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:	Brookvale Manor Private Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Hazelhill, Ballyhaunis, Mayo
Type of inspection:	Unannounced
Date of inspection:	09 November 2020
Centre ID:	OSV-0000325
Fieldwork ID:	MON-0030784

About the designated centre

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

Brookvale Manor is a purpose-built single-storey premises located in a residential area a short drive from the town of Ballyhaunis. The centre is registered to provide long and short term care for 57 residents, both male and female over the age of 18 years. Twenty-four-hour nursing care is provided. Residents' accommodation comprises of single rooms and double rooms all of which have full en-suite facilities including a shower, toilet and wash hand basin. Adequate screening to protect residents' privacy is provided in the shared bedrooms. The centre has a variety of communal space and the arrangements provide residents with a choice of quiet areas or spaces where they can socialise. There are two large sitting rooms and a dining room to the front of the building, an additional sitting/activity area that is centrally located and a foyer at the front that some residents use to read or to see their visitors. Other rooms include a laundry, sluice facilities, kitchen and staff areas and offices. There is a safe secure outdoor garden for residents to use and this was accessible from several points of the building. It was well cultivated, provided with appropriate seating and had interesting features such as a summer house where residents could sit in the shade. The centre also has two pet rabbits that lives in the garden and provides additional interest for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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
Monday 9 November 2020	10:00hrs to 18:30hrs	Catherine Sweeney	Lead
Monday 9 November 2020	10:00hrs to 18:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors spoke with seven residents on the day of the inspection. Residents spoken with stated that they felt well looked after and that the staff were kind to them. Residents appeared relaxed and comfortable in the company of staff. Staff were observed to speak with residents in a kind and respectful manner.

Inspectors observed incidences where residents needs were not responded to in a timely manner, for example;

- a resident who was not feeling well had called for help. The resident told inspectors that staff had responded but had turned the bell off and left the room without assisting the resident.
- a resident was anxious as he felt his condition had deteriorated over the previous number of days. He had communicated his concerns to the nursing staff but he felt that no action had been taken.

Some residents told the inspectors that they were kept updated with the changes in the centre in relation to COVID-19. One resident explained that they had been through a hard time during the outbreak but they were glad that things were getting back to normal.

While some residents were observed to spend time in their bedrooms, inspectors also observed that residents were facilitated to spend time in the communal areas of the centre such as the dining room and the day rooms. Resident told inspectors that they were offered choice in how and where they spent their day. Residents also spoke of how they were in communication with their families and friends and that when visiting was restricted, they could speak with their families on the phone or through window visits. This was an improvement since the last inspection.

Resident's rooms were seen to be personalised with resident's belongings such as pictures and small pieces of furniture.

Capacity and capability

This was an unannounced inspection by inspectors of social services to review the progress of a compliance plan submitted by the provider following an inspection in June 2020 during an outbreak of COVID-19. The previous inspection found multiple non-compliances related to systems of governance and management, staffing and infection control in the centre. This inspection found that while some progress had been made to address the non-compliance from the previous inspection, significant further action was required. Inspectors also followed up on two notifications of

injury to residents following a fall in the centre.

The organisational structure in the centre had changed since the last inspection. A new person in charge had been recruited and was supported by a part-time assistant director of nursing. The person in charge was supported in the operational management of the centre by a person participating in management and the provider.

Inspectors found that the governance and management systems in the centre required review and improvement. Management and staff meetings, clinical and environmental audits, infection control systems and record's of resident care were poorly documented and did not inform quality improvement. The compliance plan submitted following the poor findings of the previous inspection was not implemented within the providers own time frame. The governance systems in place did not facilitate the changes required to improve the care to residents and ensure regulatory compliance.

The rosters or the sign in log used by staff in lieu of the clocking in system reviewed did not reflect the staff members on site on the day of inspection. Roster changes had not been documented on the rosters and staffing could only be confirmed by reviewing the nursing documentation. This is a restated issue from the last inspection.

Inspectors found that staffing levels remained low and were inconsistent. For example,

- on the week of the inspection, nursing hours reduced from two nurses during the day, supported by the assistant director of nursing and the person in charge, and one nurse at night on weekdays to one nurse day and night at the weekends.
- Staff at the weekend was further reduced as the social care facilitator and the activity therapist were not rostered.
- There was no provision to replace staff in the event of unplanned leave. On the day of inspection, two staff members (one nurse and a member of the housekeeping staff)who were unable to attend work were not replaced.

Following the last inspection, the provider gave a commitment to increase the number of nurses working in the centre to two nurses by day, two nurses until midnight and then one nurse by night until 8:00am. A review of the rosters found that this commitment was not actioned. The centre had successfully recruited two part-time nurses, but this did not provide the required number of nurses to achieve the staffing level that the provider had committed to. The findings of this inspection is that the number of nurses rostered was insufficient in the context of the needs of the residents and the size and layout of the building. This is a repeat finding from the last inspection.

Staffing deficits were also noted in the housekeeping department. There was one cleaner available to clean the centre on the day of inspection and there were no staff working in the laundry.

Inspectors were concerned that the centre was not staffed to ensure that an outbreak of COVID-19 would be identified, managed, controlled and documented in a timely and effective manner as required by the National Standards for Infection Prevention and Control in Community Services 2018 and in accordance with the Health Protection Surveillance Centre (HPSC) Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

A further commitment from the provider to provider training to nurses in record keeping, falls management and care planning given following the last inspection could not be evidenced on the day of inspection. Furthermore, newly appointed staff had yet to receive mandatory training such as fire safety and manual handling training as part of their induction process.

The system in place to record the training and development records of the staff was difficult to review. There was no training matrix. The records available were not easy to follow and made it difficult to have ongoing oversight. Consequently, the provider did not have oversight of the areas of training that were outstanding and therefore could not be assured that the staff had the required knowledge pertinent to their role.

A review of the nursing documentation records found repeated poor practice that was not in line with the Nursing and Midwifery Board of Ireland (NMBI) Recording clinical practice guidelines. Nursing records were duplicated, were not an accurate reflection of the status of each resident, and did not reflect the person-centred needs of each resident.

Improvements were noted in the system of managing complaints. Recent complaints were seen to be documented and investigated in line with regulation 34, Complaints procedure.

Regulation 14: Persons in charge

A newly recruited person in charge was found to have appropriate qualifications and experience for the role.

Judgment: Compliant

Regulation 15: Staffing

The provider had failed to ensure that the number and skill mix of staff was appropriate to the needs of the residents and the size and layout of the designated centre. This was evidenced by

- inadequate supervision of residents resulting in injurious falls
- duty rosters that did not accurately reflect the staffing of the centre
- failure to increase staff in line with their own assessment of the needs of the centre following the last inspection
- inadequate staff to ensure the centre could be cleaned to a high standard
- poor contingency planning to ensure adequate staffing in the event of a second outbreak of COVID-19.

This is a restated non-compliance from the last inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the training and development for staff was difficult as records were incomplete and disjointed. Records reviewed found significant gaps in mandatory training such as infection control, fire safety, safe manual handling and safeguarding vulnerable adults in newly recruited staff, including the person in charge. The training and development system in place did not provide assurance that all staff were trained and developed appropriate to their role.

In the compliance plan submitted following the previous inspection, the provider had outlined a training and development plan for nurses in the areas of record keeping, care planning, incidents and complaints and falls management. There was no evidence that this training had taken place.

This is a restated non-compliance from the previous inspection

Judgment: Not compliant

Regulation 21: Records

A review of the nursing documentation records found NMBI guidelines for recording clinical practice were not being followed. Inspectors reviewed a sample of residents care records. There was multiple incidents of duplication of residents daily progress notes within the records of individual residents. This meant that nurses were not accurately recording the care needs of residents or the delivery of care to residents.

This is a restated non-compliance from the previous inspection.

Judgment: Not compliant

Regulation 23: Governance and management

A review of the governance and management systems in the centre found that while management communication with the person in charge had been documented, there was little evidence of a strategic plan with appropriate time lines to address the non-compliance's from the last inspection. This was evidenced by

- inadequate resources to ensure safe staffing levels
- inadequate nursing supervision and oversight
- significant gaps in staff training and development
- inadequate infection control systems
- poorly detailed contingency plan for COVID-19
- poor quality auditing system to drive quality improvement
- poorly managed systems of notification to the Chief Inspector
- inadequate oversight of maintenance issues for example, duct tape noted on outflow pipe in sluice, and damaged fire doors

This is a restated non-compliance from the last inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider is in the process of ensuring that all notifications required by the Chief Inspector will be submitted by the person in charge of the centre. This is not yet in place. The system of notification currently in place is that the person in charge is supported in submitting notifications from an off-site location. This has resulted in a number of notification errors over the past six months.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors found that improvements were made in the management of complaints. A number of complaints were recorded and investigated in line with the centre's Complaints policy.

Judgment: Compliant

Quality and safety

This inspection took place during the COVID-19 pandemic where level 5 restrictions were in place. Visiting to the centre was facilitated through window and outdoor visits; an improvement since the last inspection. On the day of inspection, the centre had two residents in isolation, both were recent admissions to the centre. These residents were in single rooms among other residents rooms and not within the designated cohorting area of Greenacres. Personal protective equipment was available outside of each room.

An inspection in June 2020 had found significant non-compliances in the area of infection control. The provider submitted a compliance plan detailing that a 'comprehensive review of the infection prevention and control measures in place was commissioned by the provider and was carried out by an external infection control nurse specialist' and that the ' recommendations from the report have been implemented...' this report was not available for review on the day of inspection. The person in charge was not informed of the recommendations from this review.

An internal infection control audit which was provided for review did not identify significant infection control issues found on this inspection. The internal audit did not result in any quality improvement interventions.

A comprehensive infection control audit and action plan was required to ensure the centre complies with regulation 27 and that it was prepared for a further outbreak of infection, such as COVID-19.

Inspectors found that fire safety systems in the centre also required review. Inspectors found that fire safety practice and the fire safety policy were not in line the requirements under regulation 28. Inspectors concluded that a fire risk assessment completed by a fire safety specialist was required to ensure the fire safety measures in place were appropriate.

While there was on-going concerns in relation to the daily clinical documentation of residents care, Inspectors found improvement in the assessment and care planning documentation. Each residents had a comprehensive and detailed assessment and care plan in place to guide care. Care planning was supported by the social care facilitator to ensure that care plans reflected the physical, social and psychological needs of each resident.

Inspectors found that resources to ensure that appropriate medical and health care are provided were not available. For example, there was no equipment available to support staff to deliver cardio-pulmonary resuscitation even though the intervention was outlined in the residents care plan.

Residents were observed to use the communal rooms in the centre and were facilitated with a schedule of activity that encouraged social engagement. Inspectors observed that residents were comfortable and relaxed in the company of staff.

Inspectors noted that there were no light switches beside residents beds. A review of this issue was required to ensure that the residents could safely exercise choice if they wished to get out of bed or read etc. during the night.

Regulation 27: Infection control

An external infection control audit had been completed in the centre since the last inspection, in line with the providers compliance plan. However, the report from this audit was not available to review. The person in charge did not have access to the report and therefore no action plan was in place to address any findings.

Inspectors found that infection control practice required review and improvement. This is evidenced by

- insufficient cleaning staff
- COVID-19 contingency plan lacks detail in relation to cohorting and staffing arrangements
- cohorting area was not used to isolate two residents on the day of the inspection
- inadequate access to appropriate hand hygiene sinks
- poor management of clinical waste
- stained and malodorous carpets throughout the centre
- uncovered bins
- poor cleaning records
- no service contract in place for bedpan washer
- no identification of clean and contaminated areas for storage
- window ledge in cleaners room corroded
- no cover for laundry trolley

This is a restated non-compliance from the previous inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors found that the fire safety systems in place did not provide adequate assurance that residents were safe from the risk of fire. This was evidenced by

- maps and fire safety procedures in place to guide residents, visitors and staff to safety in the event of an emergency were inaccurate and required review. For example, maps did not identify the route to evacuation assembly points, the location of fire fighting equipment, the location of fire doors or the

identification of compartments required for emergency evacuation.

- there were rooms in the centre with no fire detection equipment, for example, the board room.
- there was one fire panel located in the nursing station. The time taken to reach the panel from the most distant point in the centre had not been factored in to evacuation drill times in the event of an emergency.
- gaps in the staff training records for fire safety
- drill records did not contain information to identify learning and improve the efficiency of the process. The detail on the drill did not reflect the detail on the residents personal emergency evacuation plan.
- damaged fire doors
- fire doors held open with a chain and no release mechanism for automatic closure, in the event of a fire
- the fire ratings for the ceiling hatches in the sluice and the cleaners room was unknown
- poor detail contained in fire safety policy

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors found improvements in the documentation of residents assessment and development of care plans. Care plans reviewed were developed in line with the assessed needs of the resident and contained the detail required to direct care. Care plans are updated in line with regulation and professional guidelines.

This issue had been addressed since the last inspection.

Judgment: Compliant

Regulation 6: Health care

The centre did not have the resources required to ensure that high quality evidence based nursing care could be delivered. For example, some residents were assessed as requiring a high level of clinical support in the event of a sudden deterioration. There was no systems in place to support this level of clinical intervention. For example, there was no defibrillator on site in the event of a resident, staff or visitor requiring cardio-pulmonary resuscitation nor had contact been made with any emergency community support teams.

Inspectors found gaps in the nursing knowledge and processes in place to manage

residents with complex health care needs. Two incidents where residents required medical attention were brought to the attention of staff on the day of the inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors noted improvements in relation to the social engagements of residents on this inspection. Residents were observed using the communal spaces in the centre including the day and dining rooms.

A review of the record of communication with residents found good practice. Residents informed inspectors that they were kept up-to-date with changes in relation to COVID-19 such as visiting.

A review of residents bedrooms found that there was no light switches near the residents bed for them to access independently for reading and safe mobilisation. This issue required review to ensure that residents had access to exercise choice in line with the requirements under regulation 9.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brookvale Manor Private Nursing Home OSV-0000325

Inspection ID: MON-0030784

Date of inspection: 09/11/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
S: Following the inspection and taking into account the feedback and findings, a robust recruitment drive was implemented by the Registered Provider Representative (RPR) and staff have been recruited in sufficient numbers and skill mix as recommended by the Deputy Chief Inspector. In parallel with this, and in accordance with our contingency planning, service agreements are in place with a number of agencies to provide additional staff of all grades in the event of an outbreak of COVID-19 within the centre.

An in-house staffing ratio tool has been used which provides assurance that staffing takes into consideration resident needs and the size and layout of the building.

Recruitment of staff is supported by the Human Resources (HR) Department of the Group of which staff is recruited by the PIC following interview. If successful, a HR file is commenced in accordance with regulations and standards to ensure that safe effective practices are in place to recruit suitably qualified individuals for each department within the centre where required.

A revised statement of purpose has been compiled and forwarded to the Chief Inspector.

Staffing within the centre is kept under constant review by the RPR and can be revised to reflect any change in the needs and/or dependencies of our residents. This is monitored on a daily basis by the PIC (or her designate) and can be adjusted as required.

The duty roster accurately reflects those staff working within the centre on any given day.

M: Through continuous review and audit to ensure that staffing within the centre is fully reflective of the dependency and care needs of residents and is in accordance with the Statement of Purpose.
A: By the PIC and management team
R: Overview by the regional team in conjunction with the COO.

T: 27th January 2021.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
S: A review has been completed of the training and development records of staff within the centre and training records have been updated to fully evidence all training provided. A structured training schedule is in place to ensure that all newly recruited staff complete mandatory training and that update training is provided to all staff within relevant timeframes. This includes updated training for nursing staff regarding care planning, documentation, incidents, complaints and falls management. All training is provided by an appropriately qualified person. Staff training requirements are based upon the training matrix and incorporate staff skill, resident conditions and staff feedback at appraisals with regard to individual training need. The updated training schedule includes details of each staff member, when the training was last provided and the dates future training are due. The schedule is managed by the administrator and PIC in conjunction with the HR Department and Training staff and is used to plan future training dates. Delivered training is recorded electronically by the administrator and also on the staff member's HR file
M: Through audit and observation of staff to determine they are able to apply theory to practice
A: By the PIC, management and training team.
R: Overview by the regional team in conjunction with the COO.
T: 8th January 2021

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
S: All nursing staff have received training with regard to NMBI guidelines for recording of clinical practice. This training included NMBI Recording Clinical Practice Guidance and further referenced care planning, documentation, incidents and local policies and procedures around complaints and falls management. The PIC reviews the care records on an ongoing basis to ensure that these are maintained in accordance with NMBI guidelines and the training provided. Care records are also audited monthly by the PIC and/or ADON.
M: Through continuous review and audit
A: By the PIC

R: Overview by the regional team in conjunction with the COO.
T: 8th January 2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
S: The layout of the centre has been sub-divided into two separate areas. Each area has it's own roster with dedicated nurses, healthcare assistants and housekeeping teams to minimise the risk of cross-infection. An updated training matrix is in place (see above) and staff training is ongoing to promote staff development and refresh staff awareness and understanding of IPC procedures and the use of PPE.

The COVID-19 contingency plan remains under ongoing review by the PIC supported by the COO to ensure that all necessary provisions have been made to support management and staff to deal with an outbreak within the centre. The contingency plan is regularly updated to consider any new or revised national guidance. Through daily handover meetings and during safety pauses, all staff are aware of the actions to take in the event of an outbreak and the contingency plan having to be implemented.

A comprehensive review of the environment was undertaken by the maintenance team and all works identified (including re-painting of walls and woodwork throughout the centre, works to the sluice room and fire safety) have been completed.

M:Compliance visits, observational visits and additional supports to the PIC where required
A: Through the PIC and management team
R: Overview by the regional team in conjunction with the COO.
T: 8th February 2021

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
S: All future notifications will be submitted by the PIC and/or their designate in the event of the absence of the PIC
M: Through continuous review
A: By the in-house management team.

R: Overview by the regional team in conjunction with the COO.
T: 27th January 2021

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
S: The centre has been sub-divided into two zones. Each zone is staffed independently and has a separate entrance/exit, staff break and changing room. A dedicated COVID-19 breakout area has also been identified. Within the COVID-19 breakout area, there are a number of vacant rooms and the physical layout of this area is such that it can flex to cohort more or less residents in response to any potential outbreak. The sub-division of the centre has also enabled staff to more effectively manage residents in precautionary isolation within.
Dedicated houskeeping staff have been allocated to each subdivided area.
The COVID-19 contingency plan has been reviewed to reflect the cohorting and staffing arrangements.
Access to hand hygiene facilites and the provision of a cover for the laundry trolley have been included in the maintenance review and subsequent action plan.
The issues identified by inspectors in relation to staff adherence to infection prevention and control practices (e.g., management of clinical waste and cleaning records) have been addressed with the individual members of staff concerned and with all staff through the thrice daily safety pauses and at staff handover meetings
A deep clean has taken place of the centre; the mangement of storage of clean and contaminated areas has been revised and an updated service contract for the bedpan washer is in place.
The window ledge in the cleaners room has been addressed.
M: Issues requiring action will be rectified through enhanced monitoring.
A: Through the PIC and inhouse management team with audit, reflection and learnings.
R: Overview by the regional team in conjunction with the COO.
T: 8th January 2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
S: A comprehensive review has been carried out by a suitably qualified professional and all recommendations are incorporated into the maintenance action plan. The recommendations include the installation of additional emergency lighting and smoke detectors to further enhance the levels of fire safety within the centre. A review of the

environment has also been completed and risk assessed. Remedial work is ongoing to address all issues identified, including those highlighted by inspectors. All fire maps within the centre have been refreshed and policies, procedures, resident PEEP plans and the recording of fire safety drills have been reviewed and revised where necessary.
M: Through continuous review and audit.
A: By the PIC and local management team
R: Overview by the regional team in conjunction with the COO.
T: 19th February 2021

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
S: The centre is fully resourced to ensure the provision of safe high quality nursing care to meet the healthcare needs of all residents including those requiring a high level of clinical support. Following discussion with the local community emergency support team, arrangements are now in place to ensure that staff can access a local defibrillator as required. These arrangements have been communicated to all staff. Residents healthcare needs form an integral part of the three times daily safety pause meeting as an additional identification process of resident need.
M: Through audit and review.
A: Achievable by the PIC.
R: Overview by the regional team in conjunction with the COO.
T: 23rd December 2020

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
S: Residents have been re-assessed for moving and handling which includes their ability to independently mobilise at night. All residents have a bedside light which can be accessed independently for reading and safe mobilisation and the resident questionnaire has also been updated to reflect resident ability and satisfaction with light access in their bedroom.
M: Through continuous review.
A: Achieved by the PIC and Maintenance team.
R: Overview by the regional team in conjunction with the COO.
T: 4th February 2021

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	27/01/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	08/01/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	08/01/2021
Regulation 21(1)	The registered provider shall ensure that the records set out in	Not Compliant	Orange	08/01/2021

	Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	08/02/2021
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	Orange	08/02/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	08/01/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate	Not Compliant	Orange	19/02/2021

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
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, 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.	Not Compliant	Orange	19/02/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be	Not Compliant	Yellow	19/02/2021

	followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	19/02/2021
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	19/02/2021
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	27/01/2021
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 nursing care in accordance with professional guidelines issued by An Bord Altranais agus	Not Compliant	Orange	23/12/2020

	Cnáimhseachais from time to time, for a resident.			
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.	Substantially Compliant	Yellow	04/02/2021