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 & Rehabilitation Centre
Name of provider:	Brampton Care Ltd
Address of centre:	Main Street, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	28 May 2026
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0050642

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. Residents have access to outdoor gardens. The centre has 94 beds, 82 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:	71

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 28 May 2026	09:00hrs to 17:00hrs	Una Fitzgerald	Lead
Thursday 28 May 2026	09:00hrs to 17:00hrs	Sean Ryan	Support

What residents told us and what inspectors observed

From what inspectors observed and what residents reported, the overall feedback was positive about living in Brampton Care and Rehabilitation centre. Inspectors spoke with multiple residents and in general, they were complimentary about the standard of care provided in the centre. However, residents followed up by telling inspectors that there was considerable staffing changes which impacted on their care. Residents told inspectors that there was a large number of agency staff working in the centre. When asked how this impacted on their wellbeing, resident's said that the staff did not always know their care needs. Residents were highly complementary of the long term staff and praised them for their commitment to the roles. Residents were very clear that, as individuals, staff were very kind and stated that "they do their best". In addition, residents stated that noted changes in the management team, was causing distress and worry.

Brampton Care and Rehabilitation Centre is located in the town of Oranmore, County Galway. On the day of inspection, there were 71 residents living in the centre, with 23 vacancies.

A number of the residents told inspectors that they did not feel safe in the centre. They attributed this to the high turnover of staff and the regular use of agency staff, whom they did not know and who were unfamiliar with their individual needs and preferences. Residents stated that continuity of care and familiarity with staff were important factors in helping them feel safe and supported in their home.

Inspectors observed residents participating in activities facilitated by activity staff such as bingo. Activities staff were employed in the centre and residents were supported by staff to participate in activities, if they wished. The activity schedule included a range of activities such as exercise, music, quiz, and arts and crafts. Residents also had access to newspapers, radio and television. There was adequate space in the centre for the residents to participate in activities. Residents' art was displayed on the walls. Residents were complimentary about the activities in the centre.

The group activities observed on the day of the inspection were all held on the ground floor. Residents from the second and third floor came down to the ground floor to attend the activities. However, the inspectors observed that there was no social care program held outside of the ground floor. Inspectors observed multiple residents sitting in the main communal rooms for lengthy periods of time with no form of social activity, entertainment or engagement. While staff were observed walking through the communal spaces and greeting residents, there was no meaningful activity observed.

On the day of the inspection, the lunchtime meal appeared to be well-presented and appetising, including meals that were required to be modified in line with residents

needs. Residents were seen sitting together and chatting during the meal and the atmosphere appeared relaxed and social. Staff were observed to support residents who required assistance in a respectful manner. Residents were offered a choice of two main courses on the menu, and some residents were seen to eat foods that were prepared specifically for them. Residents had access to a choice of drinks.

The premises was laid out to meet the needs of residents, with handrails placed along the corridors and in bathrooms to support the residents to mobilise independently. All bedrooms were decorated to a high standard with sufficient storage space for resident personal belongings. All resident bedrooms are ensuite. Residents had access to their call bells. The centre was bright and warm. However, some areas were observed to be unclean. For example, a large bathroom on the third floor, adjacent to the dining room, that was observed to be recorded as clean, was visibly unclean. Inspectors also observed that the flooring in the communal room on the third floor was lifting which posed a potential trip hazard to residents.

There was multiple communal areas observed to be used by residents throughout the day, for example; an open plan sitting and dining room area on each floor. Communal areas were generally clean and comfortable. Residents and visitors were observed sitting in a coffee lounge area at the reception on the ground floor. A quiet room and prayer room provided comfortable peaceful spaces for residents and their families to relax and to reflect and pray if they chose. Residents had access to enclosed garden areas and there was a designated smoking area.

Visiting was facilitated in the centre, and there were several communal spaces where residents could choose to meet their visitors, apart from their bedroom.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection, with a focus on adult safeguarding measures that the registered provider had in place to safeguard residents from all types of abuse. Inspectors reviewed the systems, documentation and resources in place to ensure that residents human rights were promoted and that residents were empowered to exercise choice and control over their lives, and give them the tools to protect themselves from harm. Inspectors followed up on the compliance plan response submitted following the last inspection in January 2026 and followed up on notifications and information of concern received by the office of the Chief Inspector. To gain insight into the residents' experiences of living in the centre, inspectors spent time speaking with residents and staff, and observing the environment.

Overall, inspectors found that the systems of management and oversight in place to monitor the management of complaints, incidents of safeguarding, the implementation of individualised care plans and the supervision of staff delivering the care to residents did not meet the requirement of the regulations. The management structure within the centre was clear. However, lines of responsibility and accountability for the management of all areas of safeguarding was not clear. Known risk, escalated to the provider, was not always appropriately managed. Inspectors found that while the management structure and the staffing personal in the centre had gone through considerable changes, the systems of escalation, the systems of the supervision of staff, and the oversight of resident care was not embedded into the day-to-day operations of the centre. The failure of effective supervision adversely impacted the safety of the residents as further outlined under the respective regulations.

Brampton Care Limited is the registered provider of Brampton Care and Rehabilitation Centre. The company had two directors, one of whom worked full-time in the centre and was engaged in the day-to day oversight of the service. The person in charge worked full time and was supported by an assistant director of nursing, clinical nurse managers, a team of nurses and healthcare assistants, activities co-ordinators, housekeeping, catering, administration and maintenance staff.

Inspectors reviewed three personnel files to review the provider's recruitment practices to safeguard residents from abuse. The registered provider had ensured that the necessary information, as required by Schedule 2 of the regulations, including Garda Síochána (police) vetting disclosures, documentary evidence of relevant qualifications, required references and current registration details, was available for these staff members.

The registered provider had a system of mandatory training pertaining to safeguarding in place. All staff were required to complete this training every three years. Additional online courses on human rights training were also a local requirement. On the day of the inspection, staff training records were incomplete and were not an accurate reflection of the current staff delivering the direct care to the current residents. The training records reviewed did not include the names of current staff and the names of staff on duty on the day of inspection. The management did not have oversight of what training the staff had received in relation to safeguarding.

At the time of the inspection, the centre had a significantly high turnover of staff. There was a system of induction in place for staff who had commenced employment in the centre. The induction was a risk management initiative designed to ensure that new staff knew the residents care needs and also knew how the centre operated. However, this induction did not include any direction in relation to fire safety procedures. In addition, staff with whom the inspectors spoke, did not demonstrate appropriate knowledge regarding types of abuse and safeguarding procedures. Staff were not fully aware or the residents who had increased

monitoring in place, and were not aware why residents would be under increased monitoring.

Inspectors reviewed records of governance meetings, and resident meetings dated April 2026. Residents had expressed concern regarding the staffing turnover and shortages in the centre. Residents had given an example of a missed medical appointment as a result of staffing challenges. A review of the documented meeting records of residents meetings found that issues of concern, raised by residents had not been responded to by the provider, in a timely manner.

The systems in place for the management of complaints was not always effective. Residents spoken with outlined that the person who was responsible for the management of complaints was unclear due to the number of changes in the governance structure. A complaints policy reviewed by inspectors named a complaints officer that no longer worked in the centre.

The registered provider did not maintain records, as required by the regulations. Multiple records reviewed were either incomplete or unavailable for review. The detail is outlined under regulation 21: Records.

Regulation 15: Staffing

The number and skill mix of staff was inadequate with regard to the needs of the residents, and the size and layout of the designated centre. Planned rosters were not consistently maintained and did not provide assurance regarding the staffing arrangements in place.

- Records evidenced that residents with known safeguarding risks, who were assessed as requiring increased supervision by staff, did not have this level of supervision consistently in place. This posed a risk to resident safety.
- The skill mix of staff was not appropriate to meet residents' assessed needs. Newly appointed staff completing induction were included in the staffing complement despite having limited knowledge of residents' individual safeguarding needs, safeguarding incidents and safeguarding care plans.
- Residents' personal care and hygiene needs were not consistently attended to in a timely manner, or in line with individual care plans.
- Staffing rosters revealed multiple days when staffing levels were inadequate.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff knowledge and awareness of key safeguarding and safety arrangements were inadequate. Staff did not always demonstrate an appropriate understanding of

residents individual safeguarding plans and were therefore not fully aware of the measures in place to protect residents from identified risks and support their assessed needs and preferences. In addition, gaps were identified in staff knowledge of fire evacuation procedures relevant to their roles and responsibilities. Consequently, staff did not always have information necessary to protect residents from the risk of harm.

On the day of inspection, staff training records were incomplete and out of date. As a result, the provider was unable to demonstrate what staff training had occurred in relation to safeguarding.

Judgment: Not compliant

Regulation 21: Records

Record management was not in line with the requirements of the regulations. Inspectors found that records requested were not readily available, and when provided were not always accurate. This was evidenced by;

- the training records did not include current staff working in the centre. This meant that the provider could not confirm, from the training records, what staff had completed training in line with the requirements of the regulations.
- records of incidents with potential safeguarding implications, and the management of unexplained bruising were unavailable to review.
- Treatment provided to residents was not consistently recorded. For example; direct care delivered to individual residents. This meant that there was no system of oversight in place to ensure that residents, who were assessed as requiring 30 minute safety checks, had their checks consistently completed. The records did not provide assurances that the daily care needs of the residents had been met.
- Staffing rosters were not always accurate of the staff on duty on the days reviewed. The rosters did not reflect changes of staffing on duty that had occurred.

This is a repeated finding from the last inspection in June 2025 and January 2026 inspections.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that there was inadequate resources to ensure the effective delivery of care. This was evidenced by the following findings:

- The oversight of staffing in the centre was not sufficiently robust. On the day of this inspection there were fifteen health care assistant vacancies. These positions had not been filled and as a result there was an over reliance on the use of agency staff who had not been fully updated with the residents needs.
- Staffing levels and deployment arrangements did not ensure that residents received care in accordance with their assessed needs, preferences and care plans. At the time of inspection, 50% of the staff were provided by an external agency. The high turnover of different staff members meant that some staff did not know the residents individual care needs and could not identify to the inspectors what residents or why residents required increased monitoring. As a result, safety checks, implemented to safeguard and protect residents, were not consistently completed.

Management systems did not ensure that the service provided was safe, appropriate, and consistently monitored, evidenced by the following findings:

- The system in place for the induction of new staff was inadequate. Staff spoken with on the day of inspection had not received fire induction training and so were not fully aware of what action they should take in the event of a fire in the centre.
- The system in place for the supervision of staff was inadequate. Staff were not completing safety checks on residents who were assessed as in need of 15 and 30 minute safety checks.
- There were inadequate arrangements in place to promote staff retention and ensure continuity of care. Some residents with complex care needs required to be cared for by staff who they were familiar with. While new staff had been recruited, the induction process did not ensure that resident needs were known to incoming staff.
- The risk management systems did not ensure that risks were assessed in line with the centre's risk management policy. Specifically, the provider held overall responsibility for the operational risk in the centre. On the day of the inspection, the risk register was not available for review.
- The system of communication provided to residents on changes within the centre was inadequate. For example; the provider did not follow up on actions arising out of resident meetings.
- There was a lack of oversight of policies and procedures. For example; the complaints policy referenced a complaints officer that was no longer employed in the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents were unclear of who to voice their complaints to and attributed this to the on-going changes in the management of the centre. The complaints policy identified persons no longer working in the centre as the complaints officer.

Judgment: Substantially compliant

Quality and safety

This inspection focused on adult safeguarding. It was carried out to review the quality of the service being provided to residents, ensuring that residents were receiving a high-quality, safe service that protected them from all forms of abuse.

This inspection found that some improvement had occurred following the last inspection in January 2026 and that the management were progressing through historic safeguarding incidents while also actively working alongside residents and staff to establish systems that will be able to recognise and respond to safeguarding concerns in the centre, and to ensure all measures will be taken to protect residents from harm. Notwithstanding progress made, inspectors found that insufficient progress had been made to bring the centre into compliance with Regulation 5: Individual assessment and care planning, Regulation 8: Protection and Regulation 9: Residents' rights. As identified in the capacity and capability section, there were significant failures of oversight that negatively impacted the service provided to the residents.

The inspectors reviewed a sample of residents' care records. Residents were comprehensively assessed prior to admission, to ensure that the centre could meet their needs. Validated clinical assessments tools were available to staff to enable a high standard of nursing care assessment. Inspectors reviewed a sample of residents' safeguarding care plans and the management of behaviours that are challenging care plans; these were seen to have adequate insight into residents and their individual care needs, with possible interventions to support the resident to enable best outcomes for them. However, observations on the day coupled with conversation had with the staff on duty, found that not all staff had appropriate knowledge on the care plan details. This meant that the assessed care needs of each resident were not consistently met.

Inspectors observed that several residents had communication difficulties. Some residents had challenges communicating verbally, while other residents could communicate utilising specialist equipment. These residents had their communication difficulties documented in their care plans, and the inspectors found that staff were aware of these residents' communication needs. For non-verbal residents, inspectors observed that care plans included communication techniques to enhance the resident's understanding of what was being communicated and referenced activities to ensure the resident's participation and inclusion.

The registered provider did not ensure that all appropriate and effective safeguarding measures were in place. For example, the centre's own safeguarding policies and procedures were not consistently implemented in relation to the completion of preliminary screening assessments for unexplained injuries, in a small number of incidents. Records were not available to demonstrate that an allegation of abuse had been appropriately investigated. In addition, not all staff were aware of the safeguarding measures identified for the resident concerned. The resident reported that they had not been consulted regarding the safeguarding plan developed to support their safety.

Information regarding advocacy services was displayed in the centre and advocacy was accessed in accordance with residents' needs and consent. Arrangements were in place for consulting with residents in relation to the day-to day operation of the centre. Resident feedback was sought in areas such as activities, meals, and mealtimes, and care provision. However, while issues had been raised by residents it was not evident that these concerns were addresses or follow up with the residents.

Regulation 10: Communication difficulties

When required, residents had communication care plans developed based on the residents' known communication difficulties, for example; poor eyesight or hearing, impaired speech or their cognitive impairment. Inspectors observed staff communicating with residents in an appropriate manner, which ensured that the residents were provided with adequate time to communicate their needs.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While safeguarding assessments and care plans were in place, they were not consistently implemented as the staff in the centre were not always familiar with the residents' needs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Residents that exhibited responsive behaviours that challenge had appropriate risk assessments and updated care plans in place.

Judgment: Compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect residents from the risk of abuse. Records were not available to demonstrate that an allegation of abuse had been appropriately investigated, in line with the provider's safeguarding procedure. In addition, staff were not aware of the safeguarding measures in place for the resident concerned, and the resident reported that they had not been consulted regarding the safeguarding plan developed to support their safety.

Judgment: Not compliant

Regulation 9: Residents' rights

While resident meetings were held, and residents could be consulted about and participate in the organisation of the designated centre, concerns and queries raised by residents at these meetings were not appropriately addressed by the provider.

Some residents, who chose to remain in their bedrooms, did not receive opportunities for social interaction or participation in activities. This was not consistent with information contained within their care plans, which identified individual interests, hobbies and preferred activities. Consequently, not all residents were being supported to participate in meaningful occupation and social engagement in accordance with their wishes, preferences and rights.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brampton Care & Rehabilitation Centre OSV-0005812

Inspection ID: MON-0050642

Date of inspection: 28/05/2026

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: • The number of staff required to meet the residents' identified needs has been reviewed and enhanced to ensure all resident's identified requirements and needs are met. Any new requirements of the residents can be brought to the attention of the nursing staff at the safety pause which occurs daily and throughout the day or night. • The rosters are monitored by the senior nursing staff and signed off by the Person in Charge. In the event of staff failing to attend for duty, replacements from among our own staff are sought. Where this is not possible, agency staff from trusted agencies are requested to ensure adequate staff numbers are available to meet the residents' needs. • If and when an assessment is carried out and if increased supervision is required, this activity is supervised by the nursing team. • The skill mix is monitored and changed to meet the changing needs of the residents. Experienced staff are always deployed to mentor and support new staff members as they commence their employment. • A new handover approach is in place that provides up-to-date information regarding the changing needs of the residents. This handover is updated daily and is available to the healthcare assistants as a prompt though out their duty shift. • As part of the recruitment process a list of training modules are required to be provided by the candidates prior to their commencement in Brampton Care and Rehabilitation Centre. This list includes Safeguarding, Infection Prevention and Control. Human Rights Approach to Health and Social Care, Trust in care etc. • A robust induction for all new staff is now in place that includes the HR department and the Clinical team.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• A full review of the induction and training needs of the staff has been carried out.

• The training program has been amended, and each employee will be assigned to attend training to meet the mandatory and local requirements such as Fire, Safeguarding, IPC, Restrictive Practice, People moving and Handling, Moving and Handling, HACCP Dementia Care etc. All staff members are required to attend training as per their training schedule. Staff are encouraged to speak to the nursing management team if they need more input in these areas or lack understanding in their role while interacting with the residents.

• A training and staff development program has been developed for the next 4 months of 2026. Training is provided both internally and by external tutors.

Fire Warren training has been completed in July and Fire Training is booked for August and September, Safeguarding training is scheduled for September, Restrictive practice for August, People moving and handling and IPC for August Safeguarding training has taken place in June and July of 2026.

• A team of interviewers are in place from the clinical team to ensure candidates meet the requirements as set out in the recruitment criteria including having completed training, experience in providing care to the older person and English language skills.

• All new staff are provided with induction materials, and their progress is followed by the HR department and the Clinical Administration team to ensure they have completed the required pre-commencement training courses and also the onsite courses.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

• A full review of the training matrix has been carried out and will be monitored and reviewed on a daily basis by HR and the Clinical Administrator.

• All incidents are now being recorded in the clinical documentation/ management system.

• Where residents require more supervision, this supervision is monitored by the senior nursing team on duty. The safety pause also provides an opportunity for updating of any new information and needs of the residents.

• All staff have been educated in the identification of all forms of safeguarding concerns.

• Staff are educated to employ wherever possible a non-touch technique within the limits of the resident's people moving and handling requirements.

Regulation 23: Governance and management	Not Compliant

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

• Oversight of the staff is provided by the senior nurses on duty daily, further oversight is provided by the CNMs assigned to each floor. The ADONs and the PIC/DON provide further oversight on a daily basis. 8 HCAs have commenced employment and 12 are awaiting their compliance and on-boarding arrangements to be completed.
• The need to employ agency staff is reduced in light of this recruitment activity.
• The deployment of staff is reviewed on a daily basis, and their allocation is monitored by the nursing staff and the CNMs. Training has been provided to the nursing staff and CNMs on the allocation, supervision and deployment of staff.
• Updating information regarding the residents' needs is provided to the health care assistants daily by means of their handover sheet and safety pause.
• A review of the safety check practice has identified that these requirements are not effective other than when it is clinically indicated where more enhanced supervision is required to meet the resident's safety needs.
• A full review of Fire training has taken place. We have now 13 fire wardens in place including members from HR, Catering and Facilities teams. We have implemented an enhanced fire induction program with our Fire Wardens when new employees are onboarding. We have had a Fire Awareness week for all staff members which has provided the staff with a more robust program that is monitored on a daily basis at the CNM during their walk around and at hand over at the start of each shift. A step-by-step algo rhythm is available at the fire alert panels to reassure all the staff that their actions are correct.
• A full orientation of new staff takes place when new staff are appointed to a care area. Team leaders are also appointed to mentor the new health care assistants for a two-week period. An introduction to the residents and their needs are outlined to the new health care assistants during this onboarding process. A theory and skills competency list forms part of the induction program which must be completed and signed off by their mentor at the completion of the two week on boarding time frame. The daily handover sheets also provided information regarding the residents' needs. Nursing staff are also available if any information is required regarding resident's care.
• Risk register is updated and is now available for review.
• An action plan to meet the residents identified environment needs is in place.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

• The complaints policy identifies the stages of dealing with complaints.
• Training on managing complaints or concerns is provided to the nursing staff.
• The Complaints officer is the PIC/DON and is available to the residents or their families

Mon to Friday.
• Posters encouraging residents and their families to speak to the nursing team about their concerns are available throughout the building.
• Complaints are accepted verbally, in writing or by email.
• A response will be made within 48 hours on receipt of the complaint, which cannot be dealt with by local resolution.
• A full investigation will take place, and the resident will be included in the information gathering.
• Where a family member or loved one is the complaint they will be invited to speak with the PIC/DON to outline their concerns.
• Residents have been made aware that the complains officer is the PIC/DON.
• Where the complaint may lead to a safeguarding concern the correct procedure with be employed to ensure compliance.
• The complaints policy is available to review at the entrance to the facility.
• Complaints, Compliments and Suggestion boxes and available throughout the facility.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• A pre-admission assessment is carried out when the proposed resident is being reviewed by the Person in Charge / Director of Nursing.
• On admission a comprehensive assessment is carried out within 48 hours of admission to Brampton Care and Rehabilitation Centre.
• An ongoing assessment and care plan development takes place as the residents needs change.
• Nursing Staff monitor the resident requirements and update the care plan to meet any new identified needs. When implemented this is monitored and supervised by the CNMs on each floor.
• The 4 monthly care plan and MDT review takes place for all residents to ensure identified care needs are met.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The registered provider is updated on any protection issues by the PIC/ DON on a fortnightly basis.
• When a safeguarding plan is required residents or their legal representative are involved in the formation of the plan and is reviewed appropriately.
• Training has been provided in the area of safeguarding and abuse identification for all staff.
• When a safeguarding concern arises, a full investigation will be carried out by the senior nursing team and the Safeguarding officer to establish the facts of the concern.
• Safeguarding activity and investigations is carried out by a dedicated Safeguarding officer.
• A review of the communication activity for all residents requiring safeguarding intervention has taken place and a procedure for resident inclusion has been implemented for their involvement in all decision-making and resolution activities.
• Notification to the regulatory bodies will be made as required within the designated time frame.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Brampton Care and Rehabilitation Centre advocates a person-centred approach to promoting residents' rights. The Registered provider attends the residents' meetings alongside senior members of the Nursing team monthly. Residents are provided with the opportunity to visit with their family and loved ones at their request, and every assistance is provided to them.
• All staff are encouraged to be an advocate for the residents and to bring any requests or needs voiced by resident to the senior nursing staff so that they can be met.
• A full activity program is available for the residents to take part in that is monitored by the activity coordinators.
• All our residents' wishes and preferences are considered and residents are supported to participate in meaningful activities.
• Where a resident wishes to remain in their room and not take part in group activities a one-to one visiting program has been put in place to meet resident's preferences.
• We employ the FREDA principles of Fairness, Respect, Equality, Dignity and Autonomy in respecting residents' rights of self-determination.
• Residents' meetings take place on a monthly basis where the residents are free to voice concerns or comments they may have in a safe nonjudgmental environment.
• Advocacy organisations are available to the residents should they need external assistance.
• Arrangements are also in place for voting as necessary.

• We are currently reviewing assessments to ensure a person-centred profiling method is used to record a patient's life history, daily routines, and personal preferences. A review of the current activity and social interaction programs is being carried out to ensure the residents wishes and preferences are catered for and that are more age-appropriate activities are available the meets the needs of all our residents.
• TV and mail services are also available to provide up to date information to the residents.

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	30/10/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/09/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/08/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Not Compliant	Orange	30/09/2026

	and are available for inspection by the Chief Inspector.			
Regulation 23(1)(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	30/11/2026
Regulation 23(1)(d)	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	30/09/2026
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	30/09/2026
Regulation 5(1)	The registered provider shall, in so far as is	Substantially Compliant	Yellow	30/10/2026

	reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/09/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/09/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/10/2026
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.	Substantially Compliant	Yellow	30/10/2026