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:	Brymore House
Name of provider:	Brymore House Nursing Home Limited
Address of centre:	Thormanby Road, Howth, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	10 May 2023
Centre ID:	OSV-0000120
Fieldwork ID:	MON-0040109

About the designated centre

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

The designated centre provides care and accommodation for 28 residents; male and female over the age of 18 years. Types of care provided are long term care, transitional care and care for adults with dementia or other cognitive impairments. The centre is situated close to Howth centre and local shops and amenities. Off road car parking is available with wheelchair access provided on the ground and top floors of the building. The centre is accessible by local bus routes. This is a purpose built centre designed and opened in 1990. The building has been updated and extended to provide the current accommodation over three floors. There is a small passenger lift between floors. Accommodation is provided in single rooms some of which have en-suite shower and toilet facilities. Communal shower/bath rooms are available on each floor. Communal lounges and dining rooms are nicely decorated and provide comfortable areas for residents to congregate and socialise. There is a quiet room available on the middle floor where residents who prefer to spend their time quietly can sit or meet with their visitors in private. The dining room is situated on the ground floor overlooking the garden. There are two garden areas; a small courtyard with seating and planting which can be accessed from two of the bedrooms on the ground floor and the main garden which is a pleasant enclosed lawned area to the rear of the building. The centre is family owned and run. There is a registered nurse on duty at all times. The person in charge and the provider are available in the centre Monday to Friday and are well known to residents and their families. There is an open visiting policy in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

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
Tuesday 13 June 2023	09:50hrs to 18:00hrs	Brid McGoldrick	Lead
Wednesday 21 June 2023	13:50hrs to 16:00hrs	Siobhan Nunn	Lead
Wednesday 10 May 2023	09:00hrs to 19:00hrs	Frank Barrett	Lead
Tuesday 13 June 2023	09:50hrs to 18:00hrs	Karen McMahon	Support
Wednesday 21 June 2023	13:50hrs to 16:00hrs	Karen McMahon	Support
Wednesday 10 May 2023	09:00hrs to 19:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

This was an unannounced three day risk inspection to monitor compliance with the regulations made under the Health Act 2007 (as amended). Day One of the inspection primarily focused on a review of fire precautions and an inspection of the premises. While day two focused on a broader range of regulations, including Infection Prevention Control, Risk Management and Governance and Management. Day three focused on review of findings from day One and Two and steps taken by the centre to address major non-compliance's identified. The centre is registered for 28 residents and there were two vacancies on day one of the inspection and one vacancy on day two of inspection. The previous inspection of this centre in March 2022 had identified a number of areas that required improvement in relation to fire precautions, premises and governance and management.

Inspectors were met by a nurse on duty, on Day one of Inspection. The person in charge (PIC) and the registered provider were not available in the centre on this day, but the PIC was contactable by phone throughout the day. On day two, both the Person in Charge and Registered provider were present. On day Three, the person in charge was available.

The centre is located in an urban area close to shopping centres, residential areas, public parks, the beach and local transport links. The centre consists of a three-storey building on a steep gradient site with a well-maintained garden that provides a pleasant space for residents to sit out. Access to the centre through the front door brings visitors in at the top floor. The garden is accessible through the dining room and visitors were observed, by inspectors, to also use this access route to access the centre.The top floor consists of 11 single resident bedrooms, a day room and a conservatory. The middle floor of the building consists of 11 single bedrooms and two lounge areas. The communal rooms throughout the centre were nicely decorated and homely.The ground floor of the centre consists of the remaining six single resident bedrooms, day/dining rooms, the kitchen, laundry and storage rooms. Inspectors noted that residents' bedrooms were personalised with their belongings and photographs. Bedrooms have adequate storage for residents to store their clothes and belongings, although some pieces of furniture were noted to be in need of repair and some bedrooms needed cosmetic maintenance, such as painting and repair of missing tiles from en-suite facilities. Most bedrooms have lockers with a lockable drawer, however,none were noted to be locked on the second day of inspection and not all locks had a key for them. Management told inspectors that the key is given to residents when they request it. Some bedrooms had notices that gave information to staff about the resident's interests and preferred topics of conversation.

The three floors were serviced by a small passenger lift. The lift could take a max of three people at a time. There was also one central staircase serving the three floors of the building.

Inspectors noted some issues in relation to rooms that were accessed by staff only. There was some damage to the ceiling in the laundry and access to the hand washing sink was blocked. There was also significant damage to the wall joining the laundry to the centre and needed structural review to assess the potential risk posed by this. In the sluice room, on day one of inspection, the bedpan washer was not operating and that bedpans were being washed by hand. This posed a risk of cross contamination.This had been resolved on day two of the Inspection.

Inspectors noted issues in relation to the layout of the centre that impacted on the safety of residents in the event of a fire.The building is over 30 years old and the corridors were observed to be narrow and hard to navigate when multiple people occupied them or when staff had to navigate cleaning trollies and hoists through them. In addition inspectors found additional fire safety risks in relation to storage and final fire exit routes which were not being adequately managed. This is discussed in the Quality and Safety section of the report.

Inspectors also found, on day one of the inspection, some areas of the centre to be cold, and some residents told inspectors that they were cold. This is further discussed in the report under Quality and Safety.

Residents' appeared well groomed and content in their surroundings. Feedback from residents who the inspectors spoke with, was that the staff were gentle and caring and that they were happy residing there. Inspectors observed staff engagement with residents in the centre. Staff were seen to assist residents with care and respect and appeared to know the residents very well. Residents told inspectors that they were happy with the support received from staff and spoke of some staff members who were working at the centre for many years.

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

Capacity and capability

The leadership, governance and management of the centre was not effective as evidenced by the findings of this inspection and did not ensure the quality and safety of the care and services provided for the residents. Significant and sustained improvements were required across a number of regulations including: Governance and management, staffing,training and staff supervision, record keeping , risk management ,infection prevention and control and fire safety.

While there were some fire safety systems in place, and an upgrade to the existing fire detection and alarm system was ongoing at the time of the inspection,

significant action was required by the registered provider to ensure the risk of fire was appropriately managed.

Brymore House Nursing Home Limited is the registered provider for this designated centre. The clinical management of the centre was led by the person in charge (PIC) and was supported by nursing staff, health care assistants, kitchen staff, housekeeping, laundry, and maintenance staff. Staff training records indicated that all staff had up-to-date fire safety training, however gaps were identified in other areas of mandatory staff training.

Training matrix's, supplied to inspectors, identified gaps in the centre's own oversight system and did not reflect the dates of the most recent training, undertaken by staff. It also failed to identify when refresher training would be required on both mandatory and non-mandatory training. Management in the centre also were unsure of when staff had undertaken training or when they would need to update it.

Staff numbers were not sufficient to ensure the safe evacuation of all residents. For example, inspectors were told that one resident required the assistance of four staff members to evacuate the building. However, three staff members were on-duty at night-time.This is further discussed under Regulation 15.

Improvement was required in relation to the oversight of fire safety in the centre. The provider had put some measures in place to maintain oversight of the management of fire safety. This included a suite of fire safety checklists. These checklists covered various aspects of fire safety, for example, checks on fire evacuation routes and fire doors. The checklists were scheduled to be completed on a daily, weekly or monthly basis. However, inspectors noted that records relating to these checks were incomplete. For example, there were no records to indicate that the weekly checks on means of escape had been completed since January 2023. In addition, the checklists were not adequate to detect all of the fire safety issues that were noted by inspectors on the day of inspection. For example, the most recent check on automatic door closers had not identified that a number of cross corridor compartment doors did not close fully when released.

One fire escape route opened onto a set of steep concrete steps. The route to safety was upwards over 11 concrete steps. Residents who were living in the rooms serviced by this exit route required additional aids such as wheelchairs and evacuation ski sheets. This meant that the use of this route would be very difficult, and would impact on the evacuation of residents in the event of a fire. Inspectors also found that one resident's bedroom on the top floor was only accessible through a lounge. This created an 'inner room'; a room that does not open onto a corridor and does not have an emergency exit to the outside of the building.

The provider had commissioned a fire safety risk assessment (FSRA) dated 18/02/2023 of the designated centre. On the day of the inspection, this risk assessment was not available to inspectors. However, it was submitted as part of an urgent compliance plan in the days following the inspection. The FSRA had identified a number of significant fire safety risk issues. The provider had taken steps to

address some of the issues that were highlighted in this assessment. For example, the upgrade of the fire detection and alarm system. However, not all items rated high or extreme risks had been addressed in line with the timeframe set out in the FSRA and the provider did not have any programme of works or plans in place to address these issues. This will be discussed further under Regulation 28; Fire Precautions.

In addition, the provider had failed to fully assess or control all fire safety risks resulting from the upgrade of the fire detection and alarm system in the centre. There were no risk assessments available on the impact of these works on fire safety. Materials used for construction were found on emergency evacuation routes.

Inspectors reviewed rosters and found that there were insufficient resources provided given the layout of the centre. Staffing levels were reduced on weekends while resident dependencies remain unchanged. On rosters viewed some evidenced that there was one nurse on duty on Saturdays and Sundays. In addition, inspectors found that the person in charge was on unexpected leave and had not been replaced for the week prior to the inspection.This meant that the nurse in charge was delivering care to residents, attending to visitors,answering telephone calls as well as overseeing the fire safety works.

While residents' appeared happy and content living in the centre, inspectors identified a lack of effective and robust management systems in place for the oversight of the safety of residents' and staff and the future delivery of care and services in the centre. Audit systems in place lacked detail and evaluation methods to appropriately audit the care in the centre and to identify areas of improvement in line with evidence based practise.

Policies viewed on inspection also demonstrated a lack of a robust system of review. Many policies did not have evidence of any amendments, including polices dating back to as far as 2012/2013. The policies made available to inspectors demonstrated that the only evidence of review was a hand written date and signature at the end of the policy document. One schedule 5 policy was titled "Cognitive Impairment" and did not fully reflect that it was the policy associated with the Management of Behaviours that Challenges, (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). as required under Regulation 4: Written Policies and Procedures. The policy was in place since 2012 and was not reflective of the most up to date best practice.

Oversight and monitoring systems in respect of infection prevention and control required improvement. Issues relating to storage, hand hygiene facilities and resources required immediate and sustained attention. The provider had assigned a staff member to attend an infection prevention and control (IPC) course and on completion of this course would provide leadership on IPC in the future. Limited staffing resources in the designated centre, in particular household staff, resulted in the centre not being deep cleaned in a timely manner. A member of the household staff was absent and management had failed to put an appropriate contingency plan

in place. Many staff with no training on using cleaning chemicals or sterilisation techniques were performing cleaning.

While some data was collected on antibiotic use, more robust reviews were required of antibiotic use, infections and colonisation as recommended in the national standards. This would enable the provider to monitor antimicrobial use and and trends in development of antimicrobial resistance. Improved leadership and oversight was also required in cleaning and decontamination processes and infection prevention and control policies.

A series of immediate and urgent actions were issued to the provider over the course of the three days of inspection:

· On day one of the inspection, as a result of the risks identified, immediate actions were issued regarding the storage of material under the stairs including an oxygen cylinder, and storage in the boiler house. Immediate action was also issued relating to the servicing of the heating system within the building. The provider addressed each action during the inspection.

· Following the first day of inspection, an urgent compliance plan was issued to the provider highlighting risks relating to fire precautions and governance and management that needed to be addressed in a short period of time. The provider submitted a compliance plan following the first day, to mitigate the risks identified until permanent measures were put in place to address these risks. An additional staff member was immediately placed on night duty and additional fire safety instructions were put in place to enhance staff knowledge and to review evacuation procedures.

· On day two of inspection, Immediate action was agreed with the provider to address issues relating to the cleaning within the centre. Assurances were given by the provider committing to a deep clean of the centre in the days following the second inspection day.

· On day three an immediate action was required to remove a wooden pallet which was obstructing a fire evacuation route. This was completed on the day.

· Following day three of inspection, an urgent compliance plan was issued to the provider regarding the ongoing risks related to cleaning which had not been carried out following day two. This related to infection prevention and control practice, and the Governance and Management of the centre.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the designated centre in a timely manner.

Judgment: Compliant

Regulation 15: Staffing

The provider had failed to provide sufficient staffing levels in the centre to meet the needs of the residents, and for the size and layout of the centre. The levels were not in accordance with their statement of purpose and function. The impact of inadequate staffing was evidenced by;

A review of the staffing rosters for the previous two weeks showed that there were 11 occasions where planned staffing levels were not maintained within the household staff, leaving no household staff on duty. On a further five occasions the hours provided were 3.75 per day.There was no cleaner rostered to work on any Sunday.This impacted on effective infection prevention and control and the quality of environmental hygiene as evidenced in the findings of this report.
The provision of nursing staff varied with reduced levels on duty at weekends although resident dependency levels remained unchanged. Examination of worked and planned rosters showed in general two nurses on day duty. However on a Sunday there was only one nurse on duty for the 12 hours.
A review of numbers of staff on night duty was required to ensure the safe and timely evacuation of residents in the event of a fire emergency. One resident was documented to require four staff in the event of an evacuation, however there are only three staff rostered on at night time. This is further described under regulation 28 Fire Precautions

Judgment: Not compliant

Regulation 16: Training and staff development

The records of completed staff training were available for the inspectors to review. There were gaps identified in the records.

Dates had not been updated to reflect the most up to date training, that staff had undertaken and there was no system to identify when refresher training was required, to ensure that staff were up to date with their mandatory training requirements. Managers were unable to provide reassurance regarding training and were unsure of the training status of staff.Gaps identified in the matrix included Safe-guarding and IPC training.
There was no evidence that kitchen staff had received education regarding the provision of a varied and safe choice of meals to residents' with swallowing difficulties and dietary requirements.

The findings of this inspection found that further training was required on risk management, as management and staff had failed to identify significant risks found

in the centre over the three day inspection, which included risks in relation to fire safety and IPC including, the cleaning and decontamination of equipment.

Judgment: Not compliant

Regulation 21: Records

Records for the previous seven years were not all maintained in the centre. A small quantity of resident records for residents who no longer resided in the centre were being stored in the motor room for the lift. Records were stored loosely in boxes.This was not an appropriate area in which to store resident records. Furthermore these items were combustible which posed a fire risk in this area. Current resident records were stored in an unlocked cabinet on the middle floor of the designated centre. It was not clear who had access to these records as this was a busy area accessed by staff of all grades.

Staff advised inspectors that the majority of the schedule 2, 3 and 4 records which the provider is required to retain for a seven year period were stored off site. There was no system in place to catalogue what records were stored where. Inspectors observed that staff struggled on all inspection days to provide the necessary documentation. For example when inspectors sought worked rosters for the weeks prior to inspection managers and staff were unable to provide them as they were no longer in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. The provider had failed to ensure the service had sufficient staffing resources to;

· ensure that care was provided in a clean and safe environment that minimised the risk of transmitting a health care-associated infection.

· ensure that residents could be safely evacuated in the event of fire or emergency.make sure that staffing was in line with the centre's statement of purpose.

The governance and management systems failed to ensure that a safe and consistent service was provided. This was evidenced by:

· There were ineffective management systems to ensure that residents were adequately protected from the risk of fire. There were inconsistencies with staff knowledge and the mode of evacuation along certain escape routes.

· Repeat findings of non-compliance with Regulation 28 fire precautions were found on this inspection.

· Areas of high or extreme risk identified on this inspection, which was known to the provider though their own fire safety risk assessment (FSRA), were not actioned.

· Maintenance systems were not effective to provide a comfortable environment for residents living at the centre.

· While a schedule of audits was in place to evaluate the quality of some aspects of the service, significant improvements were required to ensure the systems in place to monitor, improve, and sustain improvement actions in key areas were ineffective in areas of the service such as clinical documentation, infection prevention and control, and the hygiene of the environment and equipment were effective. Furthermore the oversight of fire precautions and fire safety checks carried out in the centre did not identify and address areas of concern in a timely manner. For example, weekly fire door checks were not identifying containment issues where fire doors were not closing. Inspectors also observed that a number of fire doors were propped open using wedges or bins. This meant that fire and smoke would not be contained within these areas.

· The system for review of risk and hazard identification required review .Risk assessments in use in the centre were not robust and did not provide a good level of protection to residents. For example;.The entrance to the centre's car park was accessible from the resident's garden area at the rear of the building. Although this entrance was, used mainly by staff and visitors there was nothing to prevent a resident walking through the entrance and out into the car park. On the day of inspection many residents' residing in the centre had cognitive impairment and did not have capacity to ensure there own safety.

· The door to a garden shed storing maintenance tools and chemicals was propped open, using a metal bar, which provided full access to residents to items that posed a potential risk to their safety and well-being.

Judgment: Not compliant

Regulation 3: Statement of purpose

Staffing levels outlined in the Statement of Purpose were not reflective of what inspectors found on the inspection days. For example the SOP stated household

staff had a WTE of 2.8, but worked rosters for 5 weeks showed a WTE of 0.7. the compliance officer was a WTE 0.75 but only worked equivalent to 0.5.

The statement of purpose did not outline the process in place to provide cover in the event of either planned or emergency absence of the Person in Charge.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Quarterly notifications were submitted as required, by the provider.The centre did not have any three day incidents that required notification in the previous 12 months,

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available to review on the day of inspection. Many had not been updated since their implementation, with some dating back to 2012/2013. As a result they did not reflect current best guidance and legislation.The original policy documents had been signed and dated underneath and did not reflect a robust system of review or demonstrate the use of best evidence based practice. Furthermore one policy was not specific to the designated centre and was reflective of a hospital setting and referenced a sterilisation unit that was not relevant to the centre.

Judgment: Not compliant

Quality and safety

The registered provider had failed to put in place adequate systems for the monitoring and ongoing quality improvement of the services provided to residents. As a result several risks were identified that did not have mitigating measures in place.

The safety of residents in the centre was negatively impacted by significant issues in relation to fire containment and the safe evacuation of residents in the event of a fire. These were noted on inspection and subsequently highlighted to the provider in an urgent compliance plan following the first day of the inspection. Furthermore the

registered provider failed to ensure that the designated centre was clean on the three days of inspection. An urgent compliance plan was issued on day 3 of inspection in relation to Regulation 27: Infection Control.

This centre was previously inspected on 15 March 2022. The inspection found that significant improvement was required in relation to the fire safety arrangements in the centre at that time. Since the time of that inspection, the provider had taken measures to address a number of these issues. The provider had improved the emergency lighting which records showed was tested and certified on a quarterly basis by a competent external fire professional. The provider was in the process of upgrading the fire detection and alarm system at the time of inspection. However, notwithstanding the improvements that had been made since march 2022 some significant findings had not been addressed and inspectors were not assured that the provider had a time bound plan and the resources set aside to complete the actions to address these findings in a timely manner.

On day one of the Inspection, upgrade works to the fire alarm system was being carried out. Inspectors found that dust was being carried throughout the centre by staff and workers walking through works areas and into some residents' rooms. When this was queried with the nurse on duty, they confirmed that no additional cleaning resources were put in place for the duration of the works. There was on cleaner on duty until 14:00 hours on the day of inspection. These works had been completed by day three of the inspection. These issues are dealt with further under regulation 15 Staffing and regulation 27 Infection prevention and control

The provider was unable to provide assurances that adequate measures were in place to ensure the containment of fire. As outlined above, not all doors fully closed when released. In addition, the provider could not provide assurances that the doors on resident bedrooms were fire doors. Assurances in relation to the containment of fire in the attic area could not be provided.

Improvement was required in relation to the system of evacuation and fire drills in the centre. Fire drill records were not specific to high-risk areas nor were there simulated evacuation when staffing levels were at their lowest. No record of a fire evacuation of the largest compartment was available on the day of inspection. Inspectors could not be assured that the use of evacuation aids in some of the evacuation routes had been trialled by staff at the centre. Improvement was required in relation to signage relating to the evacuation of the centre. No procedure was displayed in the hallways indicating what to do in the event of a fire. As a result inspectors were not assured that the provider had adequate precautions in place to protect residents, staff and visitors in the event of a fire emergency.

On day one of the inspection the centre was noted to be cold. When inspectors asked about the heating in the centre, they were informed that all three heating system boilers, including back-up boilers had broken down during the previous night. An immediate action to restore heating was issued and heating was restored to the centre on the day of the inspection.

Inspectors observed residents receiving visitors throughout the designated centre and their visiting times were not restricted.

Residents clothes were laundered in the designated centre and they had adequate storage space. Inspectors observed that residents rooms had been personalised and they had space to display their personal belongings

Information boards/menus informing residents about their food choices were not observed throughout the centre during the inspection. Inspectors spoke with kitchen staff, who informed inspectors that menus are not used in the centre. Dinner/tea choices were generally decided on that morning based on food supplies available that day and the choices used in the previous days, to avoid repetition.

Residents were informed of the choice available to them, generally, 30 minutes before mealtimes or when they attended the dining room for their meal. Staff were asked how they communicated meal options with residents with communication difficulties, particularly hearing difficulties, in the absence of menus or menu boards. Staff were unsure of how to answer as there was no robust system in place to communicate meal choices to residents' with communication difficulties.

The catering staff did not demonstrate adequate knowledge or training on providing a varied choice of safe meal options for residents' with swallowing difficulties.

There was an activities schedule in place over the three days of inspection. However, on day one of inspection, limited activities were happening, and many residents were sitting in the day rooms watching TV, or in their bedrooms. In one area of the centre, inspectors observed residents walking around the corridors and entering other residents' bedrooms. One resident was found in some distress as they wandered without supervision or support along one corridor. There was clear evidence of a lack in staff supervision in various areas of the centre throughout the day which was impacting on residents' well being and safety. On day two and three of inspection activities including hand massage and live music were observed taking place, which residents were clearly enjoying. Residents in the centre had access to advocacy services and were facilitated to vote in the centre.

During the inspection over half the residents residing in the centre had some level of cognitive impairment, mainly as a result of Dementia, and were unable to ensure their own safety or identify potential risks. Many were mobile and enjoyed being able to mobilise, without restriction, around the centre and outside in the garden. However, inspectors were not assured that all environmental risks such as access to car park and a private dwelling on the same site had been adequately managed to protect residents who may enter into these unrestricted areas. The risk management policy did not contain all of the measures required to manage specific risks. On day two and three of the inspection a maintenance shed containing equipment, such as heavy duty shovels, was found to be propped open with a metal bar giving residents access to the contents inside.

Pharmacy services were provided by an external contractor who supplied a digital system of medication administration and provided support and services around pharmaceutical training, policies and medication audits.

Regulation 11: Visits

Visitors were seen freely visiting throughout the inspection days and there were no restrictions in place. There were appropriate communal and private spaces for residents' to receive visitors.

Judgment: Compliant

Regulation 17: Premises

The registered provider failed to have regard to the needs of the residents at the centre and provide premises which conformed to the matters set out in schedule 6 of the regulations. For example:

- Some areas of the premises were not being kept in a good state repair internally. The laundry had damage to a boxed out section of wall. The ceiling was also cracked and some sections of the paintwork required repair. There was a significant amount of dust on the shelves, and no cleaning schedule could be found for the room.
- In the sluice room, there was mould on the ceiling. There was a rusting sink which would make cleaning the area difficult.
  The translucent ceiling of Lounge C had a large amount of debris and vegetation above it which was unsightly and reduced the amount of light entering the room..
- Appropriate sluicing facilities were not provided at the centre, on the first day of inspection. The bedpan washer was out of service, resulting in staff hand washing bedpans. This had been addressed on the following days of inspection.
  A drying rack in the sluice room was rusted, and the paint on the rack was peeling off. Furthermore, there was no drip tray under this rack. This could result in cross contamination.
- Room layouts in some cases did not meet the needs of residents, for example, one bedroom opened directly into a day room, and there was no lock working on the door. This meant that other residents could access this resident's bedroom from the day room.
- Inappropriate storage was found throughout the centre for example, mobility aids were being stored in Lounge C. Chairs and laundry bins were being stored in a sluice room.

- Excessive amounts of PPE, incontinence wear, mattresses and furniture were stored on the floor in a storage room. This would make cleaning the floor area difficult.
- The layout of the staff toilet on the ground floor required review as the location of the hand-wash sink was not in close proximity to the toilet. it was located in a separate room next door, resulting in the risk of ineffective hand hygiene and potential for cross contamination.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were offered a varied choice of food throughout the day.There was also access to fresh drinking supplies and snacks. Food was prepared and cooked fresh on-site with local butchers and fish -mongers were used as suppliers. However there were some areas of improvement required:

· Written/pictorial menus were not in use in the centre to inform residents about their menu options at each meal time. Furthermore , and when spoken with, staff were unsure of how to communicate food options with residents who had hearing difficulties or cognitive impairment.

· Catering staff were knowledgeable around resident's dietary needs but lacked education and training on how to provide safe and varied choices of food to those with swallowing difficulties. As a result menu options for residents who required textured diets were reduced particularly in the evening. Evening meal choices for a resident with swallowing difficulties were primarily scrambled egg or custard.

· Staff were seen to be available to assist those who required assistance at mealtimes, however there was a lack of staff avaialble to support and supervise those residents who chose to eat their meals in their bedrooms.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy did not include a number of aspects required under the regulation including the measures and actions to control risks of abuse, accidental injury to residents ,visitors or staff and aggression and violence. Furthermore there

was no plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

The implementation of the risk management policy and the management of risks in the centre have been further discussed and addressed under Regulation 23 in the capacity and capability section of this report.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider had failed to take action to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA.

The registered provider had not ensured clear governance arrangements were in place to achieve the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example, monitoring, audit and oversight arrangements had not identified areas for improvement highlighted by inspectors during the course of the inspection.

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 centre was visibly unclean on inspection, including both occupied and vacant bedrooms, en-suites, storage rooms, and communal bathrooms.

· Several pieces of equipment used by residents, such as shower chairs and specialised chairs, were dirty and were not cleaned appropriately. This increased the risk of acquiring a health case associated infection (HCAI).

· Day three of inspection found that despite assurances from the provider many areas in the centre remained visibly unclean.

· The bedpan washer was not functioning on day one of the inspection and had been out of order for two weeks prior to inspection. There was no procedure to guide staff on how to clean and disinfect urinals which were in use during this time.

· The management of storage areas was not effective to minimise the risk of cross infection. For example, a hoist used by variours residents was stored in one residents bedroom. This increased the risk of cross infection.

· The laundry areas were not managed in a way that reduced the risk of cross infection. The system in place to ensure that items for laundering were moved from

the dirty area to the clean area was not being implemented as evidenced by the storage of linen bags containing soiled linen, in the clean linen area of the laundry.

· Chlorine granules and tablets were out of date in the blood spill kit.

· There were a limited number of dedicated hand wash sinks in the centre and the sinks in the residents' bedrooms were dual purpose-used by residents and staff.

· The hand hygiene sink in the sluice and the medication room did not comply with required specifications for for clinical hand-wash sinks.

· There was no schedule of cleaning available for curtains or for the laundry area.

· Staff were seen carrying dirty laundry into the laundry room in their gloved hands, held up against their uniform.

· Policies and procedures for infection prevention and control and health and safety required updating to reflect the national standards and evidenced based practice.

· The system for collection and management of specimens for microbiology required attention as the current practices were not evidenced based.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire, and did not provide suitable fire fighting equipment for example:

- There was inappropriate storage and excessive amounts of combustible materials in storage rooms without any fire detection, for example cupboards at the end of bedroom corridors.
- There was excessive amounts of material including furniture, files and electrical equipment found under the main stairs. This would increase the likelihood of fire starting in the stairwell and would therefore impact on the safe evacuation route for residents if a fire occurred in this area.
- A nurses station was located under a section of the main staircase in the centre. This area contained electrical equipment, and electrical cabling attached to multiple electrical devices which were in use throughout the inspection. This activity increased the risk of fire in this area. As this was a central location beneath a staircase a fire in this area could prevent residents, staff or visitors from evacuating safely using the main stairs.
- An Oxygen cylinder was found in a bag under the main stairs. When this was brought to the attention of staff, they did not know it was there. The fire

extinguisher closest to this area was not suitable for use with oxygen bottle fires. This oxygen cylinder was removed immediately.
- Petrol fuelled equipment was found stored in the boiler room. This room contained the gas boilers, and electrical distribution boards. When this was brought to the attention of maintenance staff at the centre, it was removed immediately.

The registered provider did not provide adequate means of escape for example:

- A bedroom on the top floor was an "inner room". Escape from this room is limited because a resident has to go through a day room in order to get to an escape corridor. No other means of escape was available from the room. This would impact on the evacuation of this resident in the event of a fire in the day room.
- Inspectors could not be assured that the means of escape for residents on the first floor was adequate to their needs. This evacuation route led upwards over concrete steps and would prove very difficult to use with evacuation aids such as ski sheets and wheelchairs.
- The external evacuation route from a day room on the first floor was uneven, and there was an obstructed route to the fire assembly point. There was an opening in a wall to allow evacuation to the assembly point, however, this opening was narrow and might be difficult to navigate in an emergency. Furthermore the route to the assembly point was obstructed by wheelie bins.

The registered provider did not make adequate arrangements for reviewing fire precautions for example:

- The fire safety policy at the centre was not specific to the needs and nature of the building. Though the document indicated that the procedure was reviewed annually, there was no evidence that the policy or procedure had been reviewed in line with residents dependencies, or that identified risks had been taken into account in the review.
- Personal Emergency Evacuation Plans (PEEPS) were in place at the centre, however, the assistance required for residents in an emergency situation was not clear and they did not clearly identify the required assistance for residents at night time.
- A door from the day room on the first floor, opened outwards over the stairs. This door was also fitted with a hold open device, which held the door in an open position blocking a significant amount of the stair width. This procedure restricted the movement of people using the stairs. This was causing residents using the stairs to have to manoeuvre around the door, while climbing the stairs in order to reach the landing. In the event of an emergency, this door would cause significant delays in evacuation.

The registered provider did not make adequate arrangements for detecting fires.

- While it was noted that a significant amount of work was being carried out to upgrade the fire alarm, on the day of inspection, fire detection was not

present in many rooms for example, Storage cupboards on corridors, the conservatory, and the laundry area.

The registered provider did not make adequate arrangements for containing fires. Inspectors could not be assured of effective compartmentation within the building, for example:

- The attic hatches at the top level of the centre did not appear to be fire rated hatches. Due to electrical upgrade works at the centre, some attic hatches were open. Inspectors could not be assured that containment measures were in place in the attic above containment lines. Containment lines are compartments within the building which contain fire and smoke for a specified period. These containment lines need to be effective above and below ceiling level to ensure containment of fire so that evacuation of residents to the relative safety of the next compartment can be completed.
- Fire doors throughout the building had large gaps underneath and around the perimeter. Many doors were found to remain open on release of the door holding device.
- Door closing devices were in place on all bedroom doors, however, most of the bedroom doors did not close fully when released.
- There was a lack of fire stopping material around pipe penetration in walls and ceilings was found throughout the centre, and from the external plant room.
- There was a passenger lift available at the centre, however, there were no measures in place to contain fire and smoke at the lift doors on each level. There were no lift lobbies in place, which means that a fire on any level, could spread fire and smoke through the lift, to the other floors.
- Electrical distribution boxes on evacuation corridors did not appear to be fire rated. There were also loose cables above cross corridor doors.
- There was no door to the nurses station located in the stairwell.

The procedure to be followed in the event of a fire was not displayed in a prominent place in the designated centre. There was no procedure available at the main entrance, or at the fire alarm panel.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was an appropriate pharmacy service offered to residents and a safe system of medication administration in place. Policies were in place for the safe disposal of expired or no longer required medications.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Improvement was required to ensure care plans were updated to reflect their changing needs of residents for example

- A resident with urinary catheter (a flexible tube used to drain urine from the bladder) had not been updated following their admission to Accident and emergency department. More detail was required to guide staff on measures to prevent a blockage.
- Care plans were not updated to reflect the appropriate manual handling needs of the resident.

Judgment: Substantially compliant

Regulation 8: Protection

One resident in the centre was assisted to pick up their pension in the local Post office, but there was no robust system in place to adequately record and oversee this process to ensure that resident's monies were protected.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that residents who wished to could exercise their religious rights, as there was no evidence of religious services been offered in the centre.

Residents had access to a lockable drawer in their bedrooms, but had to request a key from management if they wanted to use it.

There was no programme of activities offered at the weekend. Worked and planned rosters showed Activity staff were only rostered Monday to Friday and there was no evidence available to inspectors to show weekend activities were taking place.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
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 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brymore House OSV-0000120

Inspection ID: MON-0040109

Date of inspection: 10/05/2023

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: • Our statement of purpose has been updated to reflect current staffing levels • On day 2 of inspection, interviews were being held for housekeeping staff following a period of advertisement. Two new staff are now in employment. • 3 staff & 1 fire warden are on duty at night.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • We are redesigning our training matrix to include when refresher training is required. • All staff receive mandatory training including Safe guarding, CPR, Fire Safety Awareness & IPC with our IPC link practioneer. • Our kitchen staff are fully aware of all our residents' dietary requirements & their likes, dislikes & preferences & always tailor meals around this. • One of our RN's will attend the next available risk management course.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records:	

• All records set out in schedule 2, 3 & 4 are now stored securely in the designated center & can be retrieved immediately upon request. All records are stored in date orders & destroyed securely after 7 years. • The small number of records found have been removed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • We have increased our household staff numbers & this is also being complimented with contract cleaners during periods of annual leave/illness. • All staff are fully trained in fire precautions & evacuation procedures. Last bespoke training March 2023 & this training is provided on an annual basis & supplemented by regular fire drills & evacuations. • 80% of recommendations from our FSRA had been actioned or completed. The remainder was in progress or awaiting installation date. • We are reviewing our audit systems & types of audits we complete. This review also includes our risk & hazard identification. • We are currently reviewing all risks & hazard identification to include impact vulnerabilities, control measures & any additional measures needed. The gate to the car park area is closed & any resident who uses the garden is always supervised by a staff or family member. •This door has been fitted with a self-closing device & he has been reminded to keep this door closed at all times.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • Our statement of purpose has been updated to include all necessary requirements • Our WTE table is reflective of current staffing levels.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• All policies are being updated to include current legislation & best practice.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• As work was going on with the fire alarm upgrade damage was caused by the removal of the old system including wiring & trunking & detectors repair of these areas in underway & in some instances complete i.e., laundry, laundry room, lobby wall & corridors.
• All areas have been deep cleaned & all inappropriate equipment removed or replaced. This includes the sluice room, all store rooms & locker room.
• The bedroom that opened on to a lounge is now a private visitors room.
• Staff have been reminded to store equipment in the correct location.
• The staff toilet on the ground floor was changed to this configuration at the request of the Environmental Health Officer some time ago.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• We have recommenced the use of pictorial & written menus & all staff have been re-educated in the use of these aids.
• We have been in contact with our dietician & training on modified diets will be provided by our nutrition company.
• There was 1 resident having his meal in his room on the day of inspection, who clearly told the inspector the reason for this on that particular day, he does not require any supervision or support & if any other resident chooses to eat in their room & require support, then it is given.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• We are updating our risk management policy & a staff member will attend the next available risk management course.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• We had a shortage of household staff due to a staff serious illness, however we advertised & interviewed & for additional household staff who are now in place.
• A full deep clean of all areas was completed by contract cleaners.
• We had put a service call into the company who services our bedpan washer & were waiting an engineer call out.
• Our laundry area has been reconfigured to ensure that clean & dirty areas remain separate & staff have been reminded to use laundry skips for the transport of laundry.
• Chlorine granules have been replaced.
• The laundry area is now included on the cleaning schedule.
• Curtains are cleaned when rooms are vacated.
• We are currently updating our IPC policy to include specimen collection.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The excessive amounts of combustible materials in the store room has been removed & all areas of the center including all cupboards have fire detection installed.
• The area under the main stairs has been cleared
• The nurses station contains the main connection point for the call bell system & Wi-Fi , our electrician has certified all these connections & there is fire detection & suitable extinguishers in this area & all unnecessary electrical have been removed from this area.
• All storage areas are checked to ensure there is not inappropriate storage of equipment this includes under the stairs & boiler room.
• This top floor bedroom has been reconfigured as a visitor's room
• Resident placement within the center is now assessed on evacuation risk assessment & evacuation needs & only mobile reside within the vicinity of this first floor route.
• The floor of the evacuation route has been cleaned & is now even & obstruction free.
• The evacuation opening allows for all evacuation equipment including wheelchairs &

fire mats – this has been tested with all our equipment & this route is obstruction free.
• Our fire safety policy is being reviewed by a fire safety specialist & will take into account the nature of the building & all identified risks.
• PEEPS have been reviewed & amended to include the required night time assistance
• All our fire / compartment doors are being upgraded & we will be guided by their recommendations regarding this door from the day room on the first floor.
• Our fire alarm system upgrade has been completed & includes detection in all areas.
• We have engaged the services of a builder & fire architect to assess our attic containment lines & we will proceed with their recommendations
• A fire door company are upgrading our fire / compartment doors & we will ensure that all doors close fully.
• All pipe penetration has been assessed & fire stopping material put in place.
• Our architect is looking at ways to create lift lobbies, giving the restrictions of the building.
• All electrical distribution boxes are fire rated & certified on an annual basis & any loose cables have been tidied up.
• The fire procedure is now displayed in prominent places around the center.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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:
• Care plans are updated when necessary or if any changes in circumstances. The resident with U/C on return from A&E had no changes made to their care. All staff's, RN's & HCA's are fully aware of measures to prevent blockages.
• All residents have individual PEEPS with their full evacuation plan.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• This resident has full autonomy over her finances & only requires assistance from us in transporting her to the post office, however we have now commenced a record book which documents this process & this has been agreed with the resident.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• We are a multi denominational center & all major religious events are celebrated & a minister of the Eucharist comes every Sunday.
• We facilitate visits from clergy of all denominations & can access the web cam's form our local church's.
• Keys for the lockable drawer will now be given on admission & we have given keys to any resident who wished to have them.
• Planned activities are provided Monday to Friday as from vast experience, the weekends are busy for the residents with visitors & family outings.

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	01/07/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/09/2023
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	30/08/2023

Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	01/07/2023
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	01/07/2023
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 and are available for inspection by the Chief Inspector.	Not Compliant	Orange	13/09/2023
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	01/07/2023
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	Not Compliant	Red	30/08/2023

	effectively monitored.			
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.	Substantially Compliant	Yellow	10/09/2023
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	30/08/2023
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	30/08/2023
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	30/08/2023
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	30/08/2023

	is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	01/07/2023
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.	Not Compliant	Red	30/09/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	30/08/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	30/09/2023

	reviewing fire precautions.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	30/08/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	31/07/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	01/07/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/09/2023
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in	Not Compliant	Orange	30/09/2023

	paragraph (1) available to staff.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2023
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	30/09/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	01/07/2023
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their	Substantially Compliant	Yellow	01/07/2023

	civil, political and religious rights.			