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:	Blackrocks Nursing Home
Name of provider:	Blackrocks Nursing Home
Address of centre:	The Green Road, Foxford, Mayo
Type of inspection:	Unannounced
Date of inspection:	23 February 2023
Centre ID:	OSV-0000321
Fieldwork ID:	MON-0035277

About the designated centre

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

Blackrocks Nursing Home is a purpose-built premises. Residents are accommodated in single and twin bedrooms, all of which are en-suite with shower, toilet and wash basin facilities. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located on the outskirts of Foxford, Co. Mayo. The centre provides accommodation for a maximum of 50 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence care basis. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met. The provider employs a staff team consisting of registered nurses, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 23 February 2023	09:30hrs to 18:00hrs	Lorraine Wall	Lead
Thursday 23 February 2023	09:30hrs to 18:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Many of the residents who spoke with the inspectors said they were generally happy with their life in the centre and were very well cared for by staff. The inspectors found that there were limited opportunities for some residents to engage in meaningful social activities in line with the preferences and capacities. The inspectors also observed that although some staff chatted with residents, interactions between staff and residents, particularly in the St Anne's unit, was focused on providing care interventions and care and daily routines were not person-centred.

This was an unannounced inspection and on arrival to the centre, inspectors met with the Clinical Lead and the Clinical Nurse Manager. The person in charge was not present in the centre when the inspectors arrived but they attended the centre later that morning. Throughout the day of the inspection, inspectors met with residents and staff, observed life in the centre, staff practices and interactions.

Blackrocks Nursing Home has two units. The first unit is located at the front of the centre. The second unit, "St Anne's" is located at the back of the centre. This unit is restricted with key pad access as there are a large number of residents living with dementia who reside in this area of the centre.

The inspectors communicated with a number of residents and a small number of resident's visitors. Overall, feedback from residents was mostly positive and they were content living in the centre. Residents told inspectors that the "staff are very nice". Some residents told inspectors that the food was nice while some residents said that the "food was alright" and that they would like more choice.

Some residents told inspectors that they would like if there was more to do on a daily basis and that they would really like to be able to go for days out of the centre. One resident told the inspectors that they recently had a very enjoyable day out when they went to a nearby town for a hospital appointment and would like to be able to get out more often.

On the day of the inspection, an activities coordinator was present in the front unit of the centre and inspectors observed activities taking place here throughout the day. However the inspectors observed that residents in the St Anne's unit had no opportunity for meaningful occupation on the day of the inspection. Three staff were working in this area on the day of the inspection and inspectors observed that there was no effort made to engage residents in meaningful activities or to ensure that their social care needs were met in accordance with their interests and capacities.

Most residents in this unit were sitting in the day/ dining room. A specially adapted table was available to enable residents in comfort chairs and wheelchairs to eat their meals at the dining table. Other residents ate their meals in the sitting area or in their bedrooms. This day room overlooked a small courtyard. This courtyard was

sparsely furnished with one garden table and was uninviting with no outdoor seating available. Residents and staff told inspectors when the weather is nice, residents can go out into this area and their chairs from inside can be brought out for them to sit outside.

Inspectors observed a resident with dementia and responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) pacing the corridors for the entirety of the day. The resident was observed on several occasions to enter other residents' bedrooms. Staff on the unit did not attempt to engage with this resident or employ any of the strategies outlined in the resident's behavioural support plan to engage the resident and encourage more positive behaviours.

Inspectors observed staff supervising the day room on this unit before and after lunch. At both times there were a large number of residents in the room and there was no activity taking place. A television was on in the background but none of the residents appeared to be watching this. Furthermore inspectors observed that residents in this unit who spent a lot of time in their bedrooms had little to no meaningful interaction with staff outside of care interventions and meal times.

Inspectors observed that all of the residents' wardrobes in the St Anne's unit had been secured with cable ties. When the inspector asked staff about this, they were informed that this measure was put in place due to a resident with responsive behaviours removing other residents' clothes out of their wardrobes. This was an overly restrictive practice which clearly prevented residents from accessing their personal wardrobes freely. One resident told inspectors that they can sometimes remove the cable tie from the handle of the wardrobe if they require access, however they are unable to get it back on. This resident also told inspectors that they feel the need to check their room throughout the day to ensure that all their belongings are safe. Following this, the inspectors observed that in one resident's room, a wardrobe had been opened and residents' clothes were strewn on the floor.

In addition, residents were unable to access the garden area adjacent to the front unit of the centre without assistance from a staff member as the door was secured with a keypad lock. The doors to the small courtyard off the St Anne's unit were attached to an alarm bell. Inspectors opened the door to the courtyard and the alarm sounded. The nurse on the unit came to the door and told the inspector that they required keys to turn off the bell. When the nurse retrieved the keys, they were then able to stop the alarm bell from sounding. One resident told inspectors that they do not go outside, as they are deterred by the bells sounding and the fact that assistance is required.

During the morning of the inspection, the inspectors noticed a malodour in one of the corridors outside a resident's bedroom. Two hours later, the inspectors observed that this malodour was still present. Inspectors brought this to the attention of the person in charge and this was then addressed by staff.

Overall, the general environment including residents' bedrooms, communal areas

and toilets were clean. Alcohol hand gel dispensers were available for use on the corridors and the majority of staff were seen to use good hand hygiene techniques.

The next two sections of the report presents 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

This inspection found that management and oversight of this service was not effective, as evidenced by the findings of this report in relation to residents rights, restrictive practices, staffing, training, fire safety and infection control. The provider had completed a number of actions following the previous inspection to bring the centre into compliance with Regulation 28, however further actions were required to achieve full compliance with the regulation.

This was an unannounced inspection carried out by inspectors of social services to review compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 as amended and to follow up on actions the provider had taken since the last inspection in February 2022.

Blackrocks Nursing Home Limited is the registered provider for this designated centre. The management structure consists of the provider and the person in charge who was supported in their role by a general manager. A clinical lead had recently been employed and this person supported the management team. A team of nursing staff including two clinical nurse managers provided clinical support along with health care assistants, a part time physiotherapist, household, catering and maintenance staff making up the full complement of the staff team.

The management systems and quality assurance processes in place did not ensure that the quality and safety of the service was effectively monitored. For example, while audits were in place, these were not completed consistently and the last audits available for review were completed in September 2022. This was a repeated finding from the previous inspection.

The skill mix of staff working in the St Anne's unit on the day of the inspection was not appropriate to meet the social care needs of the residents and to ensure that residents had access to meaningful activities in line with their preferences and capacity to participate.This was found to impact on the quality of life for the residents accommodated in this unit. Furthermore rosters showed that the activities coordinator for this unit worked part time over four days per week. This was not in line with the providers statement of purpose which committed to providing two full time recreational therapists employed within the centre.

Staff training records and inspectors observations showed that there were a number of training deficits in the centre and that not all staff had access to mandatory training in fire safety and safeguarding. Additionally, there were no staff available on the St Anne's unit who had training in the provision of social activities, particularly in relation to residents with dementia.

Although there was a clinical nurse manager on duty in the centre on the day of the inspection, inspectors found that staff in the St Anne's unit were not appropriately supervised in relation to their care practices. The clinical nurse manager was not observed to attend this unit on the day of the inspection. Consequently a number of the inspectors observations on the day, in relation to a lack of engagement with residents on this unit were not picked up by the clinical nurse manager.

One resident told the inspectors that they had a complaint about an issue that had recently occurred, however they had not reported it at the time of the inspection. The resident confirmed that they did know who to report a complaint to but had not felt able to do so. The inspectors encouraged the resident to speak with the person in charge in relation to their concern on the day of the inspection which they did do and the issue was subsequently followed up by the person in charge.

Regulation 15: Staffing

On the day of the inspection, staff on the St Anne's unit did not demonstrate the appropriate skills and knowledge to ensure that residents living with dementia had access to appropriate meaningful activities in line with their interests and capacities.

Judgment: Substantially compliant

Regulation 16: Training and staff development

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

- Fire safety training: Two staff had not completed their refresher training in fire safety. Three staff had no record of having completed this training. This is discussed further under Regulation 28.
- Safeguarding vulnerable adults: One staff had not completed their refresher training and seven staff had no records of completion of safeguarding

training.

A review of staff practices and training records also identified the need for staff training in the management of restrictive practices in line with the national policy, in order to bring about improved outcomes for residents as discussed under Regulation 7 and Regulation 9.

Some staff did not recognise that the overly restrictive practices in use in one unit infringed upon the rights of many of the residents living in the centre. Nine staff had not completed their refresher training in the management of responsive behaviours since April 2020 and two staff had no record of completion of this training.

Some staff were not appropriately supervised to ensure that they carried out their work to the required standards. For example, Inspectors did not observe the Clinical Nurse Manager to visit the St Anne's unit on the day of the inspection and as a result they did not identify a number of task focused care practices observed by the inspectors.

Judgment: Not compliant

Regulation 23: Governance and management

The management and oversight systems in place to ensure compliance with the Health Act 2007 (Care and Welfare of resident in Designated centers for Older People) Regulations 2013 required improvements in the following areas:

- Systems to ensure adequate staffing resources were provided were not in place and did not ensure the effective delivery of care in accordance with the centre's statement of purpose. The number of recreational therapists employed was not in line with the centre's statement of purpose.
- The management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not effective as evidenced by the findings of this report in relation to the oversight of restrictive practices, training and Infection, prevention and control practices.
- Some risks were not appropriately managed in the centre and resulted in a culture of overly restrictive practices which were negatively impacting on residents' rights as evidenced by the findings in this report.
- The provider had failed to ensure that audits and quality checks were completed in a timely manner. For example: While audits systems were in place, including hand hygiene audits, skin integrity audits, care plan audits and nutritional care audits, some of these had not been completed since September 2022. Audits reviewed failed to identify the improvements required in the centre and lacked appropriate action plans.

Judgment: Not compliant

Quality and safety

Inspectors found that the provider needed to take further actions to ensure that residents received care and support in line with their assessed needs and that residents were supported to lead a full and meaningful life in line with their capacities and preferences. In particular, significant improvements were required in relation to residents rights; including the provision of meaningful activities for all residents, choice in relation to food and the management of responsive behaviours. In addition more focus and effort was required to bring the designated centre into compliance with Regulation 27: Infection prevention and control, Regulation 17: Premises and Regulation 28: Fire Safety.

The inspectors found resident's in the St Anne's unit did not have their social activity needs met, in line with their assessed needs. Eleven residents spent most of their day in the sitting room listening to music on the television. Three residents remained in their bedrooms for the day and one resident was observed to wander in and out of other residents' bedrooms without any intervention from staff to offer appropriate meaningful engagement or intervention to distract the resident. While there was a number of staff supervising residents in this area, there was very little meaningful interaction and staff made no effort to provide any activities or occupation for these residents. Furthermore, interaction with residents who spent a lot of time in their bedrooms was predominantly focused on care tasks and interventions and there was little to no meaningful interaction with these residents. Residents daily care records showed that when the recreational therapist was on duty, residents did have access to meaningful activities and sufficient opportunities for recreation however there was no provision made when this person was not working.

Inspectors found that residents had timely access to their general practitioners (GPs) and other allied health professionals such as speech and language therapy and dietetics.

Each resident had a suite of clinical and environmental assessments completed. Assessments such as skin integrity management, nutritional care, psychological and social wellbeing assessments, had been completed and reviewed in line with regulatory requirements. All residents had an end of life care plan in place with details on their wishes should they contract COVID-19. Care plans were detailed for the most part and guided care interventions for nursing and care staff. However, inspectors found that the behavioural support care plan of a resident who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) did not contain sufficient detail to guide staff on care delivery and some responsive behaviours observed on inspection had not been identified in the resident's care plan. In addition Inspectors observed that one resident who exhibited responsive behaviours was not receiving the appropriate level of care and supervision, in line with their assessed needs. Furthermore, of the social care plans reviewed, some of these were not being implemented in practice on the day of the

inspection, particularly for residents in the St Anne's unit.

The inspectors also found that a number of overly restrictive practices were in place in the designated centre that prevented residents from going outside to enjoy the garden areas. Furthermore residents on St Anne's unit were not able to access their personal possessions as their wardrobes had been secured with cable ties in order to prevent another resident with responsive behaviours from accessing them. These restrictions negatively impacted residents' quality of life and well-being and did not uphold their rights to have control over their personal belongings and to determine how and where they spent their day.

Infection prevention and control practices in the centre were not in line with the national standards. In addition the sluicing facilities in the centre were found to be not fit for purpose. This is discussed further under Regulation 27.

Although the premises was clean and comfortable for the most part and the provider had made some improvements in regards to the premises, in line with their compliance plan following the last inspection, some improvements were required to bring the centre into compliance with Regulation 17.

This inspection found that significant fire works at varying stages were taken by the provider to ensure there were sufficient measures in place to protect residents and others from risk of fire since the previous inspection in June 2022. The provider had been proactive and had a fire safety risk assessment carried out. A scope of works generated from this report was put in to motion. However, it was noted that the findings from the previous inspection had not been addressed. Repeated non-compliance's were identified in regard to; two dining room doors which did not close and were not connected to the fire alarm system and a fire door between the kitchen, and the dining room had gaps between the floor and the door were smoke and flames could spread through to the dining area from the kitchen. Assurances were submitted post the inspection that the provider would address the repeated non compliance's within a short period of time.

On this inspection, additional fire safety risks were identified. The inspectors found that further actions were necessary in relation to providing adequate means of escape. For example, a fire exit door was fitted with a bolt lock and a blind was hung in a way so as to impede the use of a final exit. This could cause a delay in the event of an evacuation. Assurances were given to the inspectors that these would be removed. The inspectors also observed a residents seating area which was configured in a way that it obstructed a clear route to a fire exit. Furthermore, an external gate located along an escape route was found to be secured with a length of rope. This presented a risk to staff and residents as the gates were not readily openable in the event of an evacuation. The rope was removed on the day of the inspection.

There was a significant lack of floor plans displayed in the centre. Floor plans that were displayed lacked detail and clarity for people working in the centre to be able to easily follow in the event of a fire. For example, floor plans on display did not indicate the location of evacuation areas (compartment and sub-compartment

boundaries) suitable for phased evacuation of residents from a high-risk area to a low-risk area. This would form part of the procedure to be followed by staff in the event of a fire in this centre, and, therefore, could cause confusion and loss of valuable time in the event of a fire emergency. Deficiencies in relation to fire doors, containment measures, staff training and day-to-day fire prevention in the centre required review to ensure compliance. This is discussed further under Regulation 28.

Regulation 11: Visits

Inspectors observed visits taking place in line with the Health Protection Surveillance Centre (HPSC) National guidelines**.** The centre had suitable private areas for visiting to take place in private.

Judgment: Compliant

Regulation 17: Premises

Although the provider had taken some action to improve the premises since the last inspection, such as replacing some flooring and repurposing a sluice room, further actions by the provider were necessary to ensure that the premises meets the requirements of Regulation 17 and conforms to the matters as set out in Schedule 6.

This was evidenced by the following findings;

- Items of residents' equipment such as hoists and other assistive equipment were inappropriately stored in resident areas around the centre. For example, inspectors observed that two wheelchairs, four zimmer frames and three assistive chairs were stored in a residents lounge. A bag of residents belongings, two zimmer frames and three dining room chairs were stored in another residents' lounge. Four zimmer frames were stored in the sensory room adjacent to the day room in the St Anne's unit.
- Personal protective equipment and clipboards with residents information such as fluid intake charts were inappropriately stored on handrails on corridors. This impeded residents' access to the handrails.
- A personal care trolley was stored in the boiler room on the St Anne’s unit.
- Some wall surfaces along some corridors were scuffed and had paint missing and required repair and painting.
- The new sluice room was not fit for purpose as outlined under Regulation 27.
- The external courtyard in the St Anne's unit did not have sufficient garden

seating and furniture to accommodate residents.

Judgment: Substantially compliant

Regulation 27: Infection control

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

- The provider had repurposed an outside mop room as a sluice as per actions from the compliance plan following the last inspection. This room was not on the footprint of the designated centre. The person in charge showed this room to inspectors. The sluice room was not fit for purpose and did not appear to be utilised or cleaned regularly. Leaves were strewn on the floor and there were items stored in this area including a big tray and five sweeping brushes. Inspectors found a dirty urine bottle sitting in discoloured water in a mop bucket which was left in the sink. The sluice did not have any storage racks for the purpose of storing continence equipment to dry,following decontamination and there was no bedpan decontamination system in place.
- The sluice had a stainless steel sink installed, however this did not comply with the recommended specifications for clinical hand wash sinks.
- There was no process in place for staff to decontaminate urine bottles or commodes. Some staff told inspectors that urine bottles are washed in the residents' bathrooms while some staff told inspectors that the cleaner washed the urine bottles. Inspectors spoke with the cleaner who explained that this was not part of their role. Following inspection, the inspectors were informed that the bedpan washer had been relocated outside of the building. Staff who spoke with the inspector did not report the bedpan washer as part of their practices for cleaning commode pans and urinals. Additionally, infection prevention and control guidance outlines a requirement for the bedpan washer to be within the sluice room with unobstructed access to a clinical hand wash sink.
- The fabric on some items of furniture was worn which prevented them from being adequately cleaned. This was an ongoing non compliance from the last inspection.
- The table in the visitors lounge of the St Anne’s unit was visibly unclean and did not appear to be cleaned regularly.
- Boxes were stored on the floor of a storage room in the St Anne’s unit which hindered effective cleaning.
- Items of personal protective equipment including aprons and glove boxes

were hanging on the handrails in corridors which posed a risk of transmitting a healthcare associated infection.
- A central vacuum cleaning system was in place but there was no process in place to clean and decontaminate the corrugated suction hose which was being moved from room to room in the centre. This was an ongoing non compliance from the last inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. The service was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- An office door was found to be wedged open with a chair and a hoist charger was being charged in the same room. This created a fire risk, if a fire did occur it would spread with ease
- Gas pipes which had been newly fitted were not painted or labelled as gas pipework.
- The inspectors noted no evidence was available on the day of inspection that portable appliance testing was taking place to ensure fixed and handheld electrical equipment was maintained in safe working order.

The provider needs to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, the inspectors were not assured that suitable means of escape were provided in some areas of the centre. Designated escape routes from some bedroom corridors were via another room in order to reach a final fire exit that lead to the outside. For example, a conservatory and a church. This requires a review by a competent fire consultant to ensure the centre is provide with suitable means of escape.

In addition to this, a door to a smoking room had an emergency exit sign fitted above it and was observed by the inspectors to not be a designated fire exit in line with the provider's fire evacuation procedures. This could cause confusion in the event of a fire evacuation and requires a review by the provider.

The provider needs to improve the maintenance of the means of escape, the building fabric and building services. For example, the inspectors were not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. A number of bedroom fire doors observed by the inspector had door-closer mechanisms and fire door seals missing. Gaps were noted at the bottom and

between doors. Furthermore, a smoking room door was damaged and some fire doors were fitted with non-fire rated ironmongery. A kitchen and laundry door did not meet the required fire rating for a high risk room. Assurances were provided that the kitchen and laundry door would be addressed within a four week time frame. These deficiencies posed a significant risk to residents in the event of a fire. Due to the deficiencies, the provider needs to have a full assessment of fire doors in the centre carried out by a competent fire safety expert.

Several areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures.

Up to date service records and certificates were not available for the emergency lighting system and only some certificates were available for the fire detection alarm system. Therefore, inspectors were unable to establish if the building services were being regularly maintained.

Arrangements for all staff to attend fire training required improvement by the provider. From a review of fire training records, the inspectors noted that not all staff had up-to-date fire safety training. At the time of the inspection, the provider had fire safety training sessions planned for some staff members in the coming weeks which were aimed at ensuring that all staff had completed fire safety training.

Arrangements for containment of fire in the event of a fire emergency in the centre required improvement by the provider. For example, the Inspectors noted there was an absence of appropriate fire rated doors located in the centre to form compartments suitable for the safe evacuation of residents. This compromised containment measures in the centre in the event of a fire emergency.

Furthermore, a non-fire rated reception hatch was noted by the inspectors along a means of escape and was not linked to the fire detection alarm system and fire detection was missing from some of the store rooms. This presented a significant risk of fire and smoke to spread in the event of a fire.

The displayed procedures to be followed in the event of a fire required improvement: For example, there was a significant lack of floor plans displayed in the centre. Plans that were displayed lacked detail, clarity and were out-of-date due to changes to the centre over time.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors found that a behavioural support assessment and care plan for one resident who was displaying significant responsive behaviours was not comprehensive as it did not identify the responsive behaviours and did not detail

support strategies and interventions to use to support the resident and to reduce the impact their behaviours were having on other residents..

Judgment: Substantially compliant

Regulation 6: Health care

The person in charge had ensured that residents had timely access to their general practitioners (GPs) and other allied health professionals, however, access to statutory services such as occupational therapy was insufficient. There was a long waiting time for occupational therapy services to be provided. At the time of the inspection, there were no residents awaiting an occupational therapy assessment.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspectors found that residents with responsive behaviours were not adequately supported on the day of the inspection. Not all staff had been facilitated to attend training in responding to and managing residents' responsive behaviours. Consequently, not all responsive behaviours were recognised as such or responded to, in line with the residents' care plan.The person in charge told inspectors that they were in the process of organising this training for staff and inspectors reviewed correspondence between the centre and the trainer regarding appropriate training dates.

For example, one resident's behavioural support care plan detailed the importance of meaningful engagement in order to prevent anxiety, however inspectors' observations and conversations with staff on the day found that staff did not have knowledge of this care plan or how to implement these strategies.

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

For example;

- All residents' in the front unit were restricted from accessing the garden area with use of electronically locked doors.
- All residents in the St Anne's unit were restricted from freely accessing the courtyard area without assistance from staff.
- All of the residents' wardrobes in the St Anne's unit were locked with cable

ties to prevent a resident with responsive behaviours from entering the wardrobes. Consequently, all residents were prohibited from accessing their wardrobes.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had failed to ensure that all residents were provided with opportunities to participate in meaningful social activities that met their interests and capacities.

- The inspectors observed a large number of residents sitting in the sitting room of the St Anne's unit on the day of the inspection and residents who spent their day in their bedroom, who did not have any access to social activities or meaningful interaction. Inspectors observed that residents who chose to spend the majority of the day in their bedrooms had little interaction with staff aside from when care tasks were being carried out or their meals were brought to them. Feedback from some residents who spent time in their bedrooms was that they would spend more time in the day room if there were more activities taking place.
- While there was a sufficient number of staff available on the unit to assist residents with activities, there was no active involvement with residents. This meant that residents were seated unengaged for long periods of the day. Furthermore when two residents who had significant cognitive impairment were provided with material to engage them this included a photo album and reading material, Inspectors observed that the residents were not able to engage with the materials offered to the residents. As such the inspector observed that both residents spent most of the afternoon asleep only waking when their afternoon drinks were served.

The provider had failed to ensure that residents could carry out personal activities in private. This was evidenced by:

- Residents in the St Anne's unit did not have their right to privacy in their bedrooms assured due to a resident with responsive behaviours entering their bedroom uninvited.

Residents were not supported to exercise choice in their daily routines. This was evidenced by:

- Access to the garden and courtyard areas in both units of the centre was restricted due to a keypad lock on the garden door in the unit at the front of the centre and an alarm bell on the garden door of the St Anne's unit. This meant that residents could not choose to access this outdoor space as they wished without a member of staff being available to open the doors for them.
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- The provision of one television set in twin bedrooms did not afford each resident personal choice regarding their television viewing and listening.
- While residents were provided with wholesome and nutritious food, inspectors found that residents were not offered appropriate choice at mealtimes. The daily menu was displayed in the dining room at the front of the centre and only had one choice of main meal. This dining room was not used by any residents on the day of the inspection. Staff informed inspectors that residents could request a different dinner, however, residents did not exercise this right on the day of the inspection. Furthermore when inspectors enquired how residents living with significant cognitive impairment were supported to make choices at meal times staff informed the inspectors that staff were familiar with residents' preferences and so did not offer choices at meal times. Pictorial menus were not available for residents and as such inspectors were not assured that these residents could choose what they wanted to eat from the menus on the day.
- Residents were not adequately consulted in the day to day running of the designated centre. This was evidenced by:

While residents meeting were held and residents were invited to make suggestions about the organisation of the centre through these' meetings, records showed that residents suggestions were not addressed or acted upon. For example, meeting records showed that some residents had asked for 1:1 activities in their bedrooms and other residents had requested that there be some form of activity on a daily basis. However these suggestions had not been implemented by the provider.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Blackrocks Nursing Home OSV-0000321

Inspection ID: MON-0035277

Date of inspection: 23/02/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Additional training in 'Dementia and Communication' will be provided to all health care staff working in Blackrocks Nursing Home scheduled for 29/6/23 and 30/6/23, training and refresher training will ensure all staff have the appropriate skills and knowledge to care for our residents living with dementia, in particular to allow for access to meaningful activities on the occasions the designated activities co-ordinator is not available. Staff will be made aware of the necessity to engage in meaningful activities with all residents in line with their interests and capabilities, as per a schedule previously prepared by the activities co-ordinator prior to their occasional absence from the center. There are now two full time activities co-ordinators and one part time employed. There addition to the team will ensure there are always staff available specifically for activities should a sick day occur.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In addition to providing best practice Responsive Behaviors training for all staff on 29/6/23 and 30/6/23, we are exhausting the HIQA documents for thematic inspections focused on restrictive practices in particular the Guidance document on promoting a care environment that is free from restrictive practice 2023, to upskill and re-educate all staff, both new and long term, on minimizing restrictive practices in the home in line with your standards and thus minimising restrictive practice from occurring and strengthening the implementation of Regulation 9 and Residents Rights in BNH. All overly restrictive practices occurring in the home will be reviewed and risk assessed and appropriately	

resolved.

The PIC has spoken to the CNM's, who have both assured the PIC they attend St. Annes regularly throughout each day to ensure care is being provided appropriately to the residents and all staff are now always aware of their roles and responsibilities in the unit. The inspector did not observe the CNM to visit St Annes on the day of inspection, but it is an assumption to say that the CNM did not attend the unit at all on the day of the inspection. It must be noted the HCA's providing care are always supervised and supported by the staff nurse designated specifically to St Annes, a staff nurse is present in the unit, 24hrs per day.

It was the first time some of the care staff in St. Annes had experienced a HIQA inspection causing some difficulties for some newer staff and taking this into consideration this concern has been addressed in a staff meeting and should not be a problem again.

Fire Training was scheduled after the inspection and all staff are now up to date for both new hires and refresher training as appropriate. Safeguarding of Vulnerable adults Training was scheduled after the inspection and all new staff have completed their training whilst those requiring refreshers will be complete by the end of June.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A Clinical Lead has been employed in Blackrocks Nursing Home since January 2023. As an additional member of staff (to the nursing levels) and having previously worked as a CNM in the nursing home participating in quality assurance, she is well equipped to assist the PIC, clinical nursing and management team in ensuring a system is in place for monitoring the delivery of care, which is safe, appropriate and consistent for the residents needs as required by the Health Act and in line with our Statement of Purpose. The management team have been working on promoting positive risk taking in the nursing home in addition to managing all risks in an appropriate manner through full and thorough assessment. The Clinical Lead will be taking Risk Management training on May 24th to ensure all practices in place in Blackrock's are up to date and relevant.

To ensure our clinical auditing has been carried our correctly the Clinical Lead has completed two course days:
1. Best Practice for Clinical Audit for Nurses and Midwives with the INMO on Feb 15th 2023 – 3 CEU's
2. Clinical auditing for Nurses and Senior Managers with Nursing Homes Ireland on March 20th – 1 CEU
Following from this training a new structured clinical audit plan has been implemented

for effectively monitoring auditing in the home which includes the follow through with quality improvement plans and action plans thus ensuring audit findings are acted upon in a timely manner.

A third activities coordinator has been employed and is now working full time to bring the recreational therapy team to a full time equivalent of 2.33. The statement of purpose is updated as required. The third person employed on this team will ensure there is always additional support and cover for annual leave and/or sick days for the other activities coordinators.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of all equipment including zimmer frames and extra chairs on the premises has been completed and any items which is not in use by a particular resident, or stored in a properly suitable area, has been removed from the building for storage elsewhere.

A4 file wall holders are being placed in the bedroom of each resident to securely and confidentially store charts this change removes any obstacle to the use of handrails outside residents' bedrooms.

The care trolley inappropriately stored in St Annes has been moved to one of the three other more suitable storage areas n the unit. Staff have been made aware that it is not appropriate to place the trolley in the boiler room.

The external courtyard in St Annes is being redesigned to include appropriate seating for all residents who wish to use this area. New additional furniture has been ordered for the outdoor areas. Construction will also commence to create a new larger patio with new furniture which is expected to be completed by 30/07/23 this area will complement the existing three courtyards, with enhanced accessibility for all.

The team agrees it is unsuitable and against Regulation 27 and IPC best practice to have the decontamination washer located outside of the sluice room in a separate covered area, and contact has been made with plumbers to relocate the washer into the sluice room as soon as possible as appropriate. We are awaiting confirmation of a date when they are available to complete this work. Completion date TBC.

The sluice area will be added to the footprint of the nursing home by 30/6/23

Regulation 27: Infection control	Not Compliant

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

Sluice Room: Currently in the center there are two reusable items which require decontamination from micro-organisms or foreign matter (or both), these are urine bottles and bed pans, all other consumables are single use and disposable. Currently no residents have any active infections of ESPL/CPE or otherwise. As this is the case, the management team have reviewed the current sluice room and as per Regulation 27 and the National Standards for infection prevention and control in community services 2018 believe it is suitably equipped to decontaminate urine bottles and bed pans in a safe and appropriate manner thus reducing the risk of transmission of infection through these pieces of equipment. The sluice room is equipped with a large sluice unit, drying racks, clinical wash basin and clinical waste bin as required for good IPC practices in a sluice room.

The management team agrees it is unsuitable and against Regulation 27 and IPC best practice to have the decontamination washer located outside of the sluice room in a separate covered area, and contact has been made with plumbers to relocate the washer into the sluice room as soon as possible as appropriate. We are awaiting confirmation of a date when they are available to complete this work.

A updated and revised cleaning schedule is in place to ensure the area is always kept clean and fit for purpose to ensure there is no build up of leaves in the area or any boxes left in the area.

'IPC Huddles' have been initiated and are taking place, the Huddles were initiated following training on 'Infection Control Regulation 27' completed by the Clinical Lead on March 30th 'with INMO Professional for 3 CEU's accredited, and a further course on 'Infection Control Risk Register' on May 11th with INMO again accredited 3 CEU's from NMBI.

The Huddles are providing excellent opportunities to refresh and update the knowledge of all staff in addition to their formal IPC training provided. It allows us to make a connection between their training and the practicalities of implementing that training daily working in the home thus ensuring the best IPC practice is implemented and protecting staff and residents from transmitting infections.

Regular walk abouts are taking place with maintenance to review all items in bedrooms and communal areas to quickly identify any items which need repair or replacing.

The issue of one table in St. Annes unit which was identified as unclean has been resolved. The cleaners are aware they must clean all surfaces regularly to prevent this occurring.

Additional glove holders for XL gloves have now been installed in St. Annes for the correct storage i.e. off the handrails and also flat packed aprons have been removed from surfaces reducing the risk of infections being transmitted.

The Internal vacuum system is now sanitized intermittently between areas as required. The hose is then deep cleaned and swapped out daily for a 2nd replacement hose

ensuring that it receives a thorough cleaning every evening. Cleaning schedules have been updated to reflect and the above is documented.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Wedges are now banned from the floor of the nursing home and not in use in any areas. Gas pipes have been painted yellow. A PAT testing quote has been obtained and is being scheduled for all electronic devices to ensure they are tested as required by the 30/6/23. Fire exits and venting through walls are being reviewed by the engineers engaged as part of the major fire works currently underway. The fire exit door sign above the currently unused smoking room has been removed. All door gaps have now been addressed which was in progress at the time of the inspection issues have addressed to bring gaps within safe levels, inc. Dining room, kitchen and laundry. Ironmongery and pipes penetrating through fire walls will be assessed also. All quarterly inspection certificates for Fire Alarm was provided on the day of the inspection going back over a number of years and final Annual certificate has since been provided. New emergency lighting was fitted throughout the building beginning in February 2022 which included a total of 268 new emergency lights The quarterly checks (with regard to lighting only) were limited as work was ongoing at the time, certification for April 2023 has since been provided for the system and quarterly inspections had been provided for according to and as outlined in the service contract which was provided on inspection.

Fire safety awareness training has been held and staff are now up to date. Reception hatch has been fire proofed. New floor plans will be put in place by 30/06/23 and the plans on the back of bedroom doors will be reviewed and updated as require by 30/6/23. All blinds blocking fire exits have been removed. Furniture in small day room close by fire exits has been rearranged to provide easier access to fire exits and resident mobility continues to be considered in terms of the chosen seating location.

Since February 2022 the nursing home has had a full new fire panel fitted, a 2nd slave fire panel in St. Anne's unit, automatic gas sniffer shut off detection system fitted, 268 new emergency lights and the entire attic has now been compartmentalized to further fire-proof the compartments below. One member of staff is a certified fire trainer and fire marshals and deputy fire marshals are indicated on the roster every day. There are also three fire checks daily of the entire building by a day nurse night nurse and maintenance person respectively, night drills are carried out and new sensors are being fitted to the storage presses on each corridor for completion by 30/6/23. Battery chargers have been relocated to more suitable areas.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A suitable Responsive Behaviors Champion Nurse will be appointed in the center. This champion nurse will be responsible for ensuring all residents exhibiting responsive behaviors are efficiently and accurately assessed, and for the creation of appropriate care plans to include support strategies and interventions required for the individual residents assessed needs and the impact on all other residents.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
In addition to the newly appointed Restrictive Behaviours Champion Nurse, additional training will be provided to all staff on 'Understanding Dementia and Communication'. Combined this will ensure that all staff have the ability to connect responsive behaviours care plans with actions and how to properly implement the strategies identified.

Access to all garden areas have been reviewed and risk assessed by the management team, the following improvements are being implemented to ensure all residents of the center have access to safe secure outdoor areas suitable for their individual current needs.

The courtyard in the green day room off the front unit is controlled by an electronic keypad which can be opened with the use of a 4-digit code. All residents have been made aware of this keypad code and can enter the outdoor areas whenever they wish without any restriction new patio area adjacent to the garden at the side of the building with new furniture has been constructed and installed which will be ready for use by 31/05/23.

The courtyard in St Anne's is currently being redesigned and a new area is to be constructed to provide a more suitable area for residents in the unit, most of whom are high and maximum dependency residents by 30/6/23. The newly constructed and updated area will bring the total courtyard outdoor areas to 4 in St. Anne's and complement the other new patio constructed after the inspection at the garden to the side of the building by the garden. A review of the lock system will take place to ensure residents who wish to go outside and have been assessed as been independently capable of doing so, will be able to at any time of their choosing. The redesign of the new patio area for St. Annes will facilitate easier access to the outdoors.

All wardrobes in St Annes Unit are being fitted with a key lock system. Each resident will be provided with a key to their personal wardrobe. This will ensure their belongings are safe and secure and they can access them whenever they wish 6 new wardrobes have also been ordered for St. Annes and are scheduled for delivery 28/5/23 which will have a built in locking mechanisms.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Additional training on 'Understanding Dementia and Communication' will be provided to the health care staff working in St. Annes Unit. This will ensure all staff have the appropriate skills and knowledge to provide best practice care to our dementia residents and in particular to accessing meaningful activities on the occasions one of the designated activities co-ordinator is not available. Staff will be made aware of the necessity to engage in meaningful activities with all residents in line with their interests and capabilities, as per a schedule previously prepared by one of the three activities co-ordinators in the center and ensuring continuation of activities in their absences.

Each of the bedrooms in St. Annes unit have a secure door with a working lock in place. Should a resident have the need or the want to participate in any activity in their bedroom alone they have the option to lock their door, hence the provider is ensuring the residents right to privacy is achieved.

All residents in the center are facilitated and encouraged to exercise choice in their daily lives, this includes spending time outdoors if they so wish. The courtyard in the green day room of the front unit is controlled by an electronic keypad which can be opened with the use of a 4-digit code. Residents have been made aware of this keypad code and can enter the outdoor areas whenever they choose to without any restriction or hindrance to their rights.
The courtyard in St. Annes is being redesigned to be more user friendly for our residents in St. Annes, most who are high and maximum dependency residents. A review of the lock system will also take place to ensure residents who are capable of going outside independently always have free access to the garden area. During the summer months when the weather is permitting the doors to all garden areas are freely opened for all residents to access the gardens whenever they would like.

A full review of the nutrition and mealtime experience in the center has taken place. Pre Covid-19 restrictions the main dining room was always used for mealtimes, however with the pandemic this practice changed, and residents were less eager to come to the dining room. Following a review of current practices and taking into consideration the residents' abilities and right to choose where they enjoy their meals, we are encouraging all residents to once again use the dining room, if they so wish. This allows for a more sociable mealtime experience for all residents and enables the residents to see and speak

with the cook preparing their meals.
Each day the cook on duty updates the menu board to show the options available for meal times and a choice will be offered to each resident when served by the cook, directly from the kitchen to table.
Residents with significant cognitive impairment will be offered a choice of meals using picture cards and if they have the ability to reply this information will be used for their meal choices.

The structure of residents' committee meetings has been reviewed and updated to ensure all residents' rights are being fully facilitated. The new system will ensure all issues discussed and suggestions made by the residents on the day-to-day running of their home are brought to the attention of the appropriate team in a timely manner. Minutes of the residents meeting are retained with those of the CNM/Nursing/HCA's meetings. The meeting must take place prior to CNM meetings at the end of each month to ensure all points are discussed fully at the CNM meetings and action plans are promptly implemented. In addition to the two monthly resident committee meetings facilitated for residents to attend, more frequent resident surveys have also been implemented. This will offer all residents, including those who choose not to attend the residents' meetings, input into the day-to-day running of the home and provide them with another opportunity to give their voice and opinions on matters governing the home.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/03/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/03/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Substantially Compliant	Yellow	30/06/2023

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Yellow	30/06/2023
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	30/06/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Yellow	31/05/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Not Compliant	Orange	31/05/2023

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	01/03/2023
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.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures,	Substantially Compliant	Yellow	01/03/2023

	including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/03/2023
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	30/05/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	01/03/2023
Regulation 7(1)	The person in charge shall ensure that staff	Not Compliant	Orange	30/06/2023

	have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	01/03/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	01/03/2023
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	01/03/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with	Not Compliant	Orange	01/03/2023

	their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Yellow	01/03/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Yellow	01/03/2023