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:	Brampton Care Home
Name of provider:	Brampton Care Ltd
Address of centre:	Main Street, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	27 May 2021
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0033140

About the designated centre

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

Brampton Care Home is located in the heart of Oranmore town, Co. Galway. The designated centre cares for residents with aging related health issues inclusive of physical, psychological and social concerns. The service cares for both male and female residents that are aged 18 years and over. The care extends to those with dementia, cognitive impairment, mental illness, intellectual disabilities, physical disabilities and chronic physical illness. There is 24 hour nursing care available in the centre. The centre is laid out over three floors of a four storey development. The ground floor includes a reception and coffee shop, a formal dining area, a variety of seating areas, a beauty salon, and a quiet reflection room. There is a small kitchenette available for residents use. Two enclosed courtyards form part of the living area on the ground floor of the centre. The centre has 79 beds, 67 single occupancy en-suite rooms and six double occupancy en-suite rooms. All bedroom accommodation is situated on the second floor and third floor which are accessed by two lifts. Each floor also contains a sitting room, dining room and kitchenette.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	65

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 27 May 2021	10:00hrs to 19:00hrs	Catherine Sweeney	Lead

What residents told us and what inspectors observed

The inspector spoke with ten residents on the day of the inspection. Overall, there was a sense of dissatisfaction reported from the residents. Residents voiced their frustration in relation to the poor communication from the management team. They stated that the isolation and loneliness from the national restrictions imposed to control the spread of COVID-19 was made more difficult by the current issues within the centre.

Resident reported a deterioration in the quality of the service in the past five months. The inspector observed a major building and refurbishment programme of work was on-going in the centre. The complaints made by the residents related to the increased occupancy of the centre leading to changes in the staffing arrangements, deterioration in the quality of food and meal-times, in particular, tea-time, noise levels and communication from the management team.

A common theme reported by all the residents spoken with was that they felt that staff were always rushing and under pressure. Resident were regularly told by care staff that they were 'short-staffed'. Residents stated that there had been a lot of changes in the centre in the past three to four months. One resident described the changes in staffing as 'unsettling'. Resident expressed the sadness they felt when 'good staff left'. One resident was told by staff that they could not have their tea in the communal dining room on the ground floor as there was not enough staff available. A number of residents told the inspector that while all the staff were kind to them, there was often a language barrier that made clear communication difficult. They explained that they did not always feel understood, nor could they understand what was being said to them. The residents have considered this as a reason for some of their requests going unanswered.

Residents complained that they did not enjoy tea-time in the centre. The inspector observed that residents were asked for their tea order at the same time as their dinner order. Some residents voiced that they did not know how hungry they would be or what tea they would enjoy. Residents complained that there was minimal choice on the tea-time menu. On the day of the inspection the inspector observed residents being given one option for tea. Two residents told the inspector that they were not familiar with the dish that was on offer and that it was therefore not suitable for older people of their generation. Staff told the inspector that the choice was a frittata (egg dish), soup, semolina or rice pudding. Asked if the residents could order something that was not on the menu, the staff member responded that it was not always possible because of the staff shortages. One resident had been refused a tomato sandwich for their tea. Residents told the inspector that they had raised the issue of the quality of the teatime meal with the management team on numerous occasions but no action had been taken.

An on-going complaint was that of the noise level from the building works. The residents told the inspector that there had been a number of meetings with the

provider in relation to the impact of the noise level on the quality of their lives. An action plan had been put in place to limit that times when work with high noise levels could take place and this had been agreed by the residents, the provider and the builders. However, this commitment had not been honoured and the noise level, at unpredictable times including weekends, remained unresolved.

Residents told the inspector that they had requested a resident meeting to discuss their issues of concern. A meeting was scheduled for 25 May 2021. An activity coordinator and a care assistant attended the meeting. The residents elected a resident representative who chaired the meeting. Following the meeting, the meeting record was written by the staff member. The resident representative was very concerned that the staff member had amended and added to the meeting record before the record was agreed by the residents. The resident representative spoken with indicated that it would be beneficial to have an independent advocate attending and recording residents meetings.

Residents expressed frustration that the fire alarm was being triggered on a regular basis. Their concern related to the fact that when the alarm was triggered, nobody came to reassure or inform residents as to why the alarm had gone off. A number of residents told the inspector that recently the fire alarm had sounded at 10pm at night and alarmed continuously for about an hour. There was no communication with the residents in the centre during this time. Some of the more independent residents reported providing comfort to residents who were alarmed and disorientated. Some residents reported feeling very angry about this and highlighted the negative effect it had on their quality of life in the centre. Residents reported that communication had improved in relation to the fire alarm sounding, however, the alarm activations continued to impact on the residents quality of life.

A resident explained how their vaccination record was misplaced when the resident was admitted to the centre. The resident was distressed by this as they had been admitted from abroad and they were anxious to make arrangements to have their second vaccine dose. The resident reported that there was considerable delay in any action being taken. The record was eventually found following a complaint made by the residents relative. No record of complaint was found in complaints log.

The inspector observed that the layout and size of the residents communal space on the ground floor had been reduced and did not reflect the layout of the centre's registered floor plan. This issue was addressed with the provider at a meeting following the inspection.

Capacity and capability

This was an unannounced risk inspection by an inspector of social services to follow up on unsolicited information received by the Chief Inspector from four sources in relation to the care and welfare of residents in the centre.

The provider of the designated centre was Brampton Care Limited. In July 2020, the provider had submitted an application to vary the condition of the registration to increase the occupancy from 46 to 79 registered beds. On the day of the inspection there were 65 residents accommodated in the centre. The provider was in the process of renewing the registration of the centre. A new person in charge was in position since January 2021. The person in charge reported to a general manager who had a strong presence in the centre. A review of the rosters found that staffing turnover in the centre was high.

Brampton Care centre is located in a four-storey building. There is an on-going programme of building works in the centre to renovate the ground and first floor of the building. There has been on-going renovations and building in the centre since November 2019.

The person in charge was supported by an assistant director of nursing. Both members of the nursing management team worked from Monday to Friday. Supervision during the weekend was the responsibility of the nurse in charge. A review of the rosters found that there was limited nursing supervision available as a shortage of nurses resulted in the assistant director of nursing working nursing rather than supervisory shifts. The person in charge confirmed that an operations manager had been recently recruited and was due to start in four weeks time. This role would oversee catering and housekeeping operations.

A training record was available for review. All staff had received mandatory training including fire safety, manual handling, and infection control. The record showed that staff had also received training in safeguarding vulnerable adults from abuse. A review of the complaints record found that three incidents recorded since November 2020 contained allegations of abuse towards residents, however, this had not been identified as such by staff. It was not clear from the records reviewed, that staff had received adequate and appropriate training to enable them to identify and respond to any suspected allegations of abuse.

The inspector found that management systems in relation to complaints, resident register, notification of incidents to the Chief Inspector and the policies and procedures in the centre required improvement.

A review of the complaints register found only one complaint had been documented since November 2020. The person in charge confirmed that they had received other complaints, however they were recorded within emails, or had been documented on a computer and were due to be printed. The inspector received a record of two further complaints from the person in charge during the inspection.

The inspector reviewed the complaints log and found that there was no evidence that complaints made by residents to the provider and the person in charge in relation to food standards, staffing and fire alarm and building noise had been documented.

While there was an annual review of the quality and safety of care delivered for 2020 available for review, there was no evidence that this review had been prepared

in consultation with residents and their families.

A meeting was held with the provider following this inspection. The provider gave a commitment to address the findings of this inspection and submitted an action plan on the 16 June 2021 outlining the commitments made, prior to the issuing of the inspection report. The provider voluntarily ceased admissions to the centre until 31 July 2021 or until the Chief Inspector was satisfied that the centre had returned to regulatory compliance.

Regulation 15: Staffing

On the day of the inspection, there were 65 residents accommodated in the centre. Of these, 24 has been assessed as having high to maximum dependency levels and 41 with low to medium dependency levels.

Staffing levels on the day of the inspection was adequate to meet the needs of the residents and the size and layout of the building, however, the skill-mix of the staff was poor as almost half of the nurses were recently recruited and poorly supervised.

The roster identifies two multi-task attendants. There is no reference to this position in the statement of purpose.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of the rosters found that newly recruited nurses had short induction periods prior to commencing duty, where they would be the only nurse available to the residents on a floor. This meant that nurses were not fully familiar with the health and social care needs of each resident.

Supervision arrangements for the weekend were inadequate. The senior nurse on duty at night or at the weekend was not identified on the roster. No nursing management staff were on duty during the weekend.

Assurance was required in relation to staff knowledge of safeguarding vulnerable adults. A review of the complaints record found that it was not clear if staff understood how to identify and respond appropriately to suspected incidents of abuse.

Judgment: Not compliant

Regulation 19: Directory of residents

A review of the directory of residents found that significant information, required under Schedule 4 of the regulations, was not documented. One resident did not have an admission date documented.

Judgment: Not compliant

Regulation 23: Governance and management

Inadequate governance and management systems was evidenced by

- poor oversight of nursing documentation
- poor complaints management
- incomplete entries to the directory of residents
- poor notification of incidents
- inadequate policies and procedures
- poor risk management - admissions to the centre continued in the absence of a robust risk assessment to the concerns voiced by the residents.
- inadequate staffing supervision
- inadequate recognition of safeguarding issues
- annual review not developed in consultation with residents and their families.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge failed to submit notifications as required under regulation 31. This is evidenced by

- a review of the complaints register identified three reports of allege abuse towards residents. These incidents were not recognised or identified as safeguarding issues and no notification was submitted as required under regulation 31.
- no notification received following a serious injury to a resident following a fall
- no quarterly notification submitted for January-March 2021 although staff and residents reported on-going issues with the fire alarm.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints policy and procedures in the centre found that the system in place to manage complaints required review. The complaints policy had not been updated, referring to the previous person in charge as the initial contact for the receipt of complaints.

Of the complaints reviewed, none were documented in line with the centres own policy or the requirements under regulation 34. The complaints made by residents, and acknowledged by the person in charge, were not documented in the complaints register or managed in line with the requirements under regulation 34.

Judgment: Not compliant

Quality and safety

This inspection took place during the COVID-19 pandemic. A contingency plan was in place and adhered to by all residents, staff and visitors. The centre had remained free from COVID-19 since the start of the pandemic.

Overall, the inspector found that the management of health and safety in the centre was poor. Poor supervision and oversight of care was reflected in the nursing documentation reviewed and the observations of the inspector on the day of the inspection.

The inspector was concerned that the management team had not recognised three instances of alleged abuse documented in the centre's complaints register. This meant that the allegations were not investigated in line with the centre's safeguarding policy nor where they notified to the Chief Inspector as required under regulation.

A risk register was in place and contained a number of risks associated with the on-going building had been identified and addressed. A health and safety statement for the centre contained generic environmental risk assessments. However, these risk assessments were not dated and there was little evidence that the risks had been recently reviewed. A number of risks identified the previous person in charge as the person responsible for the risk management.

A review of the incident log found that while incidents were documented, no incident investigation had been closed since November 2020. This meant that incident investigation or analysis outcomes had not been recorded and no learning from incidents had been identified and communicated to staff.

There was an electronic nursing documentation system in place. Nursing progress

reports, residents clinical assessments and care plans, allied health care professional input and a record of incidents was documented on this system.

All residents had a nursing assessment and care plan in place. A review of the care plans found that social care plans were detailed and person-centred. However, nursing assessments reviewed did not always inform the residents care plan. Some care plans were not updated to reflect the current care needs of the residents.

Residents had access to their doctor and were supported in the centre by allied health care professionals such as physiotherapy, occupational therapy, and community palliative care teams.

There was an activities schedule in place and residents confirmed that there was always something to do. A review of residents' rights was required to ensure that residents can exercise choice, have access to advocacy, and be consulted about and participate in the organisation of the designated centre.

Arrangements to protect the privacy and dignity of residents accommodated in twin rooms also required review.

Regulation 26: Risk management

A review of the risk management policy and system was required to ensure that it was up-to-date, reflected the currents risks in the centre as identified through accidents, incidents and complaints, and that it contained all the information required under regulation 26.

Judgment: Not compliant

Regulation 27: Infection control

The centre had remained COVID-19 free since the start of the pandemic. There was adequate levels of cleaning staff. Staff spoken with demonstrated an awareness of the cleaning protocols in the centre and confirmed that cleaning and infection control training had been received.

The provider had a COVID-19 contingency plan in place. Regular infection control audits had been completed. The centre was visibly clean on the day of inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The assessments reviewed by the inspector did not always inform the development of the resident's care plans. For example, a resident with a six month history of significant unexplained weight loss had been assessed as being a high risk of malnutrition. On the date that the resident was assessed, and up to the date of this inspection, there was no mention of weight loss in the residents progress report or care plan. In fact, the care plan stated that the resident was assessed as being low risk of malnutrition. The person in charge confirmed that the resident had been recently referred to the dietitian, however, the nursing documentation did not reflect this.

Judgment: Not compliant

Regulation 6: Health care

Residents had unrestricted access to a doctor of their choice. Records reviewed found that residents were referred to physiotherapy and occupational therapy when required.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector spoke with 10 residents throughout the day of the inspection. A constant theme communicated to the inspector was that residents did not feel that they were being listened to. No independent advocate was made available to facilitate residents meetings.

Resident said that they have given their feedback to the management team many times but no action has been taken.

The residents reported a lack of choice at tea-times. Residents told the inspector that they had limited access to fruit. One resident told the inspector that they get 'a banana every so often, but no other fruit'. Another resident stated that she longed for a simple salad in the evening.

The inspector found that some of the twin rooms in the centre were not fitted with privacy screens. The location of the beds in these rooms would not allow for adequate privacy for each resident. The person in charge confirmed that these bedrooms were for couples only. This is not reflected in the statement of purpose,

where the rooms accommodating two residents were described as 'twin'.
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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Brampton Care Home OSV-0005812

Inspection ID: MON-0033140

Date of inspection: 27/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. The Statement of Purpose is currently under review to include:
a. The new organisational structure within Brampton Care Home.
b. The roles of the Health Care Assistant (HCA) and/ or Cleaner.
c. The specific details with regard to double occupancy bedrooms.
To be completed 31/07/2021.

2. Management supervision within Brampton Care Home is now overseen 7 days a week. The Director of Nursing, Operations Manager, Assistant Director of Nursing and the Clinical Nurse Manager are all responsible with regard to management supervision of the multidisciplinary teams.
Completed July 2021.

3. A review of the Brampton Care Home skill mix of staff has been completed. At all times, two nurses with a minimum of three months experience in Brampton Care Home are rostered for each shift.
Completed June 2021.

4. In response to staff turnover, exit interviews now take place with all required staff.
Completed June 2021.

5. Resources including Brampton Care Home staffing plan are discussed monthly at the Management Team meetings. Where staffing issues are identified, this is overseen and actioned by the Registered Provider Representative and Director of Nursing.
Completed July 2021.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. A 5-day structured induction training for nurses is implemented and consists of education, training, and supervision.
Completed July 2021.

2. A structured induction is implemented for all new members of staff. This consists of a mix of education, training, and staff supervision.
Completed July 2021.

3. Staff induction is completed by all relevant Line Managers.
Completed July 2021.

4. Communication training via an on-line module is scheduled to be completed by all clinical and non-clinical staff within Brampton Care Home.
To be completed by clinical staff 16/07/2021 / non-clinical staff 31/07/21.

5. All Schedule 5 policies and procedures are currently under review.
To be completed 31/07/2021.

6. Staff training and development policy and procedure to be reviewed, approved, and communicated to staff.
To be completed 15/08/2021.

6. As per Regulation 15, Management supervision within Brampton Care Home is now overseen 7 days a week. The Director of Nursing, Operations Manager, Assistant Director of Nursing and the Clinical Nurse Manager are all responsible with regard to management supervision of the multidisciplinary teams.
Completed July 2021.

7. As per Regulation 15, A review of the Brampton Care Home skill mix of staff has been completed. At all times, two nurses with a minimum of three months experience in Brampton Care Home are rostered for each shift.
Completed June 2021.

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
1. A review of the Directory of Residents was completed and updated.
Completed June 2021.

2. The Directory of Residents to be audited on a monthly basis by the Director of Nursing.
Commenced July 2021.

3. Audit findings to be communicated to all members of the nursing team on a monthly basis.
Commenced July 2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. A clearly defined teams and committee structure has been developed and implemented in Brampton Care Home. This includes:
a. Management Team.
b. Multi-disciplinary Care Team.
c. Multi-disciplinary Support Team.
d. Brampton Care Home Project Team.
e. Resident Forum – Capital Development.
f. Residents Committee.
Completed June 2021.

2. The terms of reference have been developed for each of these teams which include aims and objectives, roles, frequency and required membership.
Completed June 2021.

3. All teams meet on a monthly basis, with the exception of the Resident Forum – Capital Development and Brampton Care Home Project Team who meet on a weekly basis.
Completed and ongoing June 2021.

4. A review of all individual residents' observations, assessments and care plans has commenced. The focus of this review is to ensure the person centred care for all residents.
To be completed 31/07/2021.

5. The following policies and procedures were prioritised by Brampton Care Home and reviewed, updated and approved by the Brampton Care Home Management Team. Policies include:
a. Responding to Complaints policy and procedure
b. Incident Reporting – Identification, Documentation, Rectification, Review and Communication policy and procedure
c. Risk Management

Completed July 2021.

6. The following training based on the updated processes was delivered to all staff:
a. Responding to Complaints
b. Incident Reporting – Identification, Documentation, Rectification, Review and Communication
Completed July 2021.

7. Risk Management training for all staff to be delivered.
To be completed 26/08/2021.

8. All complaints, incidents and risks reported are reviewed and discussed at the Management Team meetings on a monthly basis. Any variances identified to be overseen and actioned by the Registered Provider Representative and Director of Nursing.
Commenced July 2021.

9. The complaints, incidents, and risks processes to be audited in line with the Audit Programme for Brampton Care Home.
To be completed 30/09/2021.

10. All Schedule 5 policies and procedures are currently under review.
To be completed 31/07/2021.

11. All Schedule 5 policies and procedures as reviewed are approved by the Brampton Care Home Management Team. Education and training scheduled for all staff in line with process updates.
To be completed 31/07/2021.

12. As per Regulation 15, Management supervision within Brampton Care Home is now overseen 7 days a week. The Director of Nursing, Operations Manager, Assistant Director of Nursing, and the Clinical Nurse Manager are all responsible with regard to management supervision of the multidisciplinary teams.
Completed July 2021.

13. The following policies and procedures were prioritised by Brampton Care Home and reviewed, updated, and approved by the Brampton Care Home Management Team. Policies include:
a. Safeguarding and Protection of the Resident from Abuse policy and procedure
b. Recognising and Responding to Allegations of Abuse policy and procedure
Completed July 2021.

14. Education and communication in line with the updated and reviewed safeguarding policies and procedures to be provided to staff.
To be completed 31/07/2021.

15. An independent safeguarding audit was completed.
Completed June 2021.

16. All safeguarding quality improvement plans identified are currently under review. To

be implemented 27/08/2021.

17. The Brampton Care Home Quality and Safety Annual Review to be completed for 2021 to be carried out with the support of an independent body and will ensure the inclusion of consultation from residents and their families.
To be completed January 2022.

18. Additional Fire Safety training in relation to the fire alarm system was provided to staff.
Completed June 2021.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. All incidents reported within Brampton Care Home are notified to the Assistant Director of Nursing / Nurse in Charge and communicated to the Director of Nursing as required. The Director of Nursing and in their absence, the Assistant Director of Nursing are responsible for ensuring all notifications are submitted within the required time frame.
Completed and ongoing June 2021.

2. As per Regulation 23, All notifications submitted are trended, analysed, and discussed at the Management Team meetings on a monthly basis. Any variances identified to be overseen and actioned by the Registered Provider Representative and Director of Nursing.
Commenced July 2021.

3. As per Regulation 23, the incidents process to be audited in line with the Audit Programme for Brampton Care Home.
To be completed 30/09/2021.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. As per Regulation 23, the Responding to Complaints policy and procedure was prioritised by Brampton Care Home and reviewed, updated, and approved by the Brampton Care Home Management Team.
Completed July 2021.

2. As per Regulation 23, responding to complaints' training based on the updated processes was delivered to all staff.
Completed July 2021.

3. As per Regulation 23, all complaints reported are trended, analysed, and discussed at the Management Team meetings on a monthly basis. Any variances identified to be overseen and actioned by the Registered Provider Representative and Director of Nursing.
Commenced July 2021.

4. As per Regulation 23, the complaints processes to be audited in line with the Audit Programme for Brampton Care Home.
To be completed 30/09/2021.

5. As part of the ongoing multi-disciplinary care and support team meetings, it has been re-enforced to staff that Brampton Care Home aims to ensure a culture of openness and transparency that welcomes staff, residents, their family members and visitors' complaints, conflicts or differences of opinion in relation to the care and service provided.
Completed and ongoing July 2021.

6. Lessons learned will continue to be formally provided to staff through ongoing communication and scheduled multi-disciplinary care and support team meetings, where a complaint or issue of concern is received.
Completed and ongoing July 2021.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
1. As per Regulation 23, Risk Management was prioritised by Brampton Care Home and reviewed, updated, and approved by the Brampton Care Home Management Team.
Completed July 2021.

2. As per Regulation 23, Risk Management training for all staff to be delivered.
To be completed 30/08/2021.

3. As per Regulation 23, All risks reported are trended, analysed, and discussed at the Management Team meetings on a monthly basis. Any variances identified to be overseen and actioned by the Registered Provider Representative and Director of Nursing.
Commenced July 2021.

4. As per Regulation 23, The risks processes to be audited in line with the Audit Programme for Brampton Care Home.

To be completed 30/09/2021.

5. A review of the Brampton Care Home Risk Register has commenced to identify and mitigate risks with regard to Corporate Services, Service Provision and Care, and Health and Safety.
To be completed 15/08/2021.

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:
1. As per Regulation 23, a review of all individual residents' observations, assessments and care plans has commenced. The focus of this review is to ensure the highest quality of care outcomes for all residents.
To be completed 31/07/2021.

2. Assessment and Care plan training to be delivered to members of the nursing team. This training will discuss in detail the Care Planning Cycle, including:
• Assessment,
• Diagnosis,
• Planning,
• Implementation, and
• Evaluation.
To be completed 31/07/2021.

3. A weekly resident assessment and care planning report is extracted from the resident electronic management system to ensure there are no overdue residents' assessment or care plan review and evaluations.
To be completed 31/07/2021.

4. A specific care plan audit with the focus on residents' hydration and nutrition status to be completed and lessons learned to be provided to the nursing team.
To be completed 15/08/2021.

5. Monthly specific assessment and care plan audits, for example, pain management, wound management, and positive behavioural support to be completed by the Assistant Director of Nursing/ Clinical Nurse Manager in line with Brampton Care Home Audit Programme.
To commence August 2021.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Brampton Care Home to appoint an independent advocate to chair monthly resident committee meetings.
To be completed 16/07/2021.

2. Residents' rights audit to be completed in line with Brampton Care Home Audit Programme.
To be completed 30/09/2021.

3. An internal review of the Brampton Care Home menus was completed. This incorporates two food options for teatime.
Completed June 2021.

4. The reviewed menus to be reviewed by a nutritionist.
To be completed 23/07/2021.

5. An additional chef has been recruited and commenced employment within Brampton Care Home.
Completed June 2021.

6. The Statement of Purpose is currently under review to include:
a. The specific details with regard to double occupancy bedrooms.
To be completed 31/07/2021.

7. The management team communicate daily via handover to confirm construction priorities, potential impacts and controls implemented.
Completed and ongoing June 2021.

8. All construction priorities, potential impacts and controls implemented are communicated to individual residents daily. Additional activities including but not limited to outdoor activities, music events are scheduled to ensure no residents are affected by the priority construction days.
Completed and ongoing June 2021.

9. Weekly Resident Forum – Capital Development meetings are currently underway. This allows for residents to communicate any concerns and the provision of updates with regard to the Capital Development at Brampton Care Home.
Completed and ongoing June 2021.

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.	Substantially Compliant	Yellow	31/07/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/08/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/08/2021
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	31/07/2021
Regulation 23(c)	The registered	Not Compliant	Orange	30/09/2021

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	30/09/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/09/2021
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	30/09/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in	Not Compliant	Orange	30/09/2021

	charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	30/09/2021
Regulation 34(1)(f)	The registered 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.	Not Compliant	Orange	30/09/2021
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and	Not Compliant	Orange	30/09/2021

	any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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	15/08/2021
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	30/09/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	30/09/2021
Regulation 9(3)(f)	A registered	Not Compliant	Orange	30/09/2021

	provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.			