Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Brookhaven Nursing Home
Name of provider:	Brookhaven Nursing Home Limited
Address of centre:	Donoughmore, Ballyraggett, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	11 January 2023
Centre ID:	OSV-0000207
Fieldwork ID:	MON-0038566

About the designated centre

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

Brookhaven Nursing Home is situated in the village of Ballyragget, seven kilometres from the town of Durrow, Co. Kilkenny. The centre is registered to accommodate 71 residents, both male and female. It is a two-storey building but resident's accommodation and facilities are located on the ground floor; the staff learning hub is located upstairs. Residents' accommodation comprises single and twin bedrooms with en-suite shower and toilet facilities, two dining rooms, an activities room, sitting rooms and a sun room. There are comfortable seating alcoves throughout the centre and toilet facilities are strategically located for residents' convenience. Residents have access to five enclosed garden areas with seating and walkways. Other facilities include the main kitchen and a laundry. Brookhaven provides full-time nursing care for people with low to maximum dependency assessed needs requiring long-term residential, palliative, convalescence and respite care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

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
Wednesday 11 January 2023	09:00hrs to 17:00hrs	Mary Veale	Lead
Thursday 12 January 2023	09:00hrs to 17:00hrs	Mary Veale	Lead

What residents told us and what inspectors observed

The feedback from residents was that Brookhaven Nursing Home was a nice place to live and apart from the restrictions during the COVID-19 pandemic and a recent outbreak, most residents had choice in their daily lives. The inspector greeted the majority of the residents and spoke at length with seven residents. Not all residents were able to converse but residents who spoke with the inspector gave positive feedback. Residents said they felt safe and the two best things about living in the centre were the food and the staff.

On arrival the inspector carried out the necessary infection prevention and control precautions, such as hand hygiene and application of a face mask. After an opening meeting with the person in charge and the assistant director of nursing, the inspector was accompanied on a tour of the premises. Alcohol hand gels and PPE (personal protective equipment) dispensers were readily available throughout the centre to promote good infection control procedures. Staff were observed wearing the correct PPE and frequently performing hand hygiene.

Brookhaven Nursing Home is a two story designated centre registered to provided care for 71 residents on the outskirts of the village of Ballyragget, in County Kilkenny. There were 57 residents living in the centre and a bed was reserved for one resident who was due to be admitted to the centre in the days following this inspection. The inspector saw that bedroom accommodation consisted of 63 single and four twin bedrooms, all with en-suite shower facilities. The privacy and dignity of the residents in the multi-occupancy rooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings. The centre was divided into four wings which were called after local areas, the Attanagh wing, Donoughmore wing, Kilminan wing and Rosconnell wing. The inspector observed that bedrooms had ample storage space, some bedrooms had flat screen televisions and all had lockable locker storage. Many of the residents bedrooms had fresh jugs of water. Some bedrooms were personal to the resident's containing family photographs and personal belongings. Pressure reliving specialist mattresses, falls injury prevention mats and other supportive equipment was seen in residents bedrooms. Assistive call bells were available in both the bedroom and en-suite toilets for residents safety. The first floor of the building contained the centres administration offices. At the time of inspection the centre was operating at a reduced occupancy.

The centre was generally warm and appeared clean throughout and there was a relaxed atmosphere. The Kilminan wing felt cold on the second day of inspection and was brought to the attention of the person in charge who contacted the maintenance department to fix the heating system. The ground floor contained the centres production kitchen, laundry, staff changing facilities and maintenance rooms. Each unit had access to a secure courtyard. There was an indoor smoking room for residents who chose to smoke. There was a choice of communal spaces that residents could use on each unit including day rooms, lounge and sitting rooms.

Residents had access to a large reception area, two large dining rooms, an oratory, visitor's rooms, an aromatherapy room and a hair salon. There was suitable seating throughout and the centre had wide corridors with assistive grab rails.

Residents appeared well cared for and were relaxed. The activity schedule was displayed in the reception area. Residents whom the inspector spoke with gave positive feedback about the choice and quality of activities provided in the centre. The centre had two dedicated activity staff member who organised and provided a programme of activities with residents. There was a varied activity schedule which included, bingo, singing, exercises, and live music sessions. The inspector observed residents watching television, reading newspapers, engaging in a group activity and enjoying a live music performance. Some residents told the inspector they were looking forward to returning to their regular trip to a local coffee shop following the recent COVID-19 outbreak restrictions in the centre.

Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved. Residents said that the person in charge and assistant director of nursing were very good at communicating changes, particularly relating to the recent COVID-19 outbreak and had kept them informed as things happened.

Residents whom the inspector spoke with expressed high levels of satisfaction with the service provided, for example, the quality and choice of food and laundry services. Residents spoken with said they would have no hesitation in expressing any concerns or requests. Residents were highly complementary of the staff in the centre and stated that there were more staff working in the centre now compared to this time last year.

The inspector observed that visiting was facilitated throughout the two inspection days. The residents told the inspectors that there was no booking system in place and that their visitors could call to the centre anytime.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection carried out to monitor ongoing compliance with the regulations and standards, and to follow up on three pieces of unsolicited information that had been received by the Chief Inspector of Social Services in relation to safe guarding, residents rights, communication, staffing, training and staff development, governance and management, and complaints. The inspector also followed up on notifications submitted to the Chief Inspector. The provider had progressed the compliance plan following the previous inspection in February 2022,

and improvements were found in Regulation 5: individual assessment and care plan, and Regulation 6: health care. On this inspection, the inspector found that action was required by the registered provider to address Regulation 23: governance and management, Regulation 28: fire precautions and Regulation 31: notification of incidents. Areas of improvement were required in Regulation 9: residents rights, Regulation 16: training and staff development, Regulation 17: premises, Regulation 21: records, Regulation 27: infection prevention and control and Regulation 34: complaints procedure.

Brookhaven Nursing Home Limited were the registered provider for this centre. There were four directors in the company, one of whom was the registered provider representative. The centre was part of a group of five nursing homes and had access to group resources, for example finance and facilities management. Since the previous inspection in February 2022 the centre had, three changes of personnel in the role of person in charge (PIC). The current person in charge was appropriately qualified, and had worked in the centre for almost a year. The person in charge was supported by a recently appointed assistant director of nursing, a team of nurses, health care assistants, activity staff, housekeeping, catering, administration staff and maintenance staff.

There had been a high turnover of staff in the centre in 2021 and 2022 and the provider had ongoing recruitment efforts in place to maintain safe and consistent staffing levels. In order to ensure the care needs of residents were met the provider was employing agency staff. The inspector noted that staffing levels were in accordance with the centre's statement of purpose but equally the centres beds were at reduced occupancy.

Staff had access to education and training appropriate to their role, however improvements were required in the supervision of staff in the centre. The centre had a vacant clinical nurse manager post and a substantial number of complaints had been received in 2022 relating to poor personal care of residents. Following a concern of unsolicited information received by the Chief Inspector, the provider had identified better oversight was required for residents' safety checks. The person in charge had introduced measures in the form of checklists and staff debriefing meetings to improve systems of care but these systems required further assurances. This is discussed further under Regulation 23: governance and management. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. An annual staff performance appraisals was in place however, records of these appraisals identified that 18% of the same staff had their annual staff performance appraisal undertaken in 2021 and 2022 .

Management systems in place to monitor the centre’s quality and safety required review. The centres governance meeting minutes were not robust to drive quality improvement. Notes of governance meetings were brief, some were handwritten and did not show evidence of actions required from audits being discussed. Governance meeting agenda items included staffing, KPI’s (key performance indicators), complaints, visits, COVID-19, staff training, and refurbishment works. Locally the centre had an extensive suite of meetings such as local management meetings and staff meetings. Local management meetings took place monthly in the

centre. Records of local management meetings showed evidence of actions required from audits completed which provided a structure to drive improvement. There was evidence of a comprehensive schedule for audits in the centre for 2023. There was evidence that regular audits of staff files, call bell response time, medication management, and infection prevention control were undertaken in 2022. There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2021 with an associated quality improvement plan for 2022. The annual review of the quality and safety of care to residents in 2022 was under review.

Records and documentation, both manual and electronic were well presented, organised and supported effective care and management systems in the centre. Requested records were made available to the inspector throughout the days of inspection and records were appropriately maintained, safe and accessible. However, there were no food menus available for residents on the days of inspection.

Incidents and reports as set out in schedule 4 of the regulations were not notified to the Chief Inspector within the required time frames. The monitoring and oversight of safe guarding procedures required improvement, this is detailed under regulation 23.

The centre had a comprehensive complaints policy and procedure which clearly outlined the process of raising a complaint or a concern. Information regarding the process was clearly displayed in the centre. A record of all complaints received in 2022 was viewed. All closed complaints were managed and the outcomes of the complaints and complainants satisfaction was recorded. Residents confirmed that they would be happy to discuss a compliant or concern with the person in charge or any member of staff. However, a further review of the systems in place to identify and disseminate learning from complaints was required.

Regulation 14: Persons in charge

The person in charge worked full-time in the centre and displayed good knowledge of the residents' needs and a good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the days of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required in the oversight of supervision of training in the centre. For example:

- Systems to ensure staff have annual appraisals required review. 18% of staff, had an annual performance appraisal in both 2021 and 2022. The centres communication policy outlines that performance appraisals for new employees will be completed annually.

Judgment: Substantially compliant

Regulation 21: Records

Actions were required to ensure that all records as outlined in schedule 4 of the care and welfare of residents in designated centres for older people Regulations 2013 were available.

- Food menus were not available for residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure the centre had sufficient resources to ensure effective delivery of care as the governance structure as outlined in the statement of purpose was not implemented in practice and as required under Regulation 23(a).

For example;

- there was a commitment to a 0.2 WTE clinical director post to this centre but records of meetings indicated that the clinical director was only present in the centre intermittently.
- The post of clinical nurse manager was vacant.

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- Systems of communication were not sufficiently robust as minutes of governance meetings with the provider and clinical director were records of agenda items only. There was no record of discussions of agenda items, audits reviews or action plans to ensure cascading of the governance structure to drive quality improvement .
- Oversight of the centres complaints system required review as learning identified from investigations following complaints was not consistently identified, shared and implemented to drive quality improvement.
- The system for assessment of residents post a fall required review as a number of fall incidents involving residents were not managed in accordance with the centre's policies.
- Further oversight was required to ensure safety checks and personal care checks of residents were being completed. The person in charge had introduced measures in the form of checklists, however enhanced oversight of staff practices was required to ensure these checklists were completed in real time at the point of care delivery, as the inspector witnessed care staff signing off all the checklists in a folder in one of the sitting rooms on the second day of inspection.
- Further oversight was required of issues pertinent to fire safety as outlined further under regulation 28. Immediate action plan was issued to the provider on both days of inspection, in respect of ensuring evacuation routes were maintained clear from obstructions at all times.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services was not notified of two incidents of allegations abuse of residents. The incidents had not been appropriately reported as safeguarding concerns, and the incidents were not notified to the Chief Inspector within three days, as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints log and found the records contained adequate details of complaints and investigations undertaken. A record of the complainants' level of satisfaction was included. Actions were required to the complaints system so that learning from complaints was identified and effective measures required for improvement were put in place following a complaint review to drive quality improvement. For example:

- A compliant was received relating to missing foot pedals from wheelchairs, it was evident over the two days of inspection that a number of foot pedals had not been secured to a number of the centre's wheelchairs, and no system for managing this had been put in place.
- A complaint was received relating to a resident who had a urinary tract infection which highlighted that the residents' locker was too far away to access a drink. The Inspector observed throughout the two days of inspection, that a number of residents' bedside lockers were not within easy reach to get a drink.

Judgment: Substantially compliant

Quality and safety

Overall, residents and visitors expressed satisfaction with the care provided and the quality of life in the centre. Improvements had been noted in the area of care planning, health care and premises since the last inspection. On this inspection actions was required in the areas residents' rights, premises, infection prevention and control and fire safety.

The centre had recently had an outbreak of COVID-19 and visiting was returning to pre-outbreak visiting arrangements in the centre. Residents could receive visitors in their bedrooms where appropriate, the centre's communal areas, and visitors room. Visitors could visit at any time and there was no booking system for visiting. There was evidence in the centre's visiting log book that relatives and friends of residents

were calling daily.

Residents’ health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian, and speech and language, as required. The centre had access to GP’s from two local practices and the person in charge informed the inspector that GP’s called to the centre most evenings during the week. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The inspector saw that the residents' pre-admission assessments, nursing assessments and care plans were maintained on two separate electronic systems. Residents’ assessments, validated assessment tools and nursing progress notes were kept on one system and residents care plans were maintained on the other. Residents’ needs were comprehensively assessed prior to and following admission. Resident’s assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspector were comprehensive and person- centred. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to falls and infections. Care plans were regularly reviewed and updated following assessments and recommendations by allied health professionals. There was evidence that the care plans were reviewed by staff. Consultation had taken place with the resident or where appropriate their nominated representative to review the care plan at intervals not exceeding four months. There was evidence of ongoing communication with relatives of residents on each unit, using an invitational letter to meet residents’ relatives to inform them of updates and changes to care plans.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The risk management policy had been reviewed and updated in November 2022. The risk register contained site specific risks such as risks associated with individual residents and centre specific risks, for example; risk of residents absconding, storage of medical gases, and loss of water.

The centre was not an agent for any resident's pension. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. There was ample storage in bedrooms for residents’ personal clothing and belongings. Laundry was provided in the centre for residents.

Improvements had been made to the premises since the previous inspection, for example; some bedrooms had been redecorated and flooring had been replaced. The centre was mostly free of clutter and one sitting room was being used for storage of PPE. There was an on-going plan of preventative maintenance which included painting, upgrading to bathroom facilities and decorating bedrooms. Redecoration works were taking place on the Kilminan wing on the days of inspection. However, some areas of the centre were showing signs of wear and tear,

for example; walls in some of the bedrooms and en-suite toilets were damaged and required painting. All en-suite toilets had grab rails and call bells fitted. Communal spaces were nicely decorated and were bright, comfortable and met the needs of the residents on the days of inspection. Improvements were required in relation to the centres premises this will be discussed further under Regulation 17.

Although menus were not available, the individual dietary needs of residents were met by a holistic approach to meals. A choice of home cooked meals and snacks were offered to all residents over the two days of inspection. Residents on modified diets received the correct consistency meals and drinks, and were supervised and assisted where required to ensure their safety and nutritional needs were met. Meal times varied according to the needs and preferences of the residents. The inspector observed the residents' lunch time experience in the Ash dinning room on the first day of the inspection. The dining experiences were relaxed and there were adequate staff to provide assistance and ensure a pleasant experience for residents at meal times. Residents' weights were routinely monitored. The inspector was informed that a new chef had recently been employed in the centre and the inspector viewed a proposed four week menu.

Staff were observed to have good hygiene practices and correct use of personal protective equipment (PPE). Sufficient housekeeping resources were in place on the days of inspection. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. The cleaning schedules and records were viewed. Intensive cleaning schedules had been incorporated into the regular weekly cleaning programme in the centre. Used laundry was segregated in line with best practice guidelines and the centre's laundry had a work way flow for dirty to clean laundry which prevented a risk of cross-contamination. There was evidence that infection prevention control (IPC) was an agenda item on the minutes of the centres staff meetings. IPC audits which included COVID-19 were evident and actions required were discussed at the centres local management meetings. There was an up-to-date IPC policy which included the management of COVID-19 and multi-drug resistant organism (MDRO) infections. Nevertheless, some further improvements were required in relation to infection prevention and control, this will be discussed further in the report.

Immediate risk of obstruction to evacuation routes were identified and brought to the attention of the person in charge on both days of inspection. On first day of inspection an evacuation corridor on Rosconnell wing was obstructed by linen skips and a housekeepers trolley. On the second day of inspection, two corridors identified as evacuation routes were obstructed by linen trolleys on the Attanagh wing and Kilminan wing. All trolleys were removed from corridor areas at the request of inspector.

There was automated door closures to bedrooms in the Rosconnell wing and all compartment doors in the centre. There were no automated door closures to bedroom doors on the Attanagh wing, Donoughmore wing, and Kilminan wing. All fire doors were checked over the days of inspection and some were found not to the close properly to form a seal to contain smoke and fire. On the second day of inspection, the compartment doors and bedroom doors 23-27 on the Rosconnell

wing were being adjusted. Fire training was completed annually by staff. There was evidence that fire drills took place quarterly. There was evidence of a night time drill taking place in the centre largest compartment. Fire drills records were detailed containing the number of residents evacuated and how long the evacuation took. There was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents. All fire safety equipment service records were up to date. There were fire evacuation maps displayed throughout the centre, in each compartment. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item on the local managers meetings in the centre. There was a smoking room available for residents. On the days of inspection there was one resident who smoked and a detailed smoking risk assessment was available for this resident. A fire extinguisher, fire blanket and call bell were in place in the centre's smoking room. Nothwithstanding some of the good practices outlined in respect of fire precautions, further improvements were discussed in more detail under Regulation 28 of this report.

There was a site-specific policy on the protection of the resident from abuse. Safeguarding training had been provided to all staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with said they would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. All staff had Garda Vetting completed prior to employment.

Most residents were actively involved in the organisation of the service. There was evidence that resident meetings and informal feedback informed the service. The residents had access to an independent advocate who called to the centre almost daily, and a SAGE advocate in the centre. The advocacy service details and activities planner were displayed in the main reception area. Residents whom the inspector spoke with were complimentary of the activities provided by the centre's activities staff. Residents confirmed that their religious and civil rights were supported. Mass took place monthly in the centre. The centre has its own Eucharist minister who offered communion to residents weekly. Group activities of newspaper discussions, arts and crafts, and music entertainment took place over the days of inspection. Residents has access to daily national newspapers, weekly local papers, WI-FI, books, televisions, and radios. However,improvements were required in relation to the provision of activities for residents with advanced needs. A small cohort of residents did not have opportunities to participate in activities based on their assessed needs.

Regulation 11: Visits

Indoor visiting had resumed in line with the most up-to-date guidance for residential centres. The centre had arrangements in place to ensure the ongoing safety of

residents. There was a checklist in place to ensure that visitors had appropriate PPE and had completed hand hygiene procedure on entry to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Residents' clothes were laundered in the centre and the residents had access and control over their personal possessions and finances.

Judgment: Compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- In order to ensure that all equipment was functional and in working order, a review of the residents' wheelchairs was required as a substantial number of foot pedals were not attached and were left on window sills and store rooms. This posed a risk to the safety of the residents.
- Areas of the centre were showing signs of wear and tear, for example; walls in some of the bedrooms and en-suite toilets were damaged and required painting. The condition of the premises is intrinsically linked to infection prevention and control as damaged and scuffed surfaces cannot be cleaned and pose a risk to the spread of infection.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

A validated assessment tool was used to screen residents regularly for risk of malnutrition and dehydration. Residents' weights were closely monitored and there was timely referral and assessment of residents' by the dietitian. Meals were pleasantly presented and appropriate assistance was provided to residents during meal-times. Residents had choice for their meals on both inspection days.

Judgment: Compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

Action were required to ensure the environment was as safe as possible for residents and staff. For example;

- A review of the centre's shower chairs and commodes was required as a number of shower chairs and commodes had visible rust on the leg or wheel area. This posed a risk of cross-contamination as staff could not effectively clean the rusted parts of the shower chairs.
- The centres shower drains require review as a number of shower drains were found to be dirty on the days of inspection.
- Some of the residents' en-suite bathrooms did not have waste bins.
- A number of residents falls mats were found to be dirty on the days of inspection.
- A review of the arm chairs was required in the centre as some chairs have damaged or worn covers which posed a risk of cross-infection as staff could not effectively clean these chairs.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example:

- Compartment doors were not closing to form a seal on both sides of the Rosconnell sitting room.
- A review of the centre's bedroom doors was required. The Attanagh wing, Donoghmore wing and Kilminan wing did not have automated closure devices, some doors in these three areas did not close properly to ensure that smoke or fire could be contained in the event of a fire.
- Emergency directional light outside room 36 was not working and had not

been working for some time.

- Oversight of fire drill procedures required review as one fire drill record viewed documented that the nurse on duty failed to response to the drill for 5 minute.
- Enhanced oversight of staff practices to ensure that the means of escape were unobstructed at all times, as the inspector had to request removal of obstructing items on each day of inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The standard of care planning was good and described person-centred care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, bed rail usage and falls.

Based on a sample of care plans viewed appropriate interventions were in place for residents’ assessed needs.

Judgment: Compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP’s routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professionals as appropriate.

Judgment: Compliant

Regulation 8: Protection

There was a policy in place for the prevention, detection and response to allegations or suspicions of abuse. All staff had up-to-date training in the safeguarding of residents and were familiar with the procedures to be followed. The provider assured the inspector that all staff and volunteers had valid Garda vetting disclosures in place. The centre was not a pension-agent and did not manage monies for residents.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure that all residents were provided with opportunities to participate in activities in accordance with their interests and capacities;

- A number of residents on the Rosconnell wing spent a considerable amount of time in the sitting room with minimal stimulation other than television.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brookhaven Nursing Home OSV-0000207

Inspection ID: MON-0038566

Date of inspection: 12/01/2023

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16(1)(b) The person in charge shall ensure that staff are appropriately supervised.

The newly appointed Operations Director has devised and implemented an audit system on 24/02/2023 which will capture all staff and the date of their required appraisal review. This audit system identifies staff that are due for the next month. The relevant employees who are due for appraisal will be contacted in advance of their due date to ensure a suitable time is scheduled for annual appraisal meeting with the Director of Nursing.</td></tr>
<tr><td>Regulation 21: Records</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 21: Records:
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.

On the day of the inspection, the home had just been deemed 'over' a Covid-19 outbreak. Menus were not placed on the tables within the dining room during the outbreak for IPC reasons.

A menu was available to the residents for review. A four-week rotational menu has now been formulated and agreed with residents.</td></tr>
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Menu displays have been ordered for the nursing home where the menus will be available for the Residents to review each day. It is anticipated these menu boards will be in place by 01-04-2023.	
Regulation 23: Governance and management	Not Compliant

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

A Compliance and Quality Manager is due to commence for the group on 03-04-2023 which will add another layer of governance and support on clinical issues to the management of the centre. This role will allow for more clinical oversight on site and the Compliance and Quality Manager will support the Clinical Director

A Director of Operations has also been appointed with responsibility for all non-clinical issues in the homes.

In the absence of a Clinical Nurse Manager a staff nurse has taken on the role of senior nurse at the centre. In a bid to support her achieve the requirements for the CNM role she will undertake management training and once completed will commence in the CNM role.

Minutes of governance meetings have been reviewed with dedicated responsibility for each action required outlined clearly and recorded.

The complaints system has been reviewed and the policies updated. Learning is now noted and shared with staff during heads of Department meetings and debriefs following investigation findings.

Documentation and recording methods have been outlined to staff during staff meetings. He need for contemporaneous records has been reiterated and the PiC and ADoN review documents throughout the day to ensure compliance.

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.

Cannard falls assessments are reviewed and residents needs reassesses post each fall. Any changes to the residents status are documented in the care plan and changes notifies to staff.

The Group Facilities Manager and maintenance personnel are in the process of placing clip frames in each Resident's bedroom to ensure that appropriate documentation is available to staff to record safety checks in real time. The PIC and ADON/CNM will then review and monitor the safety checks intermittently throughout the day to ensure compliance.

New tablets have been installed throughout the home which care staff can access and enter the personal care, fluid and foot charts of Residents. Previously this had been done on paper format.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Regulation 31(1) Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.

The full review of incidents in the centre has been undertaken to ensure all necessary notifications have been submitted.
All incidents are reviewed on site by either the PiC and/or ADoN and discussed with the Clinical Director to ensure that all notifications required are submitted in a timely fashion

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Regulation 34(1)(h) The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.Group

The Facilities Manager and maintenance personnel within the centre have completed an audit of all wheelchairs. This audit resulted in a number of wheelchairs being taken out of commission. Wheelchairs have been ordered for the centre and their arrival is imminent.

A review of furniture in the resident's room has taken place with some furniture being moved (with residents' consent) to ensure they are accessible to all. Where residents

have declined furniture changes this has been documented to uphold their wishes and preferences and in some incidents, risk assessed and outlined in the risk register.

Regulation 17: Premises	Substantially Compliant

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

The Facilities Manager and maintenance personnel within the centre have completed an audit of all wheelchairs. This audit resulted in a number of wheelchairs being taken out of commission. Wheelchairs have been ordered for the centre and their arrival is imminent.

Painting work is ongoing at the centre since January 2023. A large proportion of this work has been completed post inspection. Works within the centre are due for completion by April 2023.

Regulation 27: Infection control	Substantially Compliant

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

All shower chairs and commodes within the centre have been audited. Those with signs of rust have been removed and we currently await delivery of new equipment to the centre. This is expected by 01-04-2023. Going forward this equipment will be reviewed monthly to ensure it is fit for purpose.

Shower drains have been added to the weekly deep cleaning schedule and now form part of the ongoing deep clean programme.

Waste bins noted as missing during inspection in some rooms have been put in place.

Falls alert equipment have been itemised on the daily clean list at the centre. A Steam cleaner has been purchased to ensure that all items are thoroughly cleaned.

An audit of the armchairs was carried out at the centre. Those that required cleaning have been cleaned with the steam cleaner as noted above. Replacement chairs have been ordered for the centre.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Regulation 28(1)(a) The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Works are due to commence on compartment doors as noted in the report.

A review of the bedroom doors was carried out at the centre. Contractor is due to start work on all bedroom doors that are not closing properly to ensure that smoke or fire could be contained in the event of a fire.

Regulation 28(1)(b)The registered provider shall provide adequate means of escape, including emergency lighting.

Emergency directional lights throughout the centre have been reviewed and are now in working order.

Oversight of fire drill procedures has been reviewed. A weekly fire drill is now being carried out at the centre to ensure that staff are familiar and comfortable with fire processes. Learning from the fire drills is documented by DoN and ADoN and disseminated via debrief following each drill. These weekly drills will take place for a period of 1 month to ensure all staff are fully aware of their responsibilities in the event of a fire. Once practices have been embedded the drills will commence bi monthly for a period of one month and the revert to every quarter to ensure compliance.

Regulation 28(1)(c)(ii) The registered provider shall make adequate arrangements for reviewing fire precautions.

Enhanced oversight of staff practices is underway at the centre to ensure that no items such as trolleys are obstructing fire exits or evacuation routes throughout the centre. Supervision and observation of practices by the PIC and ADoN on the floor allows for issues to be addressed immediately and learning shared.

Regulation 28(2)(iv) The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.

Oversight of fire drill procedures has been reviewed. A weekly fire drill is now being carried out at the centre to ensure that staff are familiar and comfortable with fire processes. Learning from the fire drills is documented by DoN and ADoN and disseminated via debrief following each drill. These weekly drills will take place for a period of 1 month to ensure all staff are fully aware of their responsibilities in the event of a fire. Once practices have been embedded the drills will revert to every 8 weeks to ensure compliance.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Regulation 9(2)(b) The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.

A full review of resident’s activities is underway. The activity staff will meet with all residents in the centre to ensure that all their wishes and preferences are documented and residents’ choices are being met through the weekly activity programme. This will be completed by 22/03/2023.
Once this information has been collected and disseminated the activity staff will amend the activity programme to reflect choices and commence smaller groups for residents with bespoke activity choices to ensure all residents are provided with meaningful engagements throughout the day/week.
Where residents decline to engage in this process and/or activities this will also be recorded and reflected in the care plan.

A second activities coordinator has been recruited and is due to commence in March 2023. This allows for more 1:1 and individualised activities for all Residents at the centre

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/05/2023
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	30/04/2023
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	01/04/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient	Not Compliant	Orange	01/05/2023

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	30/04/2023
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	01/04/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	01/05/2023
Regulation 28(1)(b)	The registered provider shall	Not Compliant	Orange	01/04/2023

	provide adequate means of escape, including emergency lighting.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	01/05/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	01/05/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	07/03/2023
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a	Substantially Compliant	Yellow	07/03/2023

	complaint.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	01/04/2023