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:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	04 April 2023
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0038218

About the designated centre

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

Bridhaven Nursing Home is a designated centre and is located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 182 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in six suites: on the lower ground floor - (1) Clyda is a dementia-specific unit with 18 bedrooms all single rooms with full en suite facilities of shower, toilet and wash-hand basin); on the ground floor - (2) Lee (33 beds – two twin and 29 single with en suite facilities), (3) Blackwater (37 beds – six twin and 25 single full en suite facilities) 4) Lavender (13 beds - all single full en suite bedrooms); on the first floor - (5) Bandon (45 beds – four twin and 37 single with en suite facilities), (6) Awbeg (36 beds – seven twin and 22 single with en suite facilities). Additional assisted toilet facilities are located throughout the centre adjacent to communal areas. Each suite had a day room and dining room and there are additional seating areas located at reception and throughout the centre. There is a large seating area upstairs for resident to relax with views of the enclosed bonsai garden and also the entrance plaza. Residents in Clyda have access to a well-maintained enclosed garden with walkways, garden furniture and shrubbery; there is a second smaller enclosed garden accessible from the Blackwater day room. Bridhaven Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	148

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 4 April 2023	20:30hrs to 23:50hrs	Breeda Desmond	Lead
Wednesday 5 April 2023	09:00hrs to 18:00hrs	Breeda Desmond	Lead
Tuesday 4 April 2023	20:30hrs to 23:50hrs	Caroline Connelly	Support
Wednesday 5 April 2023	09:00hrs to 18:00hrs	Caroline Connelly	Support
Wednesday 5 April 2023	09:00hrs to 18:00hrs	Robert Hennessy	Support

What residents told us and what inspectors observed

Overall, the inspectors found that while there were some good practices observed during the inspection, the practice of having most residents in their bedrooms or in bed by 8:30pm was not in keeping with a rights-based approach and a social model of care. Inspectors met many residents on both days of the inspection and spoke with approximately twenty residents in more detail, and five sets of visitors. Some residents gave positive feedback and were complimentary about the staff and the care provided, however, they reported that the quality of their food was varied with some residents satisfied, but others not. Other residents reported that the service 'could be generally better'. One resident reported that they 'wake me up around 5am and it's a long wait until breakfast'. Relatives generally reported satisfaction with the premises and care of their relatives. However, a number did report delayed responses from the management team to issues raised and concerns about turnover of staff.

This was a two-day inspection, with the first day commencing in the evening at 8:30pm. Inspectors were welcomed to the centre by the night duty staff and were guided through the infection prevention and control measures by a member of staff. This included hand hygiene, electronic temperature check and a signing in process. A meeting was held with the management team on the second day of the inspection.

There were 148 residents residing in Bridhaven at the time of inspection. Bridhaven was a three storey facility with resident accommodation set out in six units over the three floors; Clyda (dementia specific unit) was located on the lower ground floor; Blackwater, Lee Side and Lavender Cottage (dementia specific unit) on the ground floor; Bandon and Awbeg upstairs. HR offices, the main kitchen, maintenance and facilities, staff facilities, laundry, storage areas, and hairdressers' room were also accommodated on the lower ground floor.

Initially upon arrival to the centre on the first evening of the inspection, inspectors checked into all of the units to determine the staffing levels on night duty. On all but one unit, the staffing levels correlated with the planned roster; on one unit there was a shortfall of one healthcare assistant. Inspectors were very surprised to find that the centre was very quiet with most residents either in bed or in their bedrooms. In the lavender unit, which was home to 13 residents, the inspectors found that the day room was in darkness. A member of staff was sitting in the dayroom with the television on, when asked by the inspectors where were the residents, inspectors were informed that residents were in their bedrooms. The inspectors checked a number of bedrooms and confirmed that residents were in their rooms, a few had their TV on but many of the residents were awake looking at the ceiling, leading the inspectors to believe that residents could be up enjoying the lovely comfortable day room watching TV and chatting with the staff. In Clyda unit where 18 residents reside, there were three residents up, one was walking accompanied by a staff member and the other two residents relaxing in the day and

dining room. The remaining residents were in their bedrooms. In Awbeg unit where 22 residents resided, the inspectors saw that there were three residents in the day room; one resident told the inspectors that they go to bed around 10pm and another also confirmed that they usually stay up until 10pm depending on what was on TV. The nurse was in the office and the care staff was in the dining room setting up the trays for residents breakfast. On Lee Side, staff were seen preparing the supper trolley and then offered residents in the dayroom tea and cake before going to residents' bedrooms. One resident came to the kitchenette off Lee Side and made himself a cup of tea and the HCA offered him some cake. Another resident independently accessed the outdoor garden to have a cigarette before going to bed. The HCA was setting trays for breakfast at 10pm as all residents were in bed. In the Bandon unit where up to 45 residents resided, there were three residents in the day room with one member of staff. The three residents in the day room told inspectors they went to bed when they wished. A staff member who spoke to the inspectors told them that a number of residents on Bandon unit required the assistance of two staff to go to bed, so they started the process of assisting residents to bed after tea around 5.30pm and they were all in bed before the night duty staff started. In the Blackwater unit where up to 37 residents reside, there were three residents in the day room. Overall , there were approximately 12 residents out of 148 seen in different day rooms when the inspectors walked the centre at 8.30pm.

Inspectors spoke with night duty staff who were completing medication rounds. The nurse was observed to kindly and gently provide assurance to residents in their bedrooms during the medication round in a calm and relaxed manner. Inspectors asked about medication rounds and were informed that these start around 7pm with the day staff administering night medications to approximately half the residents.

There was a household staff on night duty seen cleaning and emptying waste bins. Throughout both days of inspection, it was noted that while many areas were visibly clean, other areas such as a visitor's toilet and a sluice room were visibly unclean. Some paper dispensers in bathrooms were empty and had not been replenished as part of household rounds. Many of the clinical hand-wash sinks had metal outlets. Surfaces of furniture such as hand rails on corridors, bed frames, lockers and chest of drawers were worn. Some flooring was replaced but other floor surfaces were worn and stained and looked unsightly.

On the second day of inspection, residents were seen to watch mass on television in day rooms at 10am. This was followed by staff offering resident beverages and snacks. The activities co-ordinator chatted with residents in a social manner, suggesting activities and then organising activities to suit residents. On Lee Side and Blackwater, activities were facilitated in both day rooms. One resident had stiffness and pains in their hands so the activities person gave then rolls of foam to exercise to ease out their fingers; other residents were taken for a stroll outside but did not stay too long as there was a biting cold wind blowing. Four residents were sitting outside, well wrapped up, having their cup of tea and cigarette. They had independently accessed the outdoors and knew the keycode to re-enter the building. Inspectors spoke with three of the residents who reported they were happy with the service and could raise issues if needed. In general, inspectors observed that staff

were kind and respectful when interacting with residents.

The local priest came to the centre regularly and said mass on a weekly basis. He said mass on the second day of inspection and then went around to give holy communion to residents in their bedrooms. At reception, a resident sat with the receptionist as part of their daily routine. The inspector sat with them for a while and it was evident that they were good rapport between them as they chatted and were relaxed in each others company. The receptionist had a lovely welcome for visitors to the centre and greeted them all by name and when they were leaving, she thanked them for calling.

Staff on the dementia specific units of Clyda and Lavender facilitated activities there. Staff on Lavender were asked about meal-times and they explained that meal-time was resident-led; the staff pointed out that residents were seen to enjoy the art activity so dinner time would be when they were ready, as they did not interfere or disturb them when they were settled and content.

Mealtime was observed on all units throughout the day. In Lee Side and Blackwater dining room at lunch time, initially, the television was on with a talk show programme broadcasting loudly, this was eventually turned off. Staff were seen to ask residents their choice for dinner and beverage. Three staff were seen waiting for meals to be plated up and then they served residents, offering gravy separately. Meals were pleasantly presented and looked appetising. Most staff positively engaged with residents as they served their meal. Two residents sat at one table and while one of the resident's was served the second resident did not get served for another 20 minutes. There were two sittings for dinner in this dining room. While some residents were brought across from the day room and were seated at dining tables, the remainder were brought into the day room here and waited for nearly an hour for the second sitting and their meal. In Bandon unit a number of residents came to the dining room where meals were served by a chef from the kitchen. The inspectors observed that they were plated up in a very decorative manner which looked more wholesome and appetising than the food did on the previous inspection. Improvements were also seen from the previous inspection in the Awbeg dining room where food looked fresher and more appetising. The management and catering team told inspectors that a lot of work had gone into the dining experience and that more work was ongoing. The inspectors saw and were informed by residents that the choice at tea time was very limited especially if you required a modified diet. Tea-time was observed in dining rooms as well as staff bringing meals to residents' bedrooms. On one trolley, there were bowls of semolina with red jam; the inspector enquired about the contents of other bowls and was informed the bowls contained textured salmon. A number of residents told the inspectors how inappropriate they felt semolina was as a tea-time choice.

Upgrading works to the premises were in progress with the space to the right of main reception being re-configured to accommodate the hairdressers room and this was welcomed, as currently, the hairdressers was located in the lower ground floor and was away from the main thoroughfare. The garden was near completion and this would enable a much greater outdoor space for residents as the current outdoor space was inadequate for the size of the centre and number of residents

accommodated. Other re-configuration works included the installation of custom-built kitchenette units in the dining rooms on Awbeg and Bandon; the conference room and dining room on Awbeg were being converted to day rooms; the day room on Awbeg was to become the dining room. The expansive connecting corridor between Awbeg and Bandon was being re-configured with the creation of a quiet day room. The display table in this space had the framed words of a song composed by one of the residents called 'A song for Bridhaven'. There was a mobile library trolley and staff visited residents in their bedrooms and in communal areas offering reading material. Additional reading material was provided by the local community library for residents. A residents' monthly news letter was displayed on the units. This was a colourful publication with lovely pictures of residents enjoying parties, activities special occasions and bank holiday celebrations.

The laundry was inspected on the morning of the second day of inspection. Emergency evacuation routes remained clear of obstruction. There was no laundry awaiting washing as there was dedicated night duty staff as well as day duty for the laundry. The laundry staff were knowledgeable regarding infection prevent and control protocols and explained the sequence of cleaning dirty laundry, appropriate temperatures for different items of clothing and chemicals to be added as part of the computer programme operation of the machines. She explained the process of labelling clothes of newly admitted residents and was preparing for a resident being admitted at the time of inspection. Laundry was segregated at source and laundry trolleys had pedal-operated function. There was a separate entry and exit to the laundry to prevent cross-over of dirty and clean laundry as well as specialist washing machines with a one-way operating system. Directional work-flow signage was seen within the laundry to mitigate the risk associated with cross infection.

There was a separate secure entrance to Clyda so that visitors could access the unit without needing to go through the centre. The reception area here had infection control precautionary facilities along with a sign-in sheet. The complaints procedure was displayed at the entrance. Memory aids such as large pictures were displayed to orientate residents to rooms such as toilets, bathrooms and the dining room. Large clocks were displayed in the day room and dining room. An open-shelved unit in the day room displayed the colourful memory boxes with each resident's name on the front of their box; these contained items of reminiscence for residents such as photographs and other memorabilia. Access to the enclosed garden in Clyda was via patio doors in the day room. This was a large well maintained space with walkways, shrubberies, raised flower beds and seating for residents to rest.

Alarm bells were wall mounted at the end of each corridor for easy access by staff and residents to call for help. Residents using oxygen had signage indicating oxygen in use in their bedrooms. One store room with food supplements was open and not securely maintained to prevent unauthorised access.

Throughout both days of inspection, appropriate hand hygiene including hand washing and hand sanitisation was observed. There were hand-wash hubs on all units at different locations at the start and end of corridors. All had advisory signage to explain how to wash hands appropriately and other signs displayed included the 'five moments of hand hygiene' as reminders to staff to wash their hands. Paper

towel dispensers, hand soap and pedal bins were alongside each hand-wash sink.

Dani centres were wall-mounted throughout the centre which enabled staff to easily access personal protective equipment (PPE) such as disposable hand gloves and aprons. Wall-mounted hand gel dispensers were available throughout the centre. There was a mobile nurses' station in the corner of the day room on Lee Side unit and had sanitising wipes, hand hygiene gel and pedal waste bin in line with HPSC guidance to enable effective infection control of the work station.

Emergency evacuation plans were displayed throughout the centre with a point of reference to indicate one's location in the centre; primary evacuation routes were detailed in the floor plans. Floor plans were orientated to reflect their relative position in the centre. Several of the fire guards on bedroom doors were not operational as the battery was no longer functioning and bedroom doors were seen to be maintained open with chairs, foot stools and bedside tables.

Capacity and capability

This unannounced risk inspection was triggered upon receipt of unsolicited information from a number of sources that raised concerns regarding inadequate staffing levels which negatively impacted outcomes for residents; lack of oversight of food and nutrition and resident weight loss; ineffective cleaning regimes and malodours. There was no evidence to support the allegation of residents loosing weight, however, there was evidence to verify allegations relating to the other specified issues. All of which were discussed in detail throughout the report. Overall, findings of this inspection were that management oversight of the service required action, to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored.

In addition, issues identified on the last inspection in November 2022 were followed up and there was evidence that appropriate action was taken relating to residents' access to personal possessions in twin bedrooms; and some improvement was noted in resident care documentation. Repeat findings were identified relating to fire safety precautions, the auditing process and oversight of the service, infection control, and food and nutrition. Additional areas of concern identified on this inspection included regulations relating to safeguarding and the promotion of residents rights and protection from institutional practices, staffing levels, aspects of medication management, and aspects of residents' care planning documentation.

Bridhaven Nursing Home was a designated centre for older adults and was registered to accommodate 182 residents. The provider was part of the Virtue group and the company had four directors. One of the directors acted on behalf of the provider. The centre was managed by an appropriately qualified person in charge. On site, the person in charge was supported in the delivery of care by two assistant persons in charge, four clinical nurse managers (CNMs), the health-care team, as well as household, catering and administration staff. A human resources (HR)

manager was on site full-time to support the service. A resident and family liaison manager supported families and residents with the transition into long-term care; the social care manager promoted a social model of care. A director of quality safety and risk supported the group as well as the overall governance of the centre. The majority of the management team worked Monday to Friday, usually 8am - 4pm; therefore there was limited managerial cover during evenings, night times and weekends. This was evidenced on inspection.

Quality and safety monitoring systems in place included weekly collection of key performance indicators (KPIs) such as falls, restraints, infection, weights, pressure ulcers and complaints for example. The annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents. However, while some of the audits had comprehensive action plans and initiatives undertaken to remedy the deficits identified, the audit system was not sufficiently robust to ensure the whole service was effectively monitored; evidence of this was discussed throughout the report and detailed under Regulation 23, Governance and Management.

The regional director of operations facilitated weekly teams meetings with the persons in charge of the five centre associated with the registered provider; this provided good support as well as information sharing amongst the persons in charge. Regional 'Quality Safety and Risk' meetings were facilitated and chaired by the director of quality safety and risk. Monthly 'Social, Clinical and Transition' meetings were convened. Agenda items for these meetings comprised quality improvement plans, key performance indicators, transitional management of residents, risk management and attendees included the on-site senior management.

The resident and family liaison manager completed the pre-admission assessment of residents, and these were seen to be comprehensive. The social care manager liaised with the activities staff to promote meaningful activities and pastoral care.

The duty rosters were reviewed and showed that there was regular staff shortages and evidence of this was seen on the evening of the inspection. This was further discussed under Regulation 15, Staffing. Four staff files were reviewed and all the requirements in Schedule 2 of the regulations were met. Records were well maintained and were stored correctly.

Staff training was completed in areas such as health and safety, safeguarding, palliative care, manual handling and lifting, train the trainer and dementia care; this enable staff to provide ongoing training on site to staff as the need arose as well as ongoing scheduling of training for staff. Mandatory training was up to date for all staff. However further implementation of this training and supervision of care practices were required.

In conclusion, overall, while residents' independence was supported during the day, institutional practices were observed at evening and night time. These practices, described heretofore, did not reflect a rights-based approach to care.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to re-register Bridhaven Nursing Home in a timely manner. Prescribed documentation was submitted and fees were paid.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was full time in post and had the necessary qualifications and experiences as required in legislation. She was involved in the operational management and the day-to-day running of the service.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that the number and skill mix of staff was appropriate to the size and layout of the centre:

- a review of the duty roster showed that there were regular staff shortages. This was evidenced on the evening of the inspection and staff told inspectors that this was a regular occurrence. In addition, occasionally, the duty roster was not updated to reflect the staff on duty. On the night of the inspection the duty roster did not fully reflect the staff on duty and a member of staff was actually working 10am to 10pm, whilst on the roster it said they worked 7.30am to 7.30pm. It was not clear from the roster who worked from 7.30 to 10am to cover or if the unit worked short.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors were not assured that the registered provider had appropriate staff supervision arrangements in place to ensure that care delivery was appropriately monitored and delivered. For example:

- there was a lack of a senior management presence on the floor at times to supervise and direct care, this was reported by staff, residents and relatives

- there was no managerial staff rostered for evening shifts and limited managerial presence at the weekends to ensure appropriate staff supervision.

Judgment: Substantially compliant

Regulation 21: Records

Action was required to ensure records relating to medicines were appropriately maintained in line with professional guidelines as the following were identified:

- liquid eraser was used on medication administration charts which is contrary to professional guidelines
- some medication records were incorrectly completed, and this could lead to medication errors
- while medicines were prescribed for 8pm by the medical officer, staff signed that medications were administered at 9pm even though inspectors were informed that night time medication rounds started at 7pm. Therefore it could not be determined what time they were administered and the accuracy of the record.

Judgment: Substantially compliant

Regulation 22: Insurance

A current insurance certificate was in place and included insurance against other risks, including loss or damage to a resident's property.

Judgment: Compliant

Regulation 23: Governance and management

Although there was a clear governance structure which outlined accountability and responsibility for the service, the current governance arrangements in place did not ensure the effective delivery of a safe, appropriate and consistently monitored service. Issues pertaining to the governance arrangements included:

- there was evidence of a lack of effective systems in place to monitor fire safety in the centre which was discussed further under Regulation 28
- there was a lack of oversight of practices in the centre which accommodated staffing levels and work routines rather than the rights of residents

- there was a lack of oversight of residents feedback pertaining to issues identified in residents meetings as feedback was not acted upon in a timely manner
- there was limited managerial oversight of the centre during the evenings and weekends
- the auditing process was not sufficiently robust to ensure and enable learning to inform quality improvement; many of the issues identified on inspection had not been recognised or identified in the auditing process.

Judgment: Substantially compliant

Quality and safety

Overall inspectors found that while residents were enabled to have a good quality of life during morning and afternoons with evidence of choice; they did not have the reciprocal choice afforded in the evening and night times, as previously described. Other areas requiring improvement related to fire safety precautions, the premises, the dining experience for residents, and documentation relating to assessment and care planning. These will be addressed under the relevant regulations.

A sample of residents' care planning documentation was reviewed. Personal emergency evacuation forms were in place for residents. There was good detail in the daily narrative for both day and night duty providing person-centred information on the resident's status and progress. Additional touch-screen devises were installed to enable staff to record care delivered to residents. Records examined showed that records were maintained contemporaneously and provided a comprehensive account of the care the resident received. Validated risk assessments were in place to enable staff to assess residents care needs, however, occasionally these were not comprehensively completed to adequately inform the care planning process, or information available as part of the medical history did not inform either the assessment of care planning process. This was further discussed under Regulation 5, Individual assessment and care planning.

Residents were seen to have good access to health and social care professionals such as a dietician, dental, occupational therapist (OT), speech and language therapist (SALT) and psychiatry to enable better outcomes for residents. Residents notes demonstrated that they had access to tissue viability nurse specialist to support wound care. The nutritional status of residents was monitored through regular weights and nutritional assessments. Documentation reviewed showed that monthly weights were completed and these were compared with the previous weight, where there was a loss or gain of two kgs or more, residents were re-weighed and referrals made to the appropriate allied health professional to enable better outcomes for residents. There was no evidence to show that residents' weights were not monitored or that there was a lack of oversight of residents weight status. Access to the mobile diagnostic unit enabled residents to have x rays within

the centre and negated the requirement to go to an accident and emergency department with the associated anxiety and upset. Fit-for-life physiotherapy group was held on a weekly basis as part of their positive aging programme to help residents maintain their level of muscle tone and mobility.

The principles of a restraint-free environment were promoted. Alternatives to restraint were readily available and different interventions were trialled to enable better outcomes for residents while promoting their independence and dignity.

Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. As part of the medication oversight, additional information was included such as the requirement for blood profile or heart monitoring (ECG) to be completed to enable the GP to monitor residents' response and suitability of certain medications, to ensure best outcomes for them. Inspectors joined two separate medication rounds where a sample of medication management administration records were examined. Residents had photographic identification and allergy status details. Medications requiring crushing were individually prescribed in line with best practice. Signage was displayed in areas where oxygen was stored or in use. Controlled drugs were maintained in line with professional guidelines. Nonetheless, issues were identified in the medication documentation and these were further discussed under Regulation 29, Medicines and pharmaceutical services.

A review of the dining experience had occurred following the findings of the last inspection and the project Creating an Appetite for Life was initiated. It was scheduled to commence the week following this inspection, whereby staff were being coached on how to make mealtime better for residents and this was welcomed (findings as described earlier in the report). They consulted with the executive chef for the group and a nutritionist to ensure residents received appropriate nutritional meals, served appropriately and in a pleasant atmosphere.

Residents' views were sought on the running of the centre through residents' council meetings and resident focus groups, however, some issues raised were not followed up and addressed to ensure safeguarding and residents' comfort, and mitigate the potential for recurrence.

Dedicated hand hygiene hubs were available throughout the centre, however, some did not comply with current recommended specifications for clinical hand wash sinks as specified in document HBN-09 infection control in the built environment (DoH 2013). Some clinical treatment rooms did not have suitable hand washing facilities for the preparation of medications, sterile supplies and dressing trolleys. The regional manager gave assurances that this had been actioned following the last inspection and they were awaiting delivery of equipment to upgrade and replace clinical sinks.

Daily and weekly fire safety checks were comprehensively maintained. Simulated fire drills and evacuations were undertaken on a regular basis to ensure the competency of staff regarding fire safety precautions. Staff induction training on fire precautions was comprehensive and had a emphasis on practical training. However, other issues

were identified regarding fire safety precautions and these were discussed in more detail under Regulation 28.

Regulation 11: Visits

Visiting was facilitated in line with current (April 2023) HPSC guidance. Visitors were welcomed into the centre and staff guided them through the infection control precautions.

Judgment: Compliant

Regulation 12: Personal possessions

Twin bedrooms were re-configured since the last inspection and now enabled both residents to freely access their wardrobes. Residents had a double wardrobe each and some had an additional single wardrobe to store their personal clothing. In other bedrooms some residents had an additional chest of drawers

Each resident had their own sling for use when being transferred.

Practices in the laundry demonstrated that staff had good working knowledge of chemicals and optimal temperatures to ensure clothing was laundered appropriately. On the day of inspection, laundry was up-to-date with no backlog ensuring residents clothing was returned quickly. Staff outlined the process for labelling clothing to ensure residents' clothing was returned.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the three-phase programme of works underway to upgrade the premises work remained incomplete regarding:

- the accessible outdoor space for 164 residents (18 residents in Clyda had a large enclosed garden)
- the specialist bath that was previously in situ was removed by the previous registered provider due to it's non-compliance with infection control guidelines, however, this had not been replaced to facilitate resident choice.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Action was necessary to ensure better oversight of food and nutrition in the centre as:

- there was a basket containing gluten free food items such as biscuits and cakes, however, these were open, uncovered and not stored in line with best practice guidelines regarding food storage, consequently, residents would not get fresh gluten free food
- presentation of some textured diets did not look appetising when served to residents
- the tea time menu was limited particularly for residents on modified diets and semolina being one of the regular offerings
- residents sitting together were not routinely served together in line with a normal dining experience.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Documentation was maintained on site of information provided upon residents' transfer to another health-care facility. This included residents' infection status and history, antibiotic treatment and multi-drug resistent (MDRO) status, was recorded. Discharge letters for when residents returned to the centre were seen as part of residents' documentation which enabled residents to be cared for in accordance with their current needs.

Judgment: Compliant

Regulation 27: Infection control

Notwithstanding the capital project plan in place to address the environment and equipment concerns, the following issues remained outstanding which had the potential to impact the effectiveness of infection prevention and control with the associated risk of transmitting a healthcare-associated infection within the centre:

- surfaces to furniture such as hand rails, bed frames, lockers, and bed tables were worn so effective cleaning could not be assured
- some of the hand-wash sinks did not comply with the Dept of Health clinical wash-hand basin guidance
- oversight and monitoring of cleaning throughout the centre required action as

some areas were visibly unclean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not ensured that adequate precautions regarding fire safety were taken:

- several fire safety door-stops were not operational in residents' bedrooms so fire doors in residents' bedrooms were held open with items such as chairs, bed tables which prevented the doors from acting as fire doors. This was a repeat finding,
- while fire safety training was extensive, staff interviewed lacked awareness of their role should a fire occur; this was particularly evident at night when there were reduced staffing levels
- hoists were maintained on corridors throughout the inspection, both on day and night duty, and partially obstructed emergency evacuation routes.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of care plans was examined and these showed mixed findings. There had been a lot of improvements since the previous inspection with some care plans having personalised information to inform individualised care. However many others did not have this detail and required action to enable staff provide individualised care. For example,

- one resident's assessment did not include details of their significant medical history. The care plan was not updated following blood results and referral by the GP to dietician for expert advise,
- while it was reported that residents were at risk of infection, it was not reported where or the type of infection the resident was prone to developing,
- spirituality and end-of-life care documentation of one resident showed that the information in their assessment was contradictory to the information stated in their care plan,
- one resident's assessment referred the reader to the document "This is Me" to gain insight into the resident and their life, however, there was very little information recorded here to inform staff about the very varied and interesting life this person had prior to becoming a resident in the centre,
- some care plans referred to a female resident as he, or a male resident as

she, throughout the care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to GP services who visited the centre on a weekly basis and when required. The service had the support of a consultant geriatrician which enabled better outcomes for residents, including residents in the dementia units. Residents notes showed they had timely access to specialist services such as psychiatry.

To support residents food and nutrition, they had access to speech and language and dietician specialities. Tissue viability nurse specialist support residents regarding their wound management when indicated; scientific measurements were used when monitoring wound status. Regular monitoring of bloods was facilitated in line with residents' diagnosis such as diabetes, cardiac disease, and poly pharmacy.

Judgment: Compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect residents from institutional practices:

- staff commenced assisting residents to bed or escorting them to their bedrooms from 5:30pm. Staff explained to the inspectors if a resident required the assistance of two staff on one unit, they were assisted to bed from 5.30pm and the majority of the residents that required two staff to assist them to bed, they were in bed before the day staff went off duty. One unit was seen in darkness at 8:30pm with all residents in their bedrooms, many awake, and not given the opportunity to sit in the day room to chat, watch TV, read or play a game of cards for example. Night-time medication rounds started at 7pm each evening so residents would potentially get their night sedation early
- some residents told inspectors that they were woken early and some residents received their morning medications from the night staff; early waking-up times was highlighted by residents as part of their meetings, however, no action was seen to be taken to address this issue.

All of the above was not acknowledged as institutional practice or recognised as work routines accommodating staffing levels and practices rather than the interests and rights of residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents rights were not fully enabled in the centre as follows:

- minutes of residents' meetings in 2023 were reviewed and issues raised by residents regarding staff not speaking English around them, which residents found disconcerting and made them feel uncomfortable. While there were some action plans in place to address other issues raised, an action plan was not available to show that their feedback was heard or demonstrate that actions would be implemented to mitigate recurrence of such episodes.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0038218

Date of inspection: 05/04/2023

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: The Number and skill mix of staff on the rosters are monitored in conjunction with the resident's needs using the Modified Barthel Dependency tool weekly for each household. Staff are provided with an enhancement as an interim measure to fill any vacancies and unpredicted gaps in rosters. Currently there are no foreseen gaps identified in all areas of the planned roster. When there are unplanned absences, all efforts are made to fill that vacancy including the completion of a risk assessment and plan to facilitate a staff member moving from another house and the roster updated. Weekly meetings continue to occur with the Group Director of HR and the local HR team to highlight any gaps in the roster due to unplanned sickness and the measures placed to reduce these gaps in future. Group HR are in collaboration with the local HR team to support with current recruitment needs and to address Recruitment and staffing issues in a timely and pro-active manner. Group HR provide additional support to the local HR team to assist with immediate interviewing across all disciplines to ensure that the highest quality talent is delivered to within the shortest time-period possible. The HR and Management team continue to monitor weekly sick leave reports to enable swift and appropriate action to have any absences filled where reasonably practical. Notwithstanding the above there will continue to be last minute and/or unexpected absences and through the focused HR drive currently been undertaken it is planned to establish a Relief Panel to augment HCA capability to fill such gaps. To aid in the ongoing management and monitoring of absenteeism a return-to-work meeting occurs following every absence which will aid identifying corrective action or supports required around same. Following the inspection, the duty manager on duty immediately updates the roster at the point of time ensuring that it is fully reflective of all staff on duty at any time and in addition further coaching was carried out on 29th April 2023 regarding updating of the roster to ensure all changes are reflected as initiated Daily staff allocation is discussed at handover by the RN, CNM & Senior HCA to ensure the skill mix is appropriately allocated to meet the dependency level of residents in each	

of the assigned houses and their individual sections.

The roster is checked daily, morning and throughout the day by the Duty Manager and or CNMs and Senior Management to ensure the appropriate staffing levels in planned ahead to deliver safe and effective care and updated as necessary. The planned roster & skill mix on both the day and night shifts are discussed daily to ensure a safe and effective 24 service is provided.
A new electronic rostering system is currently being rolled out across the Virtue homes with a date yet to be confirmed for Bridhaven.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
An ongoing project in all households for managerial duties to cover all aspects of practice. A new comprehensive duty list was devised for managers, RGN's and HCA's, which includes monitoring and supervision of delivery of care in each house. These quality assurance checklists are completed by ADONS and Clinical Nurse Managers in their assigned households to help assist Managers to document on the supervision and coaching of staff, this includes chatting with residents about their day with a focus on residents satisfaction and if they require anything else to enhance the quality of their daily life living in Bridhaven. In addition, a monthly schedule has been introduced to focus on a different area of practice each month, this involves supervision, auditing and coaching of staff during their work with a focus in a particular area to ensure each staff member has the knowledge and skills to deliver and document a high standard of care as per best practice. The focus for the month of May is Residents rights and is scheduled to be completed on Friday 02nd June 2023.
Recruitment process is ongoing for 1 CNM position and 1 Senior Night Nurse.
This will increase the supervision and monitoring of clinical practice in Bridhaven.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A full medication management audit was carried out post inspection including Medication Administration times, Medication Management Structures and Prescription and Administration Record to ensure all RN's are following best practice medication management guidelines. Further coaching of staff has been conducted to reinforce safe medication management. All Registered Nurses have received additional coaching on

safe medication management and medication administration record keeping as per the safe medication management guidelines and legislation.

Correction of the timing on the medication administration record and electronic Kardex was requested from the pharmacy on 14th April 2023 to ensure the relevant adjustments to their software package to reflect the times on the Kardex.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Following the inspection, a review of the induction day fire training content, schedule and training attendance was undertaken, and further individualized training developed and delivered to all staff to ensure that staff are familiar with compartments, PEEP sheets and evacuation procedures. This action was completed by Friday 21st April 2023.

A comprehensive review and analysis was carried out post inspection with residents, staff members and family involvement to ensure choice, respect and dignity are embedded as per best practice throughout the home. All residents' choices and preferences were reviewed, and changes implemented as needed and reflected in each of the residents individual person-centered care plans.

The Social Care Team roster was reviewed and amended to provide further options for late evening group activities or individual activities.

Meeting minute's structure reviewed; further education implemented regarding the completion of Action plans as part of the outcome of scheduled meetings with evidencing satisfaction with feedback outcome.

Duty roster reviewed for managerial oversight which will assist in determining if additional resources are required. Recruitment process ongoing for CNM position and Senior Night Nurse.
A review of management rosters is scheduled for completion by May 31st to ensure there is always adequate oversight of all practices and delivery of care.
Audit structure reviewed; further training implemented regarding the correct audit documentation and follow up on learning and implementation practice.
At group level a review of audit tools is scheduled to ensure all aspects of delivery of quality care is captured in audit tools. This is scheduled to be completed by July 30th, 2023.
As outlined in regulation 16 above, the daily Quality assurance check list completed by the management team will include checks on resident bedroom doors to ensure they are not held open by tables/chairs but replaced as needed.
Training to be scheduled for all managers and auditors to ensure all audits are completed

robustly and actioned as needed.
The Capital Projects manager is currently sourcing alternative mechanisms for in the event a resident chooses to keep their bedroom door open this can be facilitated safely as per their preference.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The final stage of securing the fence, which includes intercom access to ensure that all residents can freely utilize the secure garden space will be completed by 25th May 2023.

All Resident are informed at the pre-admission assessment stage that Bridhaven does not have a bath. The Residents make an informed decision regarding their choice of home based on their preference prior to admission.

A new maintenance electronic management system will be implemented on Monday 22nd May, which will assist with planning, prioritizing and implementing schedule of works including planned preventative maintenance and reactive maintenance works, which is included as part of our overall Continuous Improvement plan enhancing the overall Governance of Bridhaven Facilities.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Further training and coaching of kitchen staff commenced on 02nd May 2023 and is ongoing to ensure the food safety program is adhered to. Coaching is ongoing throught the home for all clinical staff along with kitchen staff in conjunction with the Dining Experience Project "Creating an Appetite for Life".

"Creating an Appetite for life" is a project which commenced prior to and is ongoing since inspection. This includes preparing and serving of food to ensure it is appetising which includes all food consistencies.

The menu was reviewed by dietician, SALT and executive chef on 27th April and a new menu implemented on Monday 8th May.

Futher coaching continues which includes serving of food to residents who prefers to sit together while dining, whilst respecting their wishes and preferences.

All of the above is monitored daily by the senior management team as part of the overall Governace management systems including monthly audits .

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All handsinks in bedrooms and communal area were audited and all identified items are on a phased replacement plan. 2 Clinical hand-wash sinks as per DOH clinical hand wash basin guidance are scheduled to be installed by May 30th 2023.
10 new bedside tables and lockers replaced, 30 rooms painted, 24 new chairs ordered following inspection. This forms part of our capital refurbishment 3 year plan. A comprehensive audit is scheduled for completion by 30th June 2023 of all handrails, bedside lockers, beds and all other furniture within the home, this will entail priortising replacement of furniture and fittings over the course of the next 3 years effective immediately.

Further review of the housekeeping roster with corrective action was taken. 2 newly recruited housekeeping staff received induction and additional coaching. Increased oversight and monitoring of cleaning in Bridhaven is in place since the date of inspection to ensure all areas are always clean. Daily and weekly audit schedule currently in place and findings of same are discussed at the morning governance meetings Monday, Wednesday and Friday and as needed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All door stops were audited for suitability, night time release mode and pro cell alkaline battery and replaced as needed. All door stops are currently working.
2 new types of electric doorguard and 14 new noise detector doorguards were fitted since inspection.
PEEP sheets were reviewed and were in place to ensure the residents preferences are upheld and their safety risk assessed and highlighted red on the compartment list and evacuation sheet. Care plans were reviewed which indicates in the event of a fire their door is to be attended to and closed first.

As part of the increase Governance plan a daily auditing of the door-stops is scheduled as part of the maintenance daily duties and corrective action taken immediately as needed.

Further individual training was conducted post inspection to ensure staff understood how to evacuate their residents and identify the individual compartments. All staff are confident about PEEP sheets and the information outlined in the PEEP sheets.

New storage areas were identified for hoists storage in Blackwater, Awbeg, and Lee Households and removed from the emergency evacuation routes.
As an interim measure while construction of additional storage spaces for lifting machines and trolleys are ongoing, we have allocated three rooms for storage of lifting machines as part of the fire safety plan.
Two overall house fire & evacuation drills are scheduled for Wednesday 17th May which will take place on the night shift and on the day shift. Daily walk around audit and staff coaching was implemented and ongoing regarding same.

Weekly evacuation simulation drills have been completed and continue to occur which includes information on Resident's Personal Emergency Evacuation plan and the practical demonstration and theory of Compartments.

Records are maintained of each simulated fire evacuation drill including the length of time to evacuate a compartment, the scenario and the learning that was identified during the simulation fire evacuation. The above forms part of the monthly unannounced night audit tool.

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:
Further coaching on care planning and updating of information as changes occur was reinforced with ongoing monotoring and auditing in place.

Care plans were reviewed on 02nd May to establish where the gaps were with regards to infection documentation. Coaching provided and ongoing review of care plans on a daily basis to ensure there are no discrepencies and that the gender is entered correctly.

For all new admissions, a comprehensive assessment, medical history and clinical risk assessment forms part of their care plan which is completed within 48hr of admission. An audit is completed to review the admission documentation to ensure compliance within the timeframe as per policy.
A gap analysis is ongoing with continuous improvements plans in place which includes coaching and teaching of staff. A Quality Improvement Plan is developed for all improvements in Bridhaven and group wide which is part of the monthly Governance Meeting along with the Quality Safety & Risk meetings and reports.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
An audit was initated immediately post the inspection and is our ongoing project for the month of May. This audit reviewed the residents preference for going back to bed, their choice of evening activity and their care plans updated to reflect their preferences. The audit highlighted that staff know their residents "little bits" / preferences well and respect their choice.
In consultation with various family members over the course of the last few weeks they stated how well the care staff know their family member and how comfortable they are knowing their family member is cared for in a respectful and meaningful way. This feedback/compliment was welcomed and shared with staff and entered into our comments/complaints & feedback system.
Epicare documentation system was upgraded to assist with capturing the time each residents goes back to bed as per their preference and the activities they participated in.
A project on Residents Rights is ongoing throughout the month of May.
All comments and concerns are taken serious and actioned immediately. Task orientated practices are not promoted in Bridhaven and staff are trained and coached to deliver care in a respectful and meaningful manner as per the residents preferences.
Staff are spontanous and act on the the residents requst and wishes at the time of their request. Residents are offered choice and attend activities of their choice. Carer led activities are ongoing to meet the individual or group request of the residents which is reflected in our staff values awards, we are proud of this . All care plans are under review to ensure this is reflected throughout the residents holisitic care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A series of unannounced night time audits was initiated immediately post the inspection which included;
• review of medication administration records to ensure that medications were prescribed and administered in accrdance with individual residents daily activity preferences and in accordnace with Medication Management legislation and action was completed by Friday 14th April.
• An indepth audit was completed of individual residents preferences for time of going to bed or indeed choosing to go to their room to watch Television and their care plans updated to reflect the residents preference. This project is ongoing and is due for completion on Friday 2nd June.
• Unannounced night time audits will continue to occur by the management team in

Bridhaven ,the regional director/RPR and the DQSR at a minimum twice monthly.
• Review of evening/night time rosters occuring to ensure adequate and safe staffing to facilitate residents bed time choosing .
• Resident & Relative Surveys are scheduled monthly and collated by the end of each month. The survey is focused on one household each month and actioned immediately. This is evident in the action plan and communicated to Residents at the time of actioning and an overall discussion as part of the Resident & Relative Meetings.

While the audit reviewed the residents preference for going back to bed, their choice of evening activity and their care plans updated to reflect their preferences. Staff evidently knew their residents preferences well and respect their choice.
The Epicare documentation system was updated to assist with capturing the time each residents goes back to bed as per their preference.
Comfort and safety checks were reviewed and further coaching initiated regarding the the Comfort and safety check practice at night. All medication charts were reviewed and actions taken as necessary to ensure the residents rights are upheld and respected.

A memo was generated on receipt of this information by our Social Care Manager dated 6th February 2023 as this was part of our action plan. This information was relayed to the residents and reassurance provided which the resident expressed their appreciation. Further discussion and coaching have commenced and is ongoing to ensure all action plans are updated at the time the action was taken.
Some of the actions for Regulation 9 also form part of the response for Regulation 8.
A review was completed post inspection including the process of communication of the scheduled weekly activities. The weekly schedule of activities is displayed in all prominent areas in each household and in the resident's room and is also communicated daily to each of the residents that live in Bridhaven.

This is monitored through social and recreation audits, resident feedback, and delivery of social program at house level.

Unannounced Observational audits will be completed on an ongoing monthly basis by the management team and RPR commencing Week 23rd May 2023, focusing on the lived experience of the residents and the delivery of person-centered care.

The management team will also complete unannounced observational audits in each household using the QUIS audit tool. Resident surveys are scheduled throughout the resident's journey in Bridhaven with corrective actions taken, documented and feedback provided individually and through the Resident & Relative Meetings.

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	06/04/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/05/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	24/05/2023

Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	30/05/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/05/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/05/2023
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.	Substantially Compliant	Yellow	30/05/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Substantially Compliant	Yellow	30/07/2023

	appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/12/2023
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	06/04/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	18/04/2023
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	Substantially Compliant	Yellow	18/04/2023

	procedure to be followed in the case of fire.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	18/04/2023
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	30/05/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	14/04/2023
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	30/05/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably	Substantially Compliant	Yellow	30/04/2023

	practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.			