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:	Mill Lane Manor Private Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Sallins Road, Naas, Kildare
Type of inspection:	Unannounced
Date of inspection:	05 April 2022
Centre ID:	OSV-0000066
Fieldwork ID:	MON-0035539

About the designated centre

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

Mill Lane Manor Private Nursing Home is a designated centre providing health and social care to men and women over the age of 18 years. Care is provided in a purpose-built, two-storey premises located in a residential area in Naas Co. Kildare. The building consists of 52 single occupancy bedrooms and nine twin rooms. All bedrooms have full en-suite facilities. A passenger lift is available between the ground and first floor. Communal areas include two lounges and an oratory and there is a designated hairdressing salon. There are two internal courtyards along with grounds to the front of the building. Parking is available at the front, side and rear of the centre. The centre provides a service to individuals with a range of needs including long-term care, short-term care, acquired brain injury and dementia. A short-term respite and convalescence service also operates in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 April 2022	09:40hrs to 18:30hrs	Helena Budzicz	Lead
Tuesday 5 April 2022	09:40hrs to 18:30hrs	Kathryn Hanly	Support
Tuesday 5 April 2022	09:40hrs to 18:30hrs	Sinead Lynch	Support

What residents told us and what inspectors observed

The inspectors spoke with a large number of residents and had detailed discussions with nine residents to gain an insight into their experience living in Mill Lane Manor Nursing Home. Overall, inspectors observed a relaxed and comfortable environment. While residents and visitors were generally satisfied with the service provided, some expressed concern about staff practices and management of the concerns voiced by residents.

This inspection was unannounced and completed over one day. Prior to accessing the centre, the inspectors were guided through the infection control assessment and procedures. An opening meeting was held with the person representing the provider and the person in charge prior to being accompanied on a tour of the centre.

This was a two-storey building set in the landscaped gardens within walking distance of Naas town centre. The main entrance was wheelchair accessible and led to a small enclosed porch where the infection control sign-in and equipment were located. There were spacious day rooms, sun rooms and a dining room in the centre. These communal rooms were well decorated with several artworks. Inspectors observed that residents had unrestricted access to secure outdoor courtyards, accessible from the communal dining and sitting rooms and corridors. The inspectors saw the centre's hairdressing saloon, currently being used as a staff changing room. The hairdresser and the chiropodist visited on a regular basis, and these visits were documented. However, some ladies in the centre voiced their disappointment that the hairdresser did not visit the centre for the last two months due to the recent outbreak of COVID-19.

Inspectors saw that the decor of the centre was bright and the corridors were well lighted and wide. However, painting on the walls and doors was in need of repair as passing equipment had damaged the wooden surfaces and removed areas of the paint on the walls and doors, which impacted on effective cleaning. Furthermore, there was a lack of storage space in the centre which resulted in the inappropriate storage of equipment and supplies.

The main dining room was spacious and there were adequate tables for residents to enjoy their meals. The dining room was prepared for residents before meals with condiments, table napkins and delftware. The menu of the day was displayed in the dining room, and this showed the choice for each course for the main meal.

The schedule of activities for the week was displayed on the notice board by the communal room. Residents could mobilise freely throughout the centre, and a number of residents were observed walking around independently or with the assistance of staff on the day of the inspection. On the day of the inspection, the residents were well-groomed, nicely dressed and observed to be content and happy. Mass was live-streamed in the morning, and some residents watched it in the day room. Inspectors observed younger residents leaving the centre independently,

driving their motorised wheelchairs. Another group of residents went for their choir practice on the centre's bus. Residents had access to television, radio, newspapers and books. Internet for private usage was also readily available. However, inspectors raised a concern about the availability of advocacy services for younger residents living in the centre and their assessment of needs for personal assistance support.

Inspectors spoke with some residents who were spending time in the communal room, and these residents appeared comfortable, telling the inspectors they were happy with their rooms. One resident proudly showed the pictures of their bedroom to the inspectors on their Ipad. The inspectors observed that most of the residents' bedrooms were personalised to a good standard with their personal belongings and items that were of importance to them. However, the cleanliness of carpets on the floor in some of the bedrooms needed improvement to ensure sufficient comfort for residents.

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

Capacity and capability

Lack of governance and management oversight of risks were impacting on the quality and safety of the service provided. Current systems to monitor the quality and safety of care were ineffective, and this resulted in inadequate monitoring and oversight of resident care to ensure the safety and protection of residents at all times. Furthermore, the system of risk identification was not adequate; for example, inspectors identified a number of risks during the inspection that had not been identified. As a result, the measures and actions to mitigate the risks were not in place. As a consequence of these concerns, the provider was required to provide assurances to the Chief Inspector.

This was a risk-based inspection to monitor the designated centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. The inspectors also followed up on notifications submitted to the Chief Inspector and a recent provider assurance report that had been submitted by the provider in relation to the safeguarding precautions for residents living in the centre.

The Brindley Manor Federation of Nursing Homes Limited is the registered provider of the centre. The person in charge was supported by an assistant director (ADON), and both were working full-time in management roles. The position of the second Assistant of nursing was vacant on the day of the inspection, and as a result, the inspectors found that the management structure as outlined in the statement of purpose and function was not in place. The regional manager informed inspectors that the ADON was being currently recruited. The management team also had

additional support from the group's senior management team, which consisted of a regional director, human resources manager, and quality chief officer.

The inspectors found that the systems in place to monitor, evaluate and improve the quality of the service were implemented by the management team but not followed up. For example, the management team had systems in place to monitor key performance areas, such as falls incidents, weight loss monitoring and wounds. These systems had identified some areas for improvement; however, inspectors found areas requiring action that the governance and oversight systems had not identified. While incidents involving residents had been reviewed, the system of risks identification and implementation of the action plan submitted in the notifications to the Chief Inspector required further oversight to ensure that adequate measures to support residents had been implemented.

A review of the training records evidenced that staff were supported and facilitated to attend training relevant to their role. The oversight of the nursing and caring practices required improvement to ensure that the care provided was always kept to a high standard.

While there were Schedule 5 policies in place, these were not updated, and as a result, the policies were not readily available to staff.

The centre had a complaints policy in place, and a number of complaints were recorded. A number of complaints did not have the outcome of the complaint specified. The inspectors found that the complaints records of residents' complaints and concerns were not always promptly managed and responded to in line with regulatory requirements or the centre's own policy.

Inspectors reviewed a sample of four staff files and found that they contained all information as required by Schedule 2 and 4 of the regulations, including required references and qualifications. An Garda Síochána vetting disclosures and verification of the current registration of professional staff were also available on staff files.

Regulation 15: Staffing

The registered provider had the number and skill-mix of staff appropriate to the needs of the residents on the day of the inspection. There were at least two nurses on duty during the day and night.

Judgment: Compliant

Regulation 16: Training and staff development

There was a training schedule in place, and training was scheduled on an ongoing basis. The training matrix reviewed identified that 98% of staff had completed safeguarding and 89% of staff had completed fire training. The person in charge had a plan in place for the remaining staff to complete their training on both fire and safeguarding within seven days of the inspection.

Due to risks identified on the day of the inspection, additional training and supervision of staff practices were required to ensure safe care delivery in line with evidence-based nursing practices.

Judgment: Not compliant

Regulation 21: Records

The roster did not fully set out the staff working in the centre. There was no evidence that the management personnel from the group was identified on the roster when attending the centre to ensure continued governance and management oversight of the centre and to support staff working in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems were in place were not fully effective, and therefore did not ensure that the service was appropriate, consistent and effectively monitored.

Although there was a risk register in place, the inspectors observed that this register was not up-to-date and did not include the risks identified by the inspectors on the day of the inspection or identified in the action plans in the incidents and accidents in the centre. Additionally, the management systems had not identified fire safety risks identified by inspectors on the day of the inspection as outlined under Regulation 28: Fire precautions.

The process for the review and management of the assessment of residents' individual needs and care plans required further oversight to ensure residents' needs were fully reflected.

The reason for the refusal of the medicine was not clearly documented in the resident's care plan. Furthermore, residents with mental health disorders have not been appropriately assessed with capacity-assessment tools in relation to the medication administration and continued administration of medication.

Oversight of the implementation of action plans identified following safeguarding incidents analysis were not fully implemented.

The registered provider had completed an annual review of the quality and safety of care delivered to the residents. This review was prepared in consultation with residents and their families. However, a copy of this annual review was not available to residents in the centre on the day of the inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed the centre's incident log during the course of the inspection. Records indicated that not all incidents as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. Inspectors found an example of the allegation of physical abuse, which was not notified to the Chief Inspector. The person in charge submitted the notification following the inspection.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had a copy of the complaints procedure in a prominent position in the centre, although there was no nominated person identified to deal with complaints.

The inspectors reviewed the complaints log and found no evidence that the complaints raised were investigated or analysed; therefore, there were no actions or learning outcomes documented.

Judgment: Not compliant

Regulation 4: Written policies and procedures

While Schedule 5 policies were in place, their implementation in practice was not effectively monitored, and as a result, a number of practices were found that were not in line with the centre's own policies and procedures. Furthermore, some policies were not updated in line with the latest national guidelines; therefore, the staff were not appropriately supported, trained and supervised in their practices. For example:

- The emergency policy was due for review in January 2021, a review was not completed, and the policy detailed the previous provider as the contact in the case of an emergency.
- The medicine policy was not updated in accordance with NMBI Guidance for Registered Nurses and Midwives on medicine Administration (2020).

Judgment: Not compliant

Quality and safety

The findings of this inspection show that overall, most of the residents accommodated in the designated centre enjoyed their life and were happy in the centre. Nonetheless, the health care needs of residents were found to be affected by inadequate evidence-based nursing practices and ineffective supervision. Inspectors found that improvements were necessary to ensure each resident's needs were fully assessed and that the care interventions were clearly and comprehensively described to support a consistent approach to care provision.

Residents had access to medical care, with the residents' general practitioner (GP) providing on-site reviews when required. Residents were also provided with access to other health and social professionals in line with their assessed needs. However, inspectors found that timely referrals were not always sent to the health professionals in order to seek advice and review of residents' changing needs and conditions.
Care planning was in place, and residents' needs were assessed using validated tools to inform care plans. However, the nutritional status of residents was not continually monitored through regular weights and nutritional assessments.

Residents availed of a varied activity programme. Staff spoken with were found to be generally knowledgeable about residents' likes, past hobbies, their home lives and interests. Residents' links with the community were maintained where possible.

Overall, the general environment and residents' bedrooms, communal areas, toilets, bathrooms, and sluice facilities appeared clean with few exceptions, such as the carpet covering in the centre. The inspectors observed many good examples in regard to infection prevention and control (IPC) in the centre. These included symptom monitoring of all residents, staff and visitors to the centre. There was a good oversight of the cleaning practices. The centre had appointed an Infection Control Liaise person, which proved effective during the recent COVID-19 outbreak in the centre. Notwithstanding the positive measures observed on the day of inspection, inspectors observed a number of issues that had the potential to impact on effective IPC measures in the centre.

The provider had arrangements in place to safeguard residents from abuse. A safeguarding policy detailed the roles and responsibilities and the appropriate steps

to take should a concern arise. Inspectors reviewed documentation related to recent investigations of allegations of abuse and found that where necessary investigations had been completed in a timely manner. However, the management of the centre did not take appropriate actions to prevent the re occurrence of these incidents and did not ensure that all actions were documented in the resident's care plans in a timely manner.

Regulation 11: Visits

Inspectors observed that the procedures were in place to ensure residents' families and friends could come to visit them in the centre in line with national guidance on the day of the inspection. Screening checks were consistently completed before visitors entered residents' accommodation.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Copies of information provided when a resident was transferred out of the service to another service or back to the centre were retained in the centre.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018); however, further action is required to be fully compliant. For example;

- Clinical waste was not consistently managed in line with national guidelines. The inspectors observed domestic waste inappropriately disposed of in the clinical waste stream at the main entrance, in staff rooms and in the treatment room.
- Open-but-unused portions of wound dressings were observed in the treatment room. Reuse of 'single-use only' dressings is not recommended due to the risk of contamination.
- Some antiseptic solutions had recently passed their expiry date. This may have impacted their effectiveness.
- Infection prevention and control signage was not aligned with best practices. For example, signage advised staff to wear gloves to protect themselves and

protect residents. The signage did not advise that selection of PPE must be based on the assessment of the risk of transmission of infectious microorganisms to the person cared for or healthcare worker and the risk of contamination of the clothing or skin of healthcare workers or other staff by patients' blood, body substances, secretions or excretions.

- There was limited availability of safety-engineered sharps devices available for staff use. The inspectors observed that needles in a sharps bin had been recapped before disposal. This practice increased the risk of a needle stick injury.
- The covers of several resident mattresses were worn or torn. These items could not effectively be decontaminated between uses, which presented an infection risk.
- There was a lack of appropriate storage space in the centre resulting in the inappropriate storage of equipment and supplies. For example, used and clean linen trolleys were stored on corridors.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge shall ensure that the transcribed prescriptions were accurate and completed in full and that the 10 rights of medication administration were consistently implemented. For example, the medicine administration sheets were not signed by two staff nurses when transcribing the medicine, and the date of transcription was missing. The PRN (When required) medicine transcribed medicine record missed the max dose and the indication for administration.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors were not assured that the centre safely met the assessed needs of residents. In the sample of care plans reviewed, inspectors noted the following:

- Where a resident was identified as a high risk of malnutrition and had a history of weight loss, there were gaps in the weight records. The nutritional screening tool was not completed as per the centre's policy.
- The care plan of a resident who, as per the latest assessment, should receive Level 5 minced moist diet, made reference to the fact that the resident was on a soft chopped consistency diet.
- Wound care plans were in place for residents with pressure sores; however, the wound assessment notes stated the type of dressing used to dress the

resident's wound. No evaluation of the wound healing progress and action plan was completed or analysed.

Judgment: Not compliant

Regulation 6: Health care

Improvements were required to ensure each resident had access to appropriate medical and healthcare. For example:

- Tissue viability nurse (TVN) advice had been accessed remotely for a resident. A photograph of the wound was provided to the TVN nurse to inform the assessment. However, despite the continued deteriorated condition of several pressure ulcers, no further TVN review had been arranged or followed up on the recommendations from the hospital admissions to ensure continuous wound healing oversight and progress.
- Monitoring weight for immobile residents was limited as the centre did not provide a weight scale attachment for the hoist or alternative methods of BODY MAX index estimation- the upper arm circumference (MUAC) was not used.

Judgment: Not compliant

Regulation 8: Protection

Measures to protect residents from abuse had not been implemented in line with the centre's own policies and procedures. Inspectors reviewed the incidents related to the allegation of abuse and were not assured that the provider took all reasonable measures to protect residents from abuse. While safeguarding plans were submitted to the safeguarding team, the safeguarding care plans for each individual resident affected were not created post the incident, and as a result, adequate measures were not implemented to guide the staff on how to protect the residents and to prevent the re occurrence of the incidents.

Judgment: Not compliant

Regulation 9: Residents' rights

The prospect of additional social support or advocacy for younger residents had not yet been explored. Furthermore, the admission and advocacy arrangements required

review to ensure that younger residents with complex health issues would receive support in ensuring they have appropriate care and support to effectively meet their needs.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was insufficient evidence that issues relating to fire safety had been identified and were being adequately managed in order to reduce the risk of the spread of fire. For example, a large amount of wheelchairs and residents' equipment were observed to be stored underneath the stairs beside the communal room, which posed a fire risk. Inspectors saw exposed electrical wires and a hole in the ceiling in the staff changing room. Linen was stored on the top shelf in the linen room nearby the ceiling lamp. The fire alarm sensor was covered with a glove in one of the resident's bedrooms.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant

Compliance Plan for Mill Lane Manor Private Nursing Home OSV-0000066

Inspection ID: MON-0035539

Date of inspection: 05/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Regulation 16 (1)(a): Mill Lane Manor has reviewed the existing training schedule and ensured dates are booked in to ensure all staff will be compliant in mandatory training. On the 25th of May all staff have received safeguarding training. All staff will be trained in Fire Training by 9th June 2022. The PIC will oversee the training matrix and ensure all staff have received mandatory and additional training. Training statistics will be presented monthly to the Regional Director at the governance meeting. Regulation 16 (1)(b): Mill Lane Manor has successfully recruited a second ADON who commenced in the centre on the 9th of May 2022. The company are also in the process of recruiting 2 CNM's this will further enhance the governance structure and supervision in Mill Lane Manor, by providing ADON cover 7 days a week. In the interim period, an acting ADON and Associate Regional Director supported the existing management structure, by providing onsite supervision and support. The Regional Director and other members of the Senior Management team visit the centre regularly. This is outlined on the roster.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Regulation 21 (1): The roster is now updated to ensure all staff members, including management personnel are identified on the roster while working in the centre. On call arrangements are also outlined on the roster.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23 (c): The risk register has now been reviewed and updated with all existing risks in the centre, including risks identified during the inspection. The risk register is reviewed by the PIC every month, on a day-to-day basis and when required, and is presented to the Regional Director at monthly governance meetings. In place- May 2022.

A full review of all resident's files, assessments and care plans was undertaken by the Orpea Quality Team and any learnings were shared with members of the MDT through staff meetings. All corrective actions identified in this review are currently being addressed. All nurses have received further training on care planning and are working towards completion of reviews by the 30th of June 2022. Key nurses have been identified to each resident to ensure the ongoing updates of relevant records has taken place. KPI's are completed monthly to review compliance with care planning and assessments. The results of KPIs are monitored at monthly governance meetings with the Regional Director.

Regulation 23 (f): The annual review is readily available for residents and their families. The annual review was discussed at the resident's council meeting on the 26th of May.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Regulation 31 (1): The PIC will ensure all allegations are reported to the Authority in a timely manner. The Regional Director will monitor this on an on-going basis.

Regulation 34: Complaints procedure	Not Compliant

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

Regulation 34 (1)(d): The complaints procedure has details of the nominated complaints officer within the centre and their contact details. This also includes details of the independent appeals officer and their contact details. This is displayed throughout the nursing home.

Regulation 34 (1)(f): The complaints log has been reviewed and reflects the outcome of the complaint and whether the complainant was satisfied (or not) with the outcome. The PIC keeps a record of complaints, related investigations, and outcomes.

Regulation 34 (1)(g):
Regulation 34 (1)(h):
Mill Lane Manor has introduced a new suite of Schedule 5 policies, which includes Complaints Management. This policy clearly outlines all steps to be taken by the complaints officer when dealing with a complaint. All complaints raised in Mill Lane Manor will be dealt with as per local policy. The PIC discusses all complaints and learnings identified at the monthly governance meeting with the Regional Director. This learning is also shared during staff meetings.

Regulation 34 (2): All complaints logged at the time of inspection have been thoroughly reviewed, investigated, and actioned as per local policy.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Regulation 4(1): Mill Lane Manor has introduced a new suite of Schedule 5 policies, which includes Medication Management. This policy has been developed in accordance with best practice and current NMBI guidelines. Completed May 2022.

Regulation 4 (2): These policies will be available through an online shared drive to all staff members on Epic, as well as a policy folder available in the nursing stations. All staff will be asked to sign off that they are aware of the current policy and training will be provided to staff. All staff to have read policies and training to be completed by all staff by 30th August 2022.

Regulation 4 (3): All policies will be reviewed within the timeframe set out in the regulation. To ensure this, the PIC has developed a tracker of policy review dates. In place May 2022.

Regulation 27: Infection control	Substantially Compliant

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

• All inappropriately placed clinical waste bins were removed and replaced with domestic waste bins immediately following the inspection.

• 'Single use only' symbol signage has been displayed in each clinical room. Education around the correct use has been provided to all clinical staff. This was completed on the 30th May 2022. This will be audited quarterly on our KPI audit.

• All clinical storerooms have been reviewed and any expired items have been disposed of following the inspection. The PIC has introduced a weekly checklist for nurses to check clinical stock to ensure all stock available is within the manufacturing guidelines, checklists are reviewed and signed off weekly by the PIC/ADON. Completed 30th May 2022.

• IPC signage has been reviewed and updated to reflect current guidance. The appointed IPC liaison person is responsible for ensuring that current and most relevant guidance is available to staff. Completed by the 8th of April 2022.

• All needles for use within the centre are being replaced with a safety engineered needle to reduce the risk of needle stick injury. Will be completed by the 30th June 2022.

• A mattress audit was completed on week of 23rd of May by the PIC and Associate Regional Director. An order for replacement mattresses has been submitted and mattresses were delivered on the 8th June 2022.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Mill Lane Manor has introduced a new suite of Schedule 5 policies, which includes Medication Management. This policy has been developed in accordance with best practice and current NMBI guidelines. This policy will guide nursing staff on best practices when transcribing medications. To further improve medication management in the centre, Mill Lane Manor is working with a new pharmacy commencing on the 8.08.2022.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Regulation 5(1):
• All residents are weighed monthly and a MUST completed or more frequently if their care plans indicate. An enhanced monthly weight audit is in place and is completed by the ADONs to ensure there are no gaps in' residents records.
• All care plans have been reviewed and audited by the quality team and all corrective action has been taken by the 30th of May 2022.
• Education has been provided to all nurses on the evaluation of wounds and pressure sores, and documentation is in place to support this. This is reviewed by the PIC/ADONs.

Regulation 5(4): All assessments and care plans are reviewed every 4 months. All COVID- 19 care plans have been updated with current guidance. The results of the KPIs are shared at the monthly governance meeting with the Regional Director.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Regulation 6(1)
Regulation 6(2)(c):

Mill Lane Manor has liaised with members of the MDT, including the TVN and onsite visits have resumed with immediate effect.

Mill Lane Manor has a hoist with weighing scales available in the centre. This was actioned on the 17th of March and weighing scales for hoist was received on the 6th April 2022. Education and training in relation to BMI and MUAC will be provided to all nursing staff through education by the end of July 2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Regulation 8 (1): On identifying any safeguarding issues the PIC ensures a safeguarding plan is updated on the Resident's care plan and all staff are made aware of this plan. This is completed immediately on identifying a risk and is reviewed in a timely manner. Procedure in place immediately from inspection.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Advocacy arrangements are advertised in prominent positions around the nursing home. All residents under 65years have been referred to local advocacy agencies. Mill Lane Manor will continue to support all resident to access these services as they wish.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • A nearby storeroom has been identified to appropriately store resident equipment. Equipment is no longer stored under the stairs. This was completed by the 20th of April 2022. • Exposed electrical wires and a hole in the ceiling was repaired immediately following the inspection. Completed 5th April 2022. • The linen store was reviewed, and linen was stored in a more appropriate manner on the day of the inspection. Completed on the 5th of April 2022. • The glove was immediately removed from the fire sensor on the day of the inspection. The fire sensors in all areas are checked weekly by the maintenance department. Completed on the 5th of April 2022.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	09/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	07/05/2022
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.	Substantially Compliant	Yellow	08/04/2022
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	Orange	30/05/2022

	effectively monitored.			
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Yellow	26/05/2022
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.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	20/04/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	20/04/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of	Substantially Compliant	Yellow	30/06/2022

	the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	08/04/2022
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.	Not Compliant	Orange	05/04/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall	Not Compliant	Orange	30/05/2022

	investigate all complaints promptly.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/05/2022
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	30/05/2022
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an	Not Compliant	Orange	30/05/2022

	appeals procedure, and shall put in place any measures required for improvement in response to a complaint.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Yellow	30/05/2022
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	13/06/2022
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Not Compliant	Orange	13/06/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief	Not Compliant	Orange	13/06/2022

	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.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/05/2022
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.	Not Compliant	Orange	30/05/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based	Not Compliant	Orange	30/05/2022

	nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/05/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	08/04/2022
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Substantially Compliant	Yellow	30/06/2022