation will be monitored by the in-house management team on a daily basis. IPC audits will also monitor staff practice. Results of audits will be reviewed at monthly governance meetings.
A hand hygiene sink and lockable storage will be in place in the housekeeping room by 31st March 2023.
The sink in the clinicial room will be replaced with a clinicial hand washing sink by the 10th February 2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The gaps on the resident's bedroom door and store room door were repaired in November 2022 immediately following the inspection. A system is in place from 1st January 2023 to check all doors to ensure gaps/breaches to the integrity of doors are identified and escalated as a matter of urgency.

By the 31st January 2023, fire training will be completed with all staff.
From 1st January 2023, an enhanced fire simulation drill has been completed and will be practiced monthly.This drill will be completed using night time staffing levels.
A review of the fire doors was completed following the inspection to ensure that all doors open on the activition of the fire alarm.
From 8th November 2022, a system has been established to ensure all fire safety documentation is easily accessible and all local managers are aware of the location of this.
From 8th November 2022, all relevant managers and staff have been retrained in the schedule of fire equipment safety checks (including confirming the presence of ashtrays, smoking aprons and heat detectors) and the documentation of same. These will be reviewed at monthly governance meetings from 1st February 2023.
A full review of PEEPs has been completed by 31st December 2022.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
By 28th February 2023, a review of care plans; to ensure that they reflect each individual resident's needs and guide staff appropriately to meet those needs, will be completed. This review will specifically target safeguarding care plans (to ensure appropriate supervision and safeguarding measures are in place to protect all residents) and responsive behaviour care plans (to ensure they include potential triggers and steps identified to support the resident behaviour), nutritional needs, skin integrity, wound care plans, activity care plans, and where appropriate, seizure care plans.

A new suite of clinical audits has commenced from 1st January 2023 and all nurses and managers have provided with training to audit care plans. The audit results will be monitored and overseen at monthly governance meetings.

From 1st December 2022, all Staff Nurses have received additional training on the importance of ensuring care plans are reviewed on at least 4-monthly intervals and more frequently in response to a change in the care needs of each resident.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
By 31st December 2022, training was provided for all nurses to improve their knowledge

and practice to ensure a high standard of evidenced-based person-centred care. This included training on pressure ulcer prevention, wound care, falls management and supporting residents with responsive behaviours. All staff have also received training on the importance of completing documentation in a timely and comprehensive manner.
From 23rd January 2023, increased supervision by clinical managers is in place to ensure adequate supervision of residents by all staff. This will be monitored closely on a daily basis by the in-house management team and reviewed as resident's needs change. Compliance with this will be monitored at monthly governance meetings from 1st February 2023.
From 1st January 2023, residents that require physio have been referred to the community physiotherapy department and a system has been established to ensure that all resident's health care needs that require referral to a healthcare professional, are escalated and processed in a timely manner.

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:
All staff will have received training on responsive behaviours by the 31st Janaury 2023. This will include the completion of ABC charts and de-escalation strategies.
By 31st January 2023, all residents who are involved in peer to peer incidents will have a documented risk assessment in place, which is updated to reflect the needs of each individual resident. All reported incidents will be notified in a timely manner as per regulatory requirement. Compliance with this will be audited locally and monitored monthly through the governance meeting.
Following a review of each resident's needs and preferences and the layout of the home, from 1st December 2022, all residents are in a position to move to any communal area of the home and there are no restrictions placed on residents based on their diagnosis, gender or identified care needs/dependencies.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Following a review of each resident's needs and preferences and the layout of the home, from 1st December 2022, all residents are in a position to move to any communal area of the home and there are no restrictions placed on residents based on their diagnosis, gender or identified care needs/dependencies.

From 1st January 2023, an additional activity staff member is in place to support residents to engage in meaningful social activities.

By 28th February 2023, specialist dementia training will be provided to activity staff to equip them with the knowledge in providing sensory-focused activities for residents with dementia.

By 31st March, all twin rooms will have 2 TVs with connection to headsets to enable each resident to watch and listen to individual programmes of their choice at the same time.

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 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.	Not Compliant	Orange	01/01/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/02/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	08/11/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	31/03/2023

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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.	Not Compliant	Orange	31/03/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	28/02/2023
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	28/02/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Not Compliant	Orange	31/03/2023

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire	Not Compliant	Orange	31/01/2023

	control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/01/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	06/02/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	06/02/2023
Regulation	The registered	Substantially	Yellow	31/03/2023

34(1)(f)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Compliant		
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	28/02/2023
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	Not Compliant	Orange	28/02/2023

	designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	28/02/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/02/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus	Not Compliant	Orange	01/02/2023

	Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	01/02/2023
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.	Not Compliant	Orange	31/01/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	01/12/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance	Not Compliant	Orange	01/12/2022

	with national policy as published on the website of the Department of Health from time to time.			
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	01/01/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	01/12/2022
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Substantially Compliant	Yellow	31/03/2023