

Health Information and Quality Authority  
Social Services Inspectorate

Regulatory Monitoring Visit Report  
Designated centres for older people



<b>Centre name:</b>	Bray Manor
<b>Centre ID:</b>	0018
<b>Centre address:</b>	Meath Road
	Bray
	Co. Wicklow
<b>Telephone number:</b>	01-2863127
<b>Fax number:</b>	01-2042467
<b>Email address:</b>	costellocare@eircom.net
<b>Type of centre:</b>	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
<b>Registered providers:</b>	Barravore Ltd
<b>Person in charge:</b>	Geraldine Cleary
<b>Date of inspection:</b>	25 October 2011
<b>Time inspection took place:</b>	<b>Start:</b> 10:30 hrs <b>Completion:</b> 18:30 hrs
<b>Lead inspector:</b>	Angela Ring
<b>Support inspector:</b>	None
<b>Type of inspection:</b>	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced
<b>Purpose of this inspection visit:</b>	<input checked="" type="checkbox"/> Application to vary registration conditions <input type="checkbox"/> Notification of a significant incident or event <input type="checkbox"/> Notification of a change in circumstance <input type="checkbox"/> Information received in relation to a complaint or concern <input checked="" type="checkbox"/> Regulatory Monitoring Visit Report

## About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, the inspector examines how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

**Additional inspections** take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- for centres that have not previously been inspected within a specific timeframe, a one-day regulatory monitoring visit may be carried out to focus on key regulatory requirements.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

## About the centre

### Description of services and premises

Bray Manor is a period residence which has been extended and refurbished to become a residential service for older people. It is located in a residential area adjacent to the seafront in Bray, County Wicklow and is within walking distance of the promenade, train, dart stations and bus stops. The centre provides 25 places and provides residential, respite and convalescence care to older people. There were 23 residents at the time of inspection, some of whom had dementia, a mental health condition or other medical condition. The centre has the character of a domestic home.

The facilities of the centre are on the ground, first, and second floor, with stair lift access to the upper floors. The main entrance is on the ground floor at the front of the building. The entrance opens into a conservatory area with seating and there is a hallway in this area. The hallway leads to the main sitting room, a smaller sitting room, the dining room, kitchen, treatment room, laundry, assisted bath with toilet, assisted shower, staff toilet, and a sluice room with bedpan washer. Bedroom accommodation on the ground floor consists of six single bedrooms, five of which have an en suite toilet and wash-hand basin and two twin rooms, one of which has an en suite toilet and wash-hand basin. On the first floor there is a nurses' station, a sitting room, an assisted shower, one single bedroom, and one three-bedded room with an en suite toilet and wash-hand basin.

On the second floor there is one four-bedded, one three-bedded room, one twin room with an en suite toilet and wash-hand basin and one other twin room. There is one assisted shower on this floor.

The conservatory on the ground floor looks out onto the attractive front garden with seating and garden furniture. At the back of the building there is a small secure courtyard with seating and tables.

There is limited on street parking.

### Location

Bray Manor is located adjacent to the seafront in Bray, Co Wicklow. It is within a residential area and there are shops within walking distance

<b>Date centre was first established:</b>	1 September 1997
<b>Number of residents on the date of inspection:</b>	23 + 2 in hospital

Dependency level of current residents	Max	High	Medium	Low
Number of residents	4	4	14	1

### Management structure

Baaravore Ltd is the Provider and the directors of the company are husband and wife, Shay and Sara Costello. Shay Costello is named as provider on behalf of the company and Sara Costello is the Director of Care for the centre. They are also the owners of another residential care centre (Costello's Nursing Home) which is located in Co. Longford. Shay Costello is responsible for the overall governance and maintenance and Sarah is responsible for staff education and policy review.

Geraldine Cleary is the Person in Charge and reports to the Provider. The Provider manages the accounts and the premises. All nurses, household staff, and kitchen staff report to the Person in Charge while the care assistants and senior care assistants called care managers report to the nursing staff.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1	3	1	1	0	1 Activity coordinator

## Summary of findings from this inspection

Overall the inspector found that ongoing improvements were made in all aspects of the centre. The providers and person in charge were knowledgeable of and committed to meeting the requirements in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. There was a skilled staff group with adequate staffing levels. The inspector followed up on the actions from the previous report, these included reviewing the premises issues, care planning and risk management and found that some improvements had been made in these areas.

The inspector was satisfied that the healthcare needs of residents were met. Medication was administered safely and residents had access to range of healthcare services. Care plans were in place for all residents and they were regularly reviewed. The quality of residents' lives was enhanced by the provision of activities during the day. The inspector found that the premises were homely, clean and well maintained. However, there were some improvements required in recording fire procedures, risk management, providing adequate storage and a smoking shelter, care planning, use of restraint and the policy on the prevention, detection and response to elder abuse. These areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

## Comments by residents and relatives

The inspector met with several residents and a relative. All of the feedback received was positive and several spoke of the commitment of the person in charge and the kindness she displayed to all residents. Residents said they felt safe in the centre and several said they had opportunities to leave the centre with their family or with a staff member. All residents spoken to said they enjoyed their food and their individual preferences were met. The relative of a resident described the staff in the centre as like a family and was very satisfied with the care and attention her relative received.

## Governance

### Article 5: Statement of Purpose

The inspector found that the statement of purpose accurately described the service that was provided in the centre. It was kept under review by the providers and it was made available to residents.

### Article 15: Person in Charge

The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre since 2005. She continued to keep her skills up-to-date by undertaking on going professional development and attending study days. She demonstrated an adequate knowledge of her responsibilities as outlined in the Regulations and demonstrated good organisational skills. She was supported in her role by the provider and the nurses who deputised in her absence. The inspector found that she was very knowledgeable about residents' needs and their backgrounds and often acted as an advocate for residents by sourcing external services in the community for them. She was observed engaging well with residents and relatives throughout the day of inspection.

### Article 16: Staffing

The inspector randomly examined the files of staff members and found that they contained all of the information required by the Regulations. The inspector found that there were good induction arrangements for newly employed staff member and this was confirmed by speaking with staff. There was also evidence of the person in charge monitoring the performance of staff through the use of staff appraisals.

The inspector carried out interviews with staff members and found that they were knowledgeable of the residents' individual needs, the centre's policies, fire procedures and the procedures for reporting alleged elder abuse. The inspector saw them responding to residents' needs in an informed and kind manner. Staff told the inspector that they enjoyed working in the centre and they felt very well supported by the provider and person in charge. The inspector found that staff were enthusiastic about their work and described their relationships with colleagues and residents as like a "family". There was a low turnover of staff and many of the staff had worked in the centre for several years.

Staff told the inspector that they attended handover meetings twice a day which kept them informed of residents' changing needs.

One of the company directors explained that she was responsible for providing education to staff and there were records to indicate that staff had received recent training on responding to behaviours that challenge, the prevention, detection and response to elder abuse and manual handling.

The inspector found that there were adequate numbers and skill-mix of staff on duty to meet residents' needs on the day of inspection. Residents and relatives agreed that there were adequate staff on duty to meet their needs. The inspector viewed the staff rota and found that the planned staff rota matched the staffing levels on duty.

### **Article 23: Directory of Residents**

The inspector reviewed the directory of residents and found that it was updated to include recent transfers to hospital.

### **Article 31: Risk Management Procedures**

The inspector found that practice in relation to the health and safety of residents and the management of risk promoted the safety of residents, staff and visitors. The inspector reviewed the emergency plan and found that it was sufficient to guide to staff in the event of an emergency.

There was a health and safety statement in place which related to the health and safety of residents, staff and visitors. There was a risk management policy in place, which addressed the risks identified in the Regulations such as violence and aggression, assault, residents going missing, self-harm and accidental injuries to residents and staff.

In relation to residents going missing, the staff told the inspector of regular drills carried out where staff would practice their response to a resident going missing in order for them to become familiar with the centres procedure.

Overall the inspector found that the ethos in the centre was to promote residents' independence as much as possible and several residents were seen mobilising independently throughout the day. While this practice is encouraged, the inspector found that improvements were required to ensure that the risks of residents falling were minimised whilst maintaining independence. The inspector reviewed the incidents that occurred since the previous inspection and found that there were a number of falls with two resulting in an injury to a resident in the previous four months. Incident forms were completed for each incident. However, there was little evidence of an analysis being carried out to determine the root cause of the fall and the preventative measures to be taken to prevent its reoccurrence. The inspector reviewed the residents who were "frequent fallers" and found that these residents had poor balance but wished to remain as independent as possible. The inspector found that staff were aware of residents who had a high falls risk and closely monitored them throughout the day. There were risk assessments and care plans developed for residents identified as a high falls risk. However, the residents' risk assessment and care plans were not always updated following a fall. There was some evidence of auditing falls, where data was collected on the number of falls and location of falls in the centre in the previous six months to determine patterns. The person in charge explained that a staff member now commenced duty at 7.00 am as this was deemed to be high risk time for falls. The inspector reviewed the centre's

policy on falls and found that it was not comprehensive enough to guide staff on the preventative strategies and interventions to be used for residents who experienced falls.

The inspector noted that a small number of residents smoked in their bedrooms, this was identified as a potential risk in a previous inspection. The inspector found that although smoking risk assessments were completed on these residents and there were care plans developed from the assessments, the care plans did not adequately identify the interventions in place to control the risk. In addition, the risk management policy did not cover the identification and assessment of risks associated with residents smoking in their bedrooms.

**Article 39: Complaints Procedures**

The inspector found evidence of good complaints management. The complaints policy was reviewed and it was displayed in prominent position. However, the complaints policy displayed differed from the complaints policy in the centres policy folder and therefore the centres policy required clarification.

The inspector reviewed the complaints log and saw that very few complaints were recorded from residents and relatives and there was evidence of complaints being appropriately responded to by the person in charge.

**Article 36: Notification of Incidents**

Practice in relation to notifications of incidents was satisfactory.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

**Resident Care**

**Article 9: Health Care**

The inspector found that there was good access to medical practitioners in the local area and there was evidence that residents were regularly reviewed by their general practitioner (GP). In addition to GP services, there was evidence that residents had access to mental health services where necessary and some residents attended a local mental health day centre. The person in charge explained how she sourced community services for residents, such as dental reviews, when necessary and she gave examples of how she acted as a residents advocate by arranging appointments with consultants when necessary.

The inspector reviewed a sample of residents' care plans and noted that nursing assessments and clinical risk assessments were carried out for all residents. There was a record of the resident's health condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty which was an improvement since a previous inspection. Care plans were in place which identified residents' needs and there were three-monthly reviews completed. However, the involvement of residents in the development and review of their care plans required improvement. The inspector also noted deficits in the nursing records which were not in line with best practice guidelines, all entries were not dated, timed and signed and some of the documents did not include the resident details.

The inspector reviewed the nursing notes of a small number of residents with wounds and found that there were records in place to demonstrate assessment and treatment plans.

The inspector reviewed the nursing notes of some residents whose behaviour was sometimes seen as challenging. There was a challenging behaviour policy in place and the provider gave training to staff on responding to behaviours that challenge. The inspector observed staff responding appropriately to residents with behaviours that challenged.

The inspector found that behavioural books were maintained to record behaviours. However, there was inadequate evidence of the triggers to the behaviour, a description of the behaviour and the measures to be taken to respond to the behaviour.

The provider told the inspector that she had recently attended training on the new HSE policy on the use of restraint and she had plans in place to update the centre's policy in line with the new national policy and to provide training to staff. The inspector noted that there were a small number of bedrails and recliner chairs used for residents. The inspector reviewed files for a sample of these residents and found that there was an assessment completed for the use of the restraint and there was some documentation on the release of the restraint. However, the inspector found that improvements were required in the initial assessment for the use of bedrails as there was no evidence of the risks of using restraints being considered or evidence of alternative strategies being tried prior to the use of restraint in line with the centres policy.

The inspector saw documentary evidence to demonstrate that residents' weights was recorded each month and the person in charge monitored any changes such as significant weight loss. Nutritional risk assessments were used to identify residents at risk and there was evidence of residents being prescribed supplements where necessary. The person in charge explained that she had access to the services of dietetics and speech and language therapy when required.

There were some opportunities for all residents to participate in activities appropriate to his or her interests and capacities. The inspector met with the activity coordinator who was employed in the centre five days per week. There was evidence that residents engaged in activities such as live music sessions, quizzes, newspaper reading, reminiscence, art and walks outside. The activity coordinator knew the

residents well and was seen responding to each of them as individuals. She provided individual sessions for residents with high dependency needs and these included massage, poetry reading and a chat. Some residents were seen going out with family members and another resident went out to the shops most days.

### **Article 33: Ordering, Prescribing, Storing and Administration of Medicines**

The inspector found evidence of good medication management processes. There was a comprehensive medication management policy which provided guidance to staff. The person in charge told the inspector that the pharmacist was completing medication audits and there was documentary evidence to support this. The staff nurse on duty told the inspector that she and her nursing colleagues attended training on best practice in medication management and there were records to support this.

The inspector noted that the centre's policy indicated that the maximum dose of PRN (as required) medication should be recorded on the prescription in line with best practice. However, a review of the prescriptions indicated that this practice was not being carried out and this could lead to medication administration errors.

The inspector found that medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift.

### **Article 6: General Welfare and Protection**

The inspector found that measures were in place to safeguard residents. Records showed that staff had attended a training course on the prevention, detection and response to elder abuse in 2011. The inspector found that staff spoken to were aware of their responsibilities in reporting suspected elder abuse to the person in charge. Residents confirmed to the inspector that they felt safe in the centre.

The inspector found that the centre-specific elder abuse policy gave guidance to staff on the types of abuse and the need to report suspected abuse. However, it did not provide adequate guidance on the procedures to follow in the investigation of an allegation of abuse.

### **Article 20: Food and Nutrition**

The inspector was satisfied that residents received a nutritious and varied diet. The inspector noted that meals were hot, well presented and tasty. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and with staff. The inspector saw evidence of residents participating in meaningful engagement as one of the residents had responsibility for arranging the flowers on the tables in the dining room. The person in charge maintained a comprehensive folder of each resident's dietary requirements and preferences and a

copy was available in the kitchen, this ensured that all residents' needs were met. The inspector reviewed evidence of a recent audit of the centres menu carried out by a dietician to assess its nutritional value with some improvements identified. Staff were seen assisting residents discreetly and respectfully if required. Residents confirmed that they enjoyed the food. The inspector saw residents being offered drinks throughout the day and found that the chef had a good knowledge of each resident's dietary needs and preferences.

## **Environment**

### **Article 19: Premises**

The centre was clean and homely throughout. The inspector found that most of the bedrooms were personalised and had adequate space and residents had access to locked personal storage space. There was new screening around beds provided since the previous inspection.

The provider was aware that the three multi-occupancy rooms would not be acceptable after 2015 and he told the inspector that he was in consultation with architects and engineers to address this.

The inspector noted that some of the recliner chairs were ripped and in poor repair, this did support the dignity of residents. The inspector also noted that the chairs in the dining room did not meet residents' needs due to their design as there were no hand supports. The provider was aware of this issue and stated that new dining chairs had been purchased and was awaiting delivery.

There was a small secure outdoor area for residents to access unaccompanied with a seating area. Some residents were seen sitting outside getting some fresh air.

There were some areas for improvement identified in the previous report which had still not been addressed. There was still a lack of storage with hoists stored in residents' bedrooms and there was an inadequate smoking shelter provided for residents.

### **Article 32: Fire Precautions and Records**

The procedures for fire detection and prevention required some improvement. The provider explained that he had a new contract with a fire safety company who would provide training and guidance to him on all aspects of fire procedures such as checking schedules and best practice. The inspector reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were monitored. The provider explained that new fire doors had been placed in the centre to support their procedure for horizontal evacuation. There was evidence of fire drills taking place every 6/8 weeks and this was confirmed with staff. However, the inspector found that there were no records to demonstrate that there were daily

inspections of fire exits and fire alarm panel to ensure they were in good working order. The person in charge told the inspector that these checks were always carried out but there was no record maintained.

The inspector read the training records which confirmed that most staff had attended training on fire prevention and response in August 2011 and further training was planned on 15 and 25 November 2011. The inspector found that all staff spoken with were clear about the procedure to follow in the event of a fire.

## **Closing the visit**

At the close of the inspection visit a feedback meeting was held with the providers and person in charge to report on the inspection findings, which highlighted both good practice and where improvements were needed.

### **Acknowledgements**

The inspector wish to acknowledge the co-operation and assistance of the residents, relatives, provider and staff during the inspection.

### ***Report compiled by:***

Angela Ring

Inspector of Social Services  
Social Services Inspectorate  
Health Information and Quality Authority

27 October 2011

## Provider's response to inspection report\*

<b>Centre:</b>	Bray Manor
<b>Centre ID:</b>	0018
<b>Date of inspection:</b>	25 October 2011
<b>Date of response:</b>	18 November 2011

### Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

#### 1. The provider has failed to comply with a regulatory requirement in the following respect:

There were inadequate records being maintained of all fire practices which take place at the designated centre.

#### Action required:

Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.

#### Reference:

Health Act, 2007  
Regulation 32: Fire Precautions and Records  
Standard 26: Health and Safety

\* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Since the inspection scheduled mandatory training has again taken place. Along with a fire safety trainer we are reviewing the clinical emergency plan and our record keeping and all records will be kept appropriately</p>	<p>31/11/2011</p>

**2. The provider has failed to comply with a regulatory requirement in the following respect:**

The falls policy was not comprehensive enough to guide staff as it did not encompass the centres procedure for post fall assessment and review.

The risk management policy did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

The risk management policy did not cover the identification and assessment of risks associated with smoking in bedrooms and the precautions in place to control the risks identified.

**Action required:**

Update the falls policy to ensure it is comprehensive enough to guide staff on the centres procedure for post fall assessment and review.

**Action required:**

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

**Action required:**

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

**Reference:**

Health Act, 2007  
 Regulation 31: Risk Management Procedures  
 Standard 26: Health and Safety  
 Standard 29: Management Systems

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Action 1 - The falls policy is being reviewed and updated to ensure that it is comprehensive enough to guide staff on the procedures for post fall assessment and review.</p> <p>Action 2 - As above - this is being reviewed and implemented.</p> <p>Action 3 - Again this is being reviewed and updated and we are in the process of implementing changes as required to control risks.</p>	<p>31/12/2011</p> <p>31/12/2011</p> <p>31/12/2011</p>

**3. The provider has failed to comply with a regulatory requirement in the following respect:**

The policy on elder abuse did not outline the procedure to follow in the investigation of an allegation of abuse.

**Action required:**

Put in place a policy on and procedures for the prevention, detection and response to abuse.

**Reference:**

Health Act, 2007  
 Regulation 6: General Welfare and Protection  
 Standard 8: Protection

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Whilst there is mandatory training and a policy and procedure in place we will make the policy and procedures in this area more robust and in line with current best practice.</p>	<p>31/12/2011</p>

**4. The provider has failed to comply with a regulatory requirement in the following respect:**

There was no evidence of the risks of using restraints being considered or evidence that alternatives were used prior to the use of restraint.

<b>Action required:</b>	
Provide a high standard of evidence based nursing practice.	
<b>Reference:</b>	
Health Act, 2007 Regulation 6: General Welfare and Protection Standard 21: Responding to Behaviour that is Challenging	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Prior to the use of any form of restraint we undertake a series of risk assessments and discuss the issue with the resident, their families and the doctor .The use of restraint is minimal and is recorded and is also reviewed regularly.</p> <p>The provider, Sarah Costello, has attended training on the new national guidelines and we will roll out the course to all staff and introduce the new best practice in relation to restraint. One area of this training will be implementing new assessments of the risks of using restraint and evidence of alternatives considered. This training will be delivered to small groups of staff over coming weeks.</p>	31/01/2012

<b>5. The provider has failed to comply with a regulatory requirement in the following respect:</b>
Some of the nursing records did not comply with best practice clinical guidelines as outlined in the centre's policy.
There was little evidence of resident involvement in the development of their care plan.
Falls risk assessments and care plans were not always updated following a fall.
<b>Action required:</b>
Review the nursing records to ensure that they comply with best practice clinical guidelines.
<b>Action required:</b>
Set out each resident's needs in an individual care plan developed and agreed with the resident.

<b>Action required:</b>	
Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at 3-monthly intervals.	
<b>Reference:</b>	
Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 6: General Welfare and Protection Standard 10: Assessment Standard 11: The Resident's Care Plan	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:	
We have already made changes to improve the nursing records to ensure they are in compliance with best practice. We have scheduled study and training days for staff nurses in the coming weeks to make further improvements in our clinical documentation.	31/01/2012
Following inspection, all staff nurses have reviewed the plan of care for their primary residents and identified the areas that should be more robust.	31/01/2012
Whilst all residents have numerous individualised care plans and assessments all of which are reviewed monthly, we intend to develop an enhanced holistic review of all our clients, we have developed the format and will begin implementation over the next two weeks and this will be audited within six weeks. All falls risk assessments and care plans will be reassessed after a fall.	Completed and ongoing

<b>6. The provider is failing to comply with a regulatory requirement in the following respect:</b>
Some of the recliner chairs were ripped and in poor repair.
There were inadequate storage facilities. The inspector observed assistive equipment such as hoists and commodes stored in residents bedrooms.
There was no designated smoking area and residents had to smoke outside in the courtyard including during cold weather.

<b>Action required:</b>	
Maintain the equipment for use by residents or people who work at the designated centre in good working order.	
<b>Action required:</b>	
Provide suitable storage facilities for equipment.	
<b>Action required:</b>	
Ensure the physical design and layout of the centre meets the needs of each resident.	
<b>Reference:</b>	
Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Our maintenance man has undertaken a survey of all furniture any chairs with defects will be sent for repair. We are aware that storage is restricted and have tried to create several areas for storage with limited success. We have had a meeting with a builder and asked him to explore possible areas to create storage. We have also asked him to design a pergola type smoking area for smokers.</p>	28/02/2012

## Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 14: Medication Management	Put a plan in place to ensure that the medication policy is adhered to in relation to the practice of prescribing as required medication.
Standard 21: Responding to Behaviour that is Challenging	Put a plan in place to ensure that the needs of each resident with behaviour that is challenging are managed and responded to effectively in an environment that promotes well being and has the least restrictions.
Standard 6: Complaints	Ensure that the complaints policy displayed in the centre corresponds with the centres policy.

**Any comments the provider may wish to make:**

### Provider's response:

We thank Ms. Ring for the manner in which she conducted the inspection. She interacted well with all residents and staff and was professional in all areas. Her explanation of the process and requirements was excellent. Her feedback was clear and precise and consistent with the draft report. We are pleased that Ms. Ring's findings highlight the homeliness of Bray Manor and that the close bond between our staff and residents was acknowledged. As providers, we are proud of Geraldine and the team of staff who have implemented many improvements and who provide a warm and caring environment for our clients. We are committed to ongoing staff training and improvements in the quality care we wish to provide for our residents

**Provider's name:** Sarah and Shay Costello

**Date:** 17 November 2011