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:	Newbrook Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Ballymahon Road, Mullingar, Westmeath
Type of inspection:	Unannounced
Date of inspection:	18 July 2024
Centre ID:	OSV-0005702
Fieldwork ID:	MON-0042447

About the designated centre

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

Newbrook Nursing Home is registered to accommodate 119 residents. It consists of two separate buildings, a single storey and a two story building known as Newbrook 1 and Newbrook Lodge respectively. It is located in a residential area, within a few minutes drive from the town of Mullingar. Both buildings are surrounded by spacious landscaped gardens and there are secure courtyard garden spaces attached to each building that residents can use safely. One of the courtyards was set out in a traditional shopping streetscape design to provide interest for residents. Residents are accommodated in single and double rooms.

The centre provides care to residents over the age of 18 who have care needs related to aging, dementia, intellectual disability, physical disability and acquired brain injury. Care is provided on a long and short term basis and residents who require periods of convalescence, palliative care or rehabilitation are accommodated.

The aims of the centre as described in the statement of purpose is to provide a high standard of evidenced based care and to ensure that residents live in a comfortable, clean and safe environment that they can consider a "home away from home".

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	108

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 18 July 2024	09:45hrs to 18:00hrs	Lorraine Wall	Lead
Friday 19 July 2024	09:45hrs to 18:00hrs	Catherine Rose Connolly Gargan	Support

What residents told us and what inspectors observed

Overall, inspectors observed that most residents in the centre enjoyed a good quality of life and their rights were respected. However, some improvements were required in one unit in the designated centre to ensure the residents accommodated in this unit were supported to utilise their communal spaces and vary their daily routines.

This was an unannounced inspection and on arrival, the inspectors were met by the person in charge. Following an introductory meeting, the person in charge and a clinical nurse manager accompanied the inspectors on a walk around the premises. The inspectors met with residents and staff and observed that there was a welcoming and happy atmosphere in the centre as residents prepared for their day independently or with staff assistance as needed. Staff were observed to be attentive to residents' needs and were kind, patient and caring in their interactions with residents as they assisted and cared for them.

Residents spoke positively in their feedback to the inspectors about their experiences of living in Newbrook Nursing Home. Their comments regarding the staff included that 'staff were wonderful', 'always willing to help' and 'always cheerful and smiling'. Residents said they were 'comfortable', that they enjoyed their meals' and that their care needs were well met in the centre.

The centre premises was arranged in two separate buildings known as 'Newbrook One' and 'The Lodge'. Each building has a variety of communal rooms and safe outdoor areas for residents. The inspectors observed that the outdoor gardens and courtyards well maintained and landscaped with flowerbeds, shrubs and small trees, One of the outdoor areas in Newbrook One was painted and decorated in a traditional shopping streetscape style. The inspectors observed that all the outdoor areas for residents' use had suitable outdoor seating and could be accessed by residents as they wished.

The inspectors observed that a variety of communal sitting rooms and dining areas were provided in both buildings for residents' use. However a number of these rooms were not made available to residents on the day of the inspection. Inspectors observed that with the exception of five high dependency residents who spent their time in a small sitting room on the ground floor, the majority of the residents in The Lodge spent their day in the large sitting room on the first floor. This room was used for activities, socialising and for meal times. It was not clear why residents were not offered the choice to go to the spacious dining room on the ground floor. This room was used by a small number of residents who sat together at one of the dining tables and enjoyed lunch together. The remaining tables were not set for residents meals and remained unused throughout the day of the inspection. In contrast the sitting room on the first floor became crowded when staff brought in additional

tables at lunch time for residents to eat from. Inspectors observed that residents could not move around the room with ease during this time.

Furthermore the inspectors observed that on the day of the inspection a residents' therapy room was used by staff for a handover of care meeting and for one staff member to take their meal break.

Staff were allocated to remain with residents in the communal rooms at all times and this ensured that a staff member was available to respond to residents' needs for assistance without delay. Residents' social activities in each of the communal rooms were led by a member of staff and residents were observed to be engaged and mostly participated in the social activities taking place. Residents told the inspectors that they were looking forward to the the live music session that took place in one of the sitting rooms in the afternoon. Residents with increased support needs were cared for in a less busy sitting room in each building and were supported to participate in meaningful one-to-one social activities that suited their individual capacities. Residents who spent time in their bedrooms received one-to-one visits from the activity coordinators and staff.

A local priest celebrated Mass for residents in the centre each week and a number of residents expressed their satisfaction with being able to continue to attend a weekly Mass in the centre. A large church was located in 'Newbrook One' and an oratory was available in 'The Lodge'. Residents were observed visiting the church and the oratory throughout the day.

The centre was observed to be warm and clean throughout. The communal areas were nicely decorated and furnished with comfortable seating for the residents' use. Residents' own artwork was framed and displayed along the corridor walls. The inspectors observed that a variety of other ornaments and traditional memorabilia made the residents' lived environment homely and familiar to them. Many of the residents' bedrooms were personalised with their family photographs and personal belongings, including their artwork, ornaments and soft furnishings. Some residents chose to bring small items of their favourite furniture from their homes in the community for their continued use in their bedrooms and this was facilitated. Residents in twin bedrooms had individual televisions, which facilitated them to independently choose what programmes they wanted to view and listen to. Residents had access to televisions, radios and the local and national newspapers.

Residents spoke about the residents' meetings they attended and welcomed this forum to give their feedback on the service. The residents told the inspectors that the centre had access to a wheelchair accessible bus and they were involved in planning day trips.

Residents' visitors were made welcome and were seen by the inspectors coming and going throughout the day of the inspection.

Residents told the inspectors that their general practitioner (GP) visited them without delay whenever they needed medical care. A number of residents expressed high levels of satisfaction that a physiotherapist was available to them on one and a

half days each week and told the inspectors that the physiotherapist was supporting them with improving their mobility.

Residents told the inspectors that they felt very safe and secure in the centre and that they would speak to a staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received.

The next two sections of the report, capacity and capability and quality and safety will describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that the designated centre was well managed. The inspectors found that improvements had been made since the previous inspection in July 2023 however more focus and effort were now required to address the non compliance found on this inspection and to ensure residents received a safe and appropriate service in line with their assessed needs and preferences for care and daily routines.

This was an unannounced inspection carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to follow up on information of concern that had been received by the Chief Inspector since the last inspection. The inspectors found that the information received was partially substantiated on this inspection and these findings are discussed further under the relevant regulations in this report.

Newbrook Nursing Home Unlimited Company is the registered provider for this designated centre. The designated centre is registered to accommodate up to to 119 residents. The provider entity is represented by a company director who attends the designated centre regularly. There was a clearly defined management structure in place. The management team consisted of the provider, a regional operations manager and the person in charge who was supported in their day-to-day role by an assistant director of nursing and two clinical nurse managers. A clinical nurse manager was located in each of the two buildings, Newbrook One and The Lodge. A team of nursing staff provided clinical care and support along with health care assistants. The clinical care team were supported by activity, housekeeping, catering, laundry and maintenance staff making up the full complement of the staff team.

There were enough staff on duty on the day of the inspection to meet the needs of residents and to support residents to spend their day as they wished. However, a review of the staff rosters found that there was only one cleaner on duty in 'The Lodge' at weekends even through there was no evidence of any reduction in

residents' needs. This arrangement did not ensure adequate cleaning staff resources were available each day to ensure cleaning requirements were completed.

The provider employed a dedicated trainer to support training of staff and the person in charge had a system in place to monitor staff training to ensure all staff were facilitated to complete mandatory training and were facilitated to attend a programme of professional development training. However, this inspection found that not all staff had completed up-to-date mandatory training in safeguarding residents from abuse and fire safety.

The registered provider had systems in place to monitor the quality and safety of the service, these systems were not effectively identifying non compliances as found on this inspection and consequently these non compliances were not being addressed. Furthermore, some improvements were required by the provider to ensure that where necessary improvement actions were identified that these were effectively communicated to the relevant staff. This is discussed under Regulation 23:Governance and Management.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notified to the Health Information and Quality Authority as required by the regulations.

The inspectors reviewed the complaints policy and found that it was in line with the requirements of Regulation 34. The records of complaints reviewed by the inspectors provided assurances that they were appropriately managed to the satisfaction of the complainants.

Schedule 5 policies and procedures and other policies were available to staff and were updated at intervals not exceeding three years.

The inspectors reviewed a sample of residents contracts and found that they met the requirements of Regulation 24.

Residents' views were valued and records showed that residents were facilitated and encouraged to feedback on all aspects of the service they received. This feedback was used to inform improvements in the service and the annual review of the quality and safety of the service delivered to residents in 2023.

Regulation 15: Staffing

There was enough staff with appropriate knowledge and skills available to meet residents' needs on the day of the inspection. However, from a review of the staff rosters and speaking with staff and members of the management team, the inspectors found that the household staffing numbers reduced from four staff during the week to three staff at the weekends even through there was no evidence of any

reduction in residents' needs. This did not ensure adequate cleaning staff resources were available each day. This is discussed under Regulation 23.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had completed up-to-date mandatory training as follows;

- one member of staff was overdue for refresher training on safeguarding of vulnerable adults
- two members of staff were overdue for refresher training in fire safety. This is a repeated finding from the last inspection.

Staff were not appropriately supervised to ensure they carried out their roles and responsibilities to ensure residents' needs were met. This was evidenced by the following inspection findings;

- residents repositioning charts were not completed to ensure that residents received care in line with their skin integrity risk. This was not identified by nursing staff which was a particular concern as seven residents developed pressure wounds in the designated centre during quarter two 2024.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management and oversight processes required improvements to ensure they were effective in maintaining compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and ensuring the quality and safety of care and services provided to residents.

This was evidenced by:

- The care plan audits completed did not identify that a number of care plans had not been updated to include the recommendations made by specialist practitioners such as the tissue viability nurse.
- A falls audit had been completed and highlighted locations and times falls had taken place, however there was no analysis or action plan developed to effectively address the findings and identify any improvements required to manage falls in the centre.
- The oversight of fire safety precautions did not ensure that fire policies and procedures were consistently implemented so that residents were protected. These findings are set out under Regulation 28: Fire Precautions.

- The oversight of maintenance processes did not ensue that the premises was compliant with Schedule 6 of the regulations. These findings are set out under Regulation 17: Premises.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts and found that they met the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was recently updated in line with regulatory requirements. Records of complaints received were maintained in the centre and the inspector observed that these were acknowledged and investigated in line with the centre's complaint policy. Documentation was available as to whether the complainant was satisfied with the outcome of the investigation. A Review process was available to complainants who remained dissatisfied.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies and procedures as outlined in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were up-to-date and were available in the centre.

Judgment: Compliant

Quality and safety

Overall, residents rights were respected and most residents living in this centre were facilitated to enjoy a meaningful and purposeful life with opportunities and supports to engage in social activities that interested them and were in line with their

capacities. However the inspectors found that the daily routines for those residents who were accommodated in The Lodge required review to ensure that all residents were supported to use the communal rooms available to them including their dining room if they chose to do so.

With the exception of residents' appropriate access to a dietician, residents had timely and satisfactory access to healthcare including to their general practitioner, community medical specialist services and allied health professionals.

Most residents' nursing care needs were met to a satisfactory standard. However, there were gaps in a number of residents' care plans.. Consequently, the inspectors were not assured that residents' care plans were up-to-date and clearly directed staff on the care they must provide for each resident to ensure their needs are met.

There was a programme of activities in place that reflected the interests and capacities of residents. Residents had opportunities to engage in a variety of meaningful social care activities each day. Observations on the day and feedback from residents showed that the activity programme enriched the quality of the residents' lives and improved their well-being. External musicians visit the centre and residents told the inspector that they enjoy these music sessions. Residents' social activities were tailored to meet their interests and capacities and were taking place throughout the day of the inspection in both buildings of the designated centre.

Residents had access to radio, television and newspapers. Residents were supported to exercise choice in relation to their daily routines. Resident meetings were held on a regular basis.

The inspectors reviewed minutes of residents meetings which took place every month and found that there was good attendance and feedback from residents was responded to.

The design and layout of the premises was suitable for its stated purpose. Corridors were wide and contained handrails fixed to the walls to assist residents with their mobility and independence. Residents had adequate storage space in their bedrooms and bathrooms for their clothing, assistive equipment and personal belongings. However, there were a number of areas identified as requiring maintenance and repair.These findings are discussed under Regulation 17: Premises

There was an up to date infection prevention and control policy that provided guidance to staff regarding standards of practice and procedures required to ensure that residents were protected from infection. Non compliances identified on the last inspection were found to have been satisfactorily addressed to completion. Residents' assistive equipment was clean, in a good state of repair and there was a system in place to confirm that the equipment had been cleaned and was ready to be used again.

Regular fire safety checking procedures and servicing of fire safety equipment was in place to ensure residents' safety. However, assurances were not adequate regarding regarding residents' safe evacuation in the event of an emergency.

Actions by the provider were also necessary to address deficits identified in the effectiveness of fire doors to ensure residents' safety in the event of a fire. There was an overall positive approach by staff on this inspection regarding their care and support of a small number of residents who were predisposed to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Restrictive practices in place reflected the National Restraint Policy guidelines and the number of restrictive full-length bedrails in use was reducing with use of alternative less restrictive equipment such as: sensor alert mats, low profile beds and foam mattresses placed by residents' beds. Records showed that where restrictions were in use, appropriate assessments were completed. Procedures were in place to ensure residents' safety was monitored when restrictive equipment was in use and to ensure that use was not prolonged.

Measures were in place to ensure residents were safeguarded from abuse and that any concerns were managed and fully investigated.

Regulation 17: Premises

The communal sitting room on the first floor floor in The Lodge was used as a multi-purpose room for both sitting and dining purposes. Inspectors observed that this room did not meet the needs of the residents for both purposes because when the additional tables were brought into the room at meal times the room became cluttered and there was not enough circulation space for residents to move about safely.

Not all areas of the premises conformed to the requirements set out in schedule 6 of the regulations as follows;

- The cabinets under the sinks in some resident's bedrooms required replacing as the paint was worn and chipped. This finding is repeated from the previous two inspections.
- Part of the carpet was missing outside the lift and on the way into the communal sitting room on the first floor.
- Paint was missing on the door frame into bedroom 27 and did not support effective cleaning
- The surface on the footrest was torn and did not support effective cleaning.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider ensured that procedures consistent with the National standards for Infection Prevention and Control in Community Services (2018) published by the Authority, were implemented by staff. The provider had effectively addressed the findings of the last inspection to ensure residents were protected from risk of infection.

The centre environment and equipment was managed in a way that minimised the risk of transmitting a healthcare-associated infection. For example, alcohol hand gel dispensers and clinical hand hygiene sinks were located along corridors convenient to the point of care (where care procedure takes place) for staff use. Staff completed hand hygiene procedures as appropriate.

Waste was appropriately segregated and disposed of. Floor and surface cleaning procedures were in line with best practice guidelines and cleaning schedules were in place and were completed by staff.

Judgment: Compliant

Regulation 28: Fire precautions

Actions were required by the provider to ensure adequate precautions were in place to protect residents and others from the risk of fire and compliance with Regulation 28, Fire precautions as follows;

- Assurances regarding residents' safe evacuation in the event of a fire in the centre were not adequate as the fire evacuation drill records reviewed did not give assurances that the following procedures and risks were addressed;
    - calling the emergency services
    - records of the last two simulated emergency evacuation drills referenced prolonged evacuation times and it was not evident that actions had been taken to reduce these timelines to ensure residents' safety.
    - the records of the simulated emergency evacuation drill information available did not provide assurances that staff supervision for residents post their evacuation had been considered as part of the evacuation procedure. At the time of this inspection, the inspectors confirmed that many of the residents in the centre would require supervision post evacuation to ensure their safety.
    - the evacuation drill records did not provide assurances that residents' personal emergency evacuation assessments were referred to and used to inform the simulated emergency evacuation drill procedures.

Arrangements were not in place to confirm completion of weekly checks of the fire doors to ensure their effective operation at all times.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While, each residents' needs were regularly assessed, actions were necessary to ensure that residents' care plans were up-to-date and that the care interventions that staff must complete to meet residents' assessed needs are clearly described. This was evidenced by the following findings;

- one resident's nutrition care plan was recently updated but did not accurately reference the interventions recommended by the dietician. This posed a risk that this pertinent information would not be communicated to all staff caring for this resident.
- one resident's behaviour support care plan did not detail the extent of the responsive behaviours experienced by the resident and the most effective person-centred interventions that staff should complete to effectively support this resident and de-escalate their behaviours.
- a care plan for one resident with an assessed high risk of falling referenced a list of the falls they sustained but did not reference effective actions to mitigate their risk of falling.
- assessment of residents' social care needs was limited and did not clearly identify the social activities that they should have opportunity and be supported to participate in to meet their interests and capacities. As a consequence, assurances were not available that the needs of residents who were unable or did not wish to participate in the group activities taking place in the sitting room were adequately met.
- one resident with two wounds did not have a separate wound care plan to reference each wound and the care plan in place did not accurately reference the interventions recommended by the tissue viability nurse. This posed a risk that this pertinent information would not be communicated to all staff caring for this resident.
- assessment of one resident's wound by nursing staff since 20 June 2024 did not identify that this resident's wound was deteriorating and consequently there was a delay in referring this resident for review by their GP.
- there was evidence of residents developing pressure ulcers in the centre and the inspectors found that the frequency with which staff must assist residents to change their body position to maintain their skin integrity when in bed or seated in a chair during the day and night was not set out in their care plans. Consequently, residents' records of care delivered evidenced gaps and inconsistencies in the frequency with which individual resident's repositioning was completed.

Judgment: Not compliant

Regulation 6: Health care

Residents with unintentional weight loss did not have consistent access to a dietician because the dietician sometimes completed residents' assessments and treatment plans remotely based on information provided to them by staff in the centre. Furthermore, this arrangement meant that residents did not always have opportunity to meet the dietician to discuss their needs and the treatment plans prepared for them if they wished to do so.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents accommodated in 'The Lodge' were offered the choice to take their meals in the comfortable dining room on the ground floor of the building. This meant that apart from during personal care interventions, residents spent most or all of their time each day sitting in the same place in the communal lounge on the first floor.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A positive and supportive approach was used by staff in their care of those residents who intermittently experienced episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were observed to be attentive to residents' individual needs for support and residents responded well to the care and supports provided by staff.

All staff were facilitated to attend appropriate training to ensure they had up-to-date knowledge and skills to effectively care for residents with responsive behaviours.

The person in charge and staff were committed to minimal restraint use in the centre and their practices reflected the national restraint policy guidelines.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Newbrook Nursing Home OSV-0005702

Inspection ID: MON-0042447

Date of inspection: 18/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Training
The DON completes a Training Needs analysis quarterly and submits to the training Officer. This is reviewed by the training facilitator and Quality, Safety and Risk Manager. Training is planned and scheduled on site by the training facilitator or the inhouse trainers. The nursing home has three in-house trainers who deliver training in Manual Handling, Safeguarding. Training is recorded on a training matrix .Any staff who are on planned or unplanned leave will be made dormant on training matrix to ensure clarity .Any staff returning from leave will have training scheduled in the first week of return to duty by the DON .staff have access to and are facilitated to attend all training in the Centre ,the mandatory training Fire and Safeguarding will be prioritized. Going forward any staff who do not attend their planned training or refresher training will be unable to continue with planned duty until training is completed. Training is discussed at senior management meetings, with targets and shortfalls discussed and actioned. The Director of Nursing the Provider and Compliance Officer will continue with oversight of training. Training will be discussed at the 6 weekly Management Meeting.

Staff Supervision
Supervision has been discussed at senior management level and the DON will examine current practices with planned quality improvement in this area. The Supervision of care staff by the DON, ADON, CNMs (x 4), staff nurses and senior HCAs has been strengthened by reorganising the skill mix on duty. The CNM and senior nurses will attend in house CNM training on 1st October 2024 to examine their current knowledge and practice and serve to promote quality improvement in all areas of clinical direction and supervision in the centre. The CNM will now conduct two daily walkarounds during shift to enhance supervision of nurses and care assistants. The CNM will feedback to the ADON/DON.

The DON/ADON will continue to conduct staff appraisal during the induction period for new staff and yearly for all other staff.

Skin Integrity Risks
The CNM will oversee the residents skin integrity and supervise the nursing staff in documentation, management and appropriate referral of residents in relation to any risks associated with pressure area care. A new referral form has been developed for referring residents to the TVN.

Nurses and care staff will attend Pressure area care training as a matter of priority (completed in August 2024/September 2024). Further training is scheduled for 18th October 2024. One nurse has attended a tissue viability course in RCSI.

The in-house TVN is available on a retained basis to provide training and wound assessments / advice. TVN training for all staff is ongoing (July, Aug, Sept) and planned. Care planning and documentation of wounds is included in the training. Care Plan training has been completed (July/Aug 2024). The TVN will visit onsite to provide training, support and advice in relation to all areas of skin integrity. The DON/ADON/CNM will communicate with the TVN Nurse to discuss residents progress and improvement in the skin integrity of residents.

The DON will examine weekly the current Pressure wounds, documentation, care plans, nursing interventions, repositioning and all basic aspects of comprehensive skin integrity interventions. The ADON/CNM will oversee the referral of residents to members of the multidisciplinary team as part of the Residents holistic care with an enhanced focus on skin integrity. The CNM will review wounds weekly when completing the KPIs.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Care Plan
The DON has implemented the following actions to further improve the care plans .
• Care Plan training planned and completed (July/Aug/Sept 2024)
• The care plan audit has been adapted to identify gaps in the residents' care plan.
• A review of the Care Plan format is also being undertaken.
• The Care Plans are reviewed by the DON/ADON with the named nurse on a one-to-one basis to discuss the content of the care plan and give constructive feedback. Nurses will receive feedback on the content, documentation and interventions in the care plan.
• Nurses will continue to seek advice and support from the specialized TVN nurse.
• Daily morning huddle conducted by the DON/ADON with the staff on duty (Nurses and HCA) to discuss a residents care plan to promote enhanced understanding and learning. Care plans are being reviewed and updated as necessary to inform staff on the care that must be provided to meet each residents' needs.

Falls
• The falls will be reviewed and discussed by the DON/ADON and the nursing home Physio.
• The Falls audit does allow for analysis and actions to be completed. There will be oversight of this by the Compliance Officer when compiling monthly KPI's that these are completed.
• The Current posey alarm system had been reviewed prior to Inspection. The nursing home has ordered a new wireless sensor device alarm system (Daza). The wireless sensor is designed to sit on the floor of the resident's room and scan the area. The devices sensor will trigger residents' movement. This will enhance resident safety, improve response times and reduce noise disturbance in the centre. This is a quality improvement that had been discussed at management meetings in relation to proposed Fall reduction interventions.
• Falls are reviewed at Management Meetings.

Skin Integrity Risks
The CNM will oversee the residents skin integrity and supervise the nursing staff in documentation, management and appropriate referral of residents in relation to any risks associated with pressure area care.

Nurses and care staff will attend Pressure area care training as a matter of priority (completed in August 2024/September 2024). One nurse has attended a tissue viability course in RCSI.

The in-house TVN is available on a retained basis to provide training and wound assessments / advice. TVN training for all staff is ongoing (July, Aug, Sept) and planned. Care planning and documentation of wounds is included in the training. Care Plan training has been completed (July/Aug 2024). The TVN will visit onsite to provide training, support and advice in relation to all areas of skin integrity. The DON/ADON/CNM will communicate with the TVN Nurse to discuss residents progress and improvement in the skin integrity of residents.

The DON will examine weekly the current Pressure wounds, documentation, care plans, nursing interventions, repositioning and all basic aspects of comprehensive skin integrity interventions. The ADON /CNM will oversee the referral of residents to members of the multidisciplinary team as part of the Residents holistic care with an enhanced focus on skin integrity. The CNM will review wounds weekly when completing the KPIs.

Fire
The process of recording fire drills has been revised to ensure that PEEPs, supervision of residents' post-evacuation and calling the emergency services are considered. The existing Fire Drill form has been reviewed and following this review has been replaced with two new forms to differentiate between a False Alarm and a Fire Drill
• False Alarm Recording Form
• Fire Drill Recording Form

The weekly Fire Checks continue and are recorded in the Fire Book Oversight of weekly Fire Checks is taking place.

Any false alarm is logged on Xyea as an incident.

Maintenance
The DON/ADON will continue to meet with the maintenance team weekly to plan and action all necessary works and improvements. This is further discussed by the DON at the Management Meeting with the Provider and actioned accordingly with timescale.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Communal Room
DON has reviewed the Communal sitting room and considered inspectors feedback. Initially the first floor sitting room mealtimes were reviewed to ensure the room is not cluttered and residents can move safely around the room. All residents are given the choice as to where they want to take their meal. An existing dining room downstairs in Newbrook Lodge is now being promoted among the residents and since September they have started to use this additional space for mealtimes as discussed at the inspection feedback .This the verbal feedback from residents to date is positive.

Residents Therapy Room
All staff are reminded of the planned purpose and function of all rooms in the nursing home. Staff have an allocated handover area. Staff are provided with a suitable break room .This has been communicated at Staff Team meetings .The CNM will supervise the nursing home staff daily.

Maintenance
A comprehensive schedule of maintenance works has been prepared. This will be prioritized based upon risk.

• Resident sinks in Belvedere unit have all been replaced (Sept 2024).
• The carpet is being replaced.
• Painting of door frames is currently taking place to ensure effective cleaning.
• All equipment has been audited and any that is damaged has been taken out of circulation.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The current Fire Precautions have been reviewed.

• The process of recording fire drills has been revised to ensure that PEEPs, supervision of resident's post-evacuation and calling the emergency services are considered.

• The DON/ADON will oversee weekly Fire Door Checks. Any deficits will be reported to the provider and actioned accordingly.

• Fire Drills have been reviewed and a new SMART approach to ensure the Fire Drills are Specific, Measurable, Accurate, Realistic and Time related. Staff will practice and endeavour to evacuate each compartment in the shortest possible time and practice fire drills on that basis. The Company Fire Trainer is visiting onsite (Aug, Sept) to conduct and oversee Fire Drill practice. The provider is updated on this progress to reassure that safe systems for evacuation are working, in place and effective within an appropriate timeframe.

• Fire Drill Form reviewed and redesigned to further clarify the difference between a False Alarm and a Fire Drill.

• We are reviewing the safe evacuation time in conjunction with a fire safety professional.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Care Plans
The DON/ADON/CNM have reviewed care plans in the Centre. Care Plans have been reviewed and updated to inform staff of the care that must be provided to meet each resident's needs. This includes recommendations from multidisciplinary teams, supports and de-escalation interventions for residents who display responsive behaviours and social activities that are individual to the resident.
Nurses have received training and feedback on the care plans. All staff are informed and updated daily on residents care requirements that must be provided to meet each resident's needs. This includes recommendations from multidisciplinary teams, supports and de-escalation interventions for residents who display responsive behaviour and social activities that are individual to the resident.
All nursing staff will receive further Care Planning Training.
The care plan audit has been adapted to identify gaps in the residents' care plan.
A review of the Care Plan format is also being undertaken

TVN
• Separate wound care plans have been developed for residents who have wounds.
• One nurse has attended a tissue viability course in RCSI. Nurses are receiving training

from our in-house TVN who is available on a retained basis to provide training and wound assessments / advice
Falls
The Falls audit does allow for analysis and actions to be completed. There will be oversight of this by the Compliance Officer when compiling monthly KPI's that these are completed. Falls are reviewed at Management Meetings.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

All residents have access to a Dietician and there is an existing process in place. Residents are referred to the Dietitian by the nursing team and the Dietician attends the Centre in person to review the resident. Changes or interventions to the resident's nutrition and hydration are documented in the Dietician therapy notes, progress notes and the Care plan. The care plan is communicated at handover with all clinical staff. The catering department are informed of any dietary changes. The multidisciplinary team and the residents GP are informed of any recommendations.
All documentation and dates in relation to Dietitian visits and recommendations will be visible in the care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The DON /ADON are reviewing the communal sitting rooms and dining areas in both buildings. The arrangements as to where residents sit for their meals have been reviewed. Residents are reminded that there are a variety of dining areas in the Centre where they may choose to take their meals.

Since the inspection the existing dining room on the ground floor of Newbrook Lodge has been refreshed and promoted among the residents and is now in use. Residents were consulted and participated in this quality improvement. The verbal feedback from residents is positive and residents are observed to be comfortable at lunchtime.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	31/10/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Substantially Compliant	Yellow	31/12/2024

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/11/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2024
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	30/09/2024
Regulation 28(2)(iii)	The registered provider shall make adequate arrangements for calling the fire service.	Not Compliant	Orange	30/09/2024
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.	Not Compliant	Orange	31/10/2024

Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/10/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	31/10/2024
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	30/09/2024