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:	Bushy Park Nursing Home
Name of provider:	Bushy Park Nursing Home Limited
Address of centre:	Nenagh Road, Borrisokane, Tipperary
Type of inspection:	Unannounced
Date of inspection:	25 February 2025
Centre ID:	OSV-0000410
Fieldwork ID:	MON-0041236

About the designated centre

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

Bushypark nursing home is a purpose-built single-storey nursing home that provides 24-hour nursing care. It can accommodate up to 30 residents both male and female over the age of 18 years. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It is located on the outskirts of the town of Borrisokane. It provides short and long-term care primarily to older persons. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared en suite bedrooms. There are separate dining, day and activities rooms as well as an enclosed garden area available for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	30

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 25 February 2025	10:15hrs to 19:15hrs	John Greaney	Lead
Tuesday 25 February 2025	10:15hrs to 19:15hrs	Niall Whelton	Lead

What residents told us and what inspectors observed

This was a one-day unannounced inspection of Bushy Park Nursing Home conducted by two inspectors of social services. Inspectors met with a large number of the residents over the course of the inspection and spoke with five in more detail. Residents gave positive feedback about their lives in the centre and were complimentary about staff and the care provided. They reported that staff were caring and kind. Overall, inspectors found that residents were supported to have a good quality of life.

Following an opening meeting with a director of Bushy Park Nursing Home Ltd. and the director of nursing (DON), inspectors were accompanied on a tour of the centre. Bushy Park Nursing Home is purpose-built and is predominantly a single storey premises on the outskirts of Borrisokane, County Tipperary and is registered to provide care for 34 residents. There is an attic area that is predominantly used for administrative purposes and residents do not have access to this area. On the day of this inspection there were 30 residents living in the centre. Bedroom accommodation comprises 13 twin bedrooms and eight single bedrooms, however, four of the twin bedrooms were used to, and configured for, the accommodation of one resident only. All bedrooms, except two of the twin rooms, are en suite with a shower, toilet and wash hand basin. The two twin rooms that do not have en suite facilities share a bathroom between them. An application to vary Condition 3 has been received to reduced the number of registered beds from 34 to 30 in light of the reduction in occupancy of the four twin rooms.

There is a 59-bedded extension being built to the rear of the premises and the masonry work is at an advanced stage. At the last inspection, conducted on 08 May 2024, it was found that some internal construction works had also taken place within the centre. Some of these works were done to remedy the impact of building works on fire safety and in particular a change in emergency evacuation routes. Other changes were carried out to improve the living environment, such as the reconfiguration of four en suite bathrooms, the removal of a wall in a sitting room and a reduction in occupancy of four twin bedrooms to single rooms.

As already stated, construction was underway on a large extension to the rear of the premises. While construction work was underway on the day of the inspection, there was no evidence of excessive noise or dust on the day of the inspection. However the construction works did impact on natural light entering some bedrooms as a result of building materials being stored close to residents' bedroom windows. While this did not prevent residents from opening their windows it did block light from entering the rooms. There was also a negative impact on residents' privacy due to the potential to see directly into the centre and in particular residents' bedrooms by anybody on the scaffolding on the new building.

While the centre generally provided a homely environment for residents, improvements were required in respect of premises which in turn impacted some

aspects of infection prevention and control. For example, inspectors observed the inappropriate storage of equipment in the housekeeping room and in the sluice room. This had the potential to cause cross contamination. It was also noted that a number of wash hand basins were visibly unclean. The layout of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process.

Inspectors spent time observing staff and resident interaction in the various areas of the centre. Residents were observed moving freely around the centre throughout the day. Staff supervised communal areas appropriately, and those residents who chose to remain in their bedrooms, or who were unable to join the communal areas were supported by staff throughout the day. Familiar, respectful conversations were overheard between residents and staff, and there was a relaxed atmosphere in the centre. It was evident that residents' choices and preferences in their daily routines were respected. Inspectors observed that staff were kind, patient, and attentive to residents' needs. Inspectors observed that personal care was attended to a good standard. It was evident from talking with staff that they knew the residents and their individual needs well.

There were two separate call bell systems, one for each side of the premises. While the observations of inspectors were that staff responded appropriately to requests for assistance from residents, there was a continuous sequence of codes that were displayed before the room number from which the call bell was initiated displayed on the screen. Management could not confirm what these codes related to and undertook to have this addressed as a matter of urgency.

There was a schedule of activities in place and residents were aware of the activities available in the centre. Discussions with activity staff indicated that they were familiar with residents and their interests. Regular residents' meetings were held in the centre and from a review of minutes of these meetings, issues such as activities, food, laundry and ongoing building works were discussed. Information regarding advocacy services was displayed in the centre and records demonstrated that this service was made available to residents if needed. Residents has access to daily national newspapers, weekly local newspapers, books, televisions, and radios.

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

Overall, residents expressed satisfaction with the standard of care and were supported to enjoy a good quality of life. However, significant improvements were required in relation to the oversight of quality and safety, particularly in relation to the impact of the ongoing construction on the daily lives of residents living in the

centre and on fire safety.

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The registered provider is Bushy Park Nursing Home Limited, a company comprising three directors. The person in charge was appointed to the role in June 2022. She is an experienced nurse and manager. The person in charge is supported by an assistant director of nursing (ADON), a general manager who is also a director, and a part-time practice development coordinator. There is a clearly defined management structure in place with which staff are familiar and are aware of their individual roles and responsibilities within the structure.

As found on the most recent inspection, conducted on 08 May 2024, the provider had commenced the construction of a 59-bedded extension adjacent to the current building.The provider had also carried out works on the existing premises, some of which enhanced the facilities available to residents. These changes had been made without engaging with the office of the Chief Inspector. As the changes resulted in a change to the facilities of the centre and a reduction in bed capacity, the provider was requested to submit an application to vary conditions 1 and 3 of the registration. Following the submission of the applications there has been significant engagement with the provider in order to gain information to support a decision on the application. The requested information included a fire safety risk assessment (FSRA) that encompassed all the changes to the premises. Despite this engagement, that included written and telephone correspondence, the requested assurances were not provided. As a result, a cautionary meeting was held with the provider on 13 January 2025 due to the failure of the registered provider to submit the requested information. At this meeting the required information was again requested and this was also outlined in the record of the meeting that was issued to the provider. Again, this information was not forthcoming and an inspection of the centre was scheduled.

The provider had completed a risk assessment for managing the risk to residents during construction activity. While the risk assessment was signed as being updated as recently as January 2025, the measures and controls in place had not been updated. For example, the risk assessment references a smoking room to the rear with the door removed; this arrangement had changed and the smoking area was relocated to an external shelter. The assessment also indicated that the construction site was securely fenced off from the existing building with a safe exit passage around the back of the building. However the construction site extended to the walls of the nursing home and inspectors observed building materials being stored adjacent to the rear of the building beside residents' windows. This in particular impacted on the bedrooms of four residents to the rear of the centre.

Inspectors saw that there were systems in place to deliver quality care to residents and this was continuously monitored with oversight from senior management team. The systems included a comprehensive auditing programme, which was overseen by the person in charge and the practice development coordinator. Both clinical and non-clinical audits were completed on a monthly and quarterly basis and quality

action plans were in place to address any issues identified. Audits included medicines management, dementia care audits, nutritional status, restrictive practice and observations of staff and resident interactions. An annual review had been conducted of the quality and safety of care delivered to residents in 2024 with a quality improvement plan for 2025. Despite this oversight, significant improvements were required in relation to governance and management. This related to failure to submit information to the office of the chief inspector, predominantly related to fire safety issues. Improvements were also required in relation to the oversight of safeguarding with the centre. These issues are discussed in more detail under Regulation 23 of this report.

The centre was staffed in accordance with the statement of purpose and there was an appropriate skill mix of staff to support the provision of a high standard of care. Nursing and healthcare staff were supported by housekeeping, catering, laundry, activity and administrative staff.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

Information requested to support the decision-making process for an application to vary Condition 1 of the registration of the designated centre was not submitted despite repeated requests for this information.

Judgment: Not compliant

Regulation 15: Staffing

On the day of inspection, there were sufficient numbers of staff and an appropriate skill-mix across all departments to meet the assessed needs of the residents. The inspector observed skilled staff providing care for residents in a respectful manner.

Judgment: Compliant

Regulation 16: Training and staff development

Records viewed by the inspector confirmed that there was a high level of training provided in the centre. Training such as safeguarding of vulnerable adults, moving and handling, and fire safety was completed by most staff. Training was scheduled to take place in the weeks following this inspection for the small number of staff that were overdue attendance at mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

Action was required by the registered provider in relation to governance and management. For example:

- despite ongoing engagement with the provider to request information, predominantly related to fire safety, this information had not been submitted by the date of the inspection
- the provider did not have a safeguarding plan in place for known safeguarding risks. Additionally, adequate arrangements were not in place to ensure that mitigation measures identified in a safeguarding risk assessment could be implemented, particularly in evenings and weekends when senior management may not be present in the centre
- systems of oversight of fire precautions and reviewing fire safety were not adequate and required action; this is further detailed under Regulation 28: Fire Precautions
- action was required in relation to the oversight of quality and safety of care, particularly in relation to the ongoing construction works. For example:
    - the impact of construction on the privacy and lived experience of residents as detailed in this report was not captured or addressed through the audit process
    - significant deficits in the the maintenance of the premises were identified on inspection and are outlined in detail under Regulation 17 of this report. These issues were not identified or addressed by the provider through their audit process
- the provider was not operating the centre in in accordance with Condition 1 of their registration by failing to submit information that would allow the Chief Inspector to vary that condition.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed four contracts for the provision of care and services. All of the contracts reviewed met the requirements of the regulations. For example, they set out the terms and conditions of the agreement, and any additional fees for other services.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge ensured that all required incidents were notified to the Chief Inspector within the specified time frames, for example, incidents of serious injuries requiring urgent medical attention, and the incidents of restrictive practice use in the centre.

Judgment: Compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight was required to improve the quality and safety of service provision. Action was required by the provider to ensure that residents were adequately protected from the risk of fire. Action was also required to ensure that residents received a high standard of nursing care, particularly in relation to recording clinical observations and monitoring the deteriorating resident. These and other required improvements are outlined in more detail under relevant sections of this report.

Residents' clinical risks were assessed using a variety of validated tools to support the development of care plans. A sample of care plans viewed by inspectors were generally comprehensive and person-centred. There was adequate detail in the care plans to guide staff on care delivery, based on residents assessed needs and expressed preferences. However, a review of nursing records indicated that guidance in relation to care delivery was not always followed, particularly in relation to the recording of clinical observations. Additionally, action was required in relation to the monitoring of residents that may have been deteriorating. This is discussed in more detail under Regulation 6 of this report.

There were arrangements in place to refer residents to allied health and specialist services, such as occupational therapy, dietetics, and speech and language therapy. A physiotherapist visited the centre one day each week to provide group exercises and also to carry out individual assessments.

Inspectors found the oversight of cleanliness and infection control within the designated centre required review to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018). For example, staff changing rooms were unsuitable for purpose and posed a risk of cross contamination. Additionally, there was inappropriate storage of equipment in ancillary rooms that could impact on infection control practices. This will be discussed in more detail under Regulation 27.

Training records indicated that all staff had completed safeguarding training, and a

safeguarding policy provided support and guidance in recognising and responding to allegations of abuse. Staff spoken with were clear about their role in protecting residents from abuse. Residents reported that they felt safe living in the centre. Notwithstanding these good practices, some improvement was required in supporting staff and management in safeguarding all persons in the centre from potential abuse. This will be discussed further under Regulation 8: Protection.

Residents spoken with by inspectors expressed satisfaction with the care and support received from staff. Inspectors observed that the residents were supervised in the communal rooms and were encouraged to engage in meaningful activities throughout the day of the inspection. Residents views on the running of the centre were sought through regular residents' meetings and surveys. It was evident from a review of minutes of these meetings that residents' views were sought on activities, food and the ongoing construction work.

The premises was generally designed and laid out to meet the needs of the residents living in the centre. Ongoing construction works, however, were having an impact on the living environment. Some of these impacts could have been prevented if the construction works were carried out in accordance with the risk assessment conducted prior to the commencement of the works. For example, if there was a clear separation of the construction site from the existing building, the entry of light into bedrooms may not have been obstructed. There was also a need for better oversight of the general maintenance and upkeep of the premises. These and other issues are discussed in more detail under Regulation 17; Premises.

Regarding fire safety, overall, escape routes were unobstructed and available for use. Owing to construction works to the rear, the configuration of the corridor escape to the rear was rearranged to lead to the front of the building where a smoking room was re-designated as an escape corridor. This was an adequate route of escape, however, emergency lighting outside the door and a level threshold at the door were not provided.

The full of extent of fire compartment boundaries to facilitate progressive horizontal evacuation, could not be fully determined during the inspection. Some alterations to en suites realigned walls, which were previously fire compartment walls; this required assessment by the provider's competent fire safety professional. Following the inspection, the provider confirmed that a fire safety risk assessment of the designated centre would be completed in the week following the inspection. Personal emergency evacuation plans (PEEP) were in place for residents, however, they were not reviewed as required. Fire safety is discussed in more detail under Regulation 28 of this report.

Regulation 17: Premises

Action was required by the provider to ensure compliance with Regulation 17 and Schedule 6;

- the call bell system was not adequate. There were two call bell systems in operation; one for the communal rooms and four twin rooms, the other for the remainder of the building. The older system relied on a schedule displayed to determine the location of the call bell. Neither system had been serviced and there was apparent faults where 'F' was displayed on the panel for seven devices. As the system is a rotational display, staff would have to wait for the sequence of seven faults to be displayed before seeing the room number of the alarm that had been activated. Further issues with the call bell system included:
    - the call bells in at least two en suites did not work
    - the call bell cords in some en suites were missing
    - there was no call bell provided in the external smoking shelter
- the door and flue to an external boiler were close to residents' windows; the provider confirmed carbon monoxide alarms were installed following the inspection
- the management of residents' personal storage was not adequate. In one room a resident's chest of drawers was being used to store incontinence wear, which did not belong to the resident. The shared wardrobe was a three door configuration and resulted in one resident having more wardrobe space than the other
- there was a strong malodour emanating from the sluice room, which was not adequately ventilated
- the servicing of the bed pan washer was not up-to-date
- the servicing of the heating boilers were not up-to-date
- the downpipe from the roof gutter was missing and water was flowing onto the ground creating a dip on an external escape route.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had not 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. For example:

- there was inappropriate storage of staff clothing and a step ladder in the housekeeping room. This increased the risk of contaminating cleaning equipment
- there was no wash hand basin in the housekeeping room to support hand hygiene practices
- a number of wash hand basins were noted to be unclean
- another ladder was stored in a sluice room, which is not a suitable place to store such equipment. Additionally, it obstructed access to the wash hand basin
- urinals were stored in a shared bathroom on top of the toilet cistern. It was not clear if the urinal had been cleaned after use or to which resident it

belonged
- a staff changing room in an external building was in a poor state of repair and unclean. Dining chairs in the room had a green coating on the legs similar in appearance to mould. Construction workers were also using the toilet facilities in the changing room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors were not assured that the provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire.

The provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example:

- there was combustible storage in attics, which would escalate a fire should one start in the attic
- the door to the kitchen was propped open by a device fixed to the floor; it was not connected to the fire alarm system and would only close by manual release and not on activation of the fire alarm system
- there were two shut off points in the kitchen for the gas supply, one for each cooker. These were not accessible and required moving a stainless steel counter. There was electrical sockets fitted to the back of the cooker. Staff and management did not know where the altered external shut off point to the gas supply was located
- poor practices with the use of extension cords, for example, in the laundry there was one hanging down by the washing machine
- furniture used in the smoking shelter did not have an appropriate label to demonstrate it is suitably fire retardant
- an oxygen cylinder was stored beneath a residents bed, this was immediately removed during the inspection

The arrangements for providing adequate means of escape including emergency lighting required action:

- the provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety if the power in the building failed
- the provision of exit signage was not adequate; a number of compartment doors had escape signage to one side of the door only and in some corridors, there was a lack of visible escape signage to direct occupants towards the next compartment or exits
- the external route from an exit to the side led to an uneven surface which comprised an area of concrete and grit; this would not be a suitable surface for mobility aids and wheelchairs as the surface was not firm enough

- the exits to the front of the building, had a change in level of approximately 70mm; this meant that escape by residents using mobility aids or in wheelchairs may be impeded
- the means of escape for staff from the first floor was not adequate; there was a single stairs and parts of the first floor required moving through up to three rooms to get to the stairs. The stairs discharged into a corridor and not to an exit

The measures in place to detect and contain fire were not adequate. Fire containment in the centre required assessment, for example;

- there was inadequate containment of fire to the kitchen, a room of increased fire risk. The doors from the kitchen to the dining room were not effective fire rated doors for the risk in the kitchen. Furthermore, the cooking extract hood passed through the ceiling into the attic above and it was not known if this was fire separated in the attic; assurance is required in this regard
- the provision of an extension to the rear, meant that the door to the boiler room now opened into the building. This was a fire door designed to open externally as it had ventilation louvers, creating a risk of the fire and products of combustion into the building
- the enclosure to the laundry room included thirty minute fire doors; the laundry room has an increased risk of fire and should be provided with sixty minute fire containment
- the ceiling of the electrical room, had additional plasterboard fitted to the ceiling, however, the joints were not taped and sealed and not sealed around the edges of the ceiling
- there was a lack of clarity regarding the size and extent of fire compartment boundaries. The evacuation strategy in the centre was progressive horizontal evacuation, which means assisting residents from the area where a fire starts through to the next fire compartment. The apparent fire compartments reflected on the evacuation floor plans were of a reasonable size, however, recent alterations to the centre had altered fire compartments, therefore the effectiveness of the fire compartments were not assured
- the fire doors within some of the fire compartment walls were full height glazed thirty minute doors and would not be sufficient or effective to protect residents where used for progressive horizontal evacuation
- ceilings throughout had recessed lighting fittings, non-fire rated attic hatches and ventilation extract units which compromised the fire containment of ceilings. The sluice room had timber panels in the ceiling as a result of damage from a leak, further compromising fire containment
- The walls between the first floor storage areas and the attics above residents accommodation, were not adequately fire rated. These storerooms contained a large amount of combustible storage and increased the risk to residents; if a fire started in the first floor storage areas, it could spread to the attics above residents' bedrooms
- there were service penetrations through fire resisting construction which were not adequately sealed up, creating a risk that fire would not be adequately contained
- the store under the stairs was not fitted with a smoke detector; furthermore

the door was not a fire door creating a deficit in fire containment between the ground floor and the stairs to the first floor

The arrangements for maintaining fire equipment, means of escape, building fabric and building services were not effective:

- maintenance deficits to fire doors were impacting fire containment, for example, screws were missing to hinges, gaps were observed around doors, some heal and smoke seals were missing
- there was no record of a periodic inspection report for the electrical installation
- the log of weekly tests of the fire alarm system were not being completed
- while the emergency lighting was being inspected and tested at quarterly intervals as required, the appropriate paperwork to show the system had received an annual inspection and test (to show the system is free from faults and deviations) was not available

The measures in place to safely evacuate residents, staff knowledge and the drill practices in the centre required action:

- residents' evacuation requirements were set out in PEEPs (Personal Emergency Evacuation Plans); some of these had not been reviewed since March 2024
- simulated evacuation drills were being completed, however, the scenario to evacuate a full compartment with reduced staffing levels had not been carried out since March 2024
- assurance was required that the fire safety training covered all aspects of the regulations, for example, conversations with management and staff resulted in confusion regarding the capabilities of the fire alarm panel and what information would be displayed on the panel. Some relayed that it identified the zone only, others indicated it would identify the room name and number. This confusion would result in a potential delay in the event of fire

There were fire evacuation drawings displayed throughout the centre. The fire compartments shown for the purpose of progressive horizontal evacuation were not accurate and required updating.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of residents' documentation was reviewed by inspectors. All care plans reviewed were personalised and updated regularly and contained detailed information specific to the individual needs of the residents and were sufficiently detailed to direct care. Comprehensive assessments were completed using validated tools and these were used to inform the care plans. There was evidence of ongoing

discussion and consultation with the families in relation to care plans. Care plans were maintained under regular review and updated as required.

Judgment: Compliant

Regulation 6: Health care

Action was required to ensure that residents at all time received a high standard of nursing care. For example:

- while neurological observations were conducted for most residents following un-witnessed falls and when a head injury was suspected, records were not available to indicate that these were done for all residents
- blood sugar levels were not recorded for all residents with a diagnosis of diabetes at the frequency recommended in the residents' care plans
- records of clinical observations were not always maintained to support the monitoring of residents that may have been deteriorating clinically

Judgment: Not compliant

Regulation 8: Protection

Action was required to ensure that measures were in place to safeguard all persons in the designated centre from abuse. While a safeguarding risk assessment was conducted in relation to a potential safeguarding concern, it was not sufficiently comprehensive to take account of known risks. Additionally, a detailed safeguarding plan was not in place.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required by the provider to support the rights of residents living in the centre. For example:

- adequate measures were not taken to ensure that the construction works underway did not impact on the right to privacy for residents living in the centre. The construction site extended across the full rear of the registered centre, which may impact residents' privacy in their bedrooms. This particularly related to the potential to see directly into residents' bedrooms

from scaffolding walkways and areas where building materials were stored
- construction supplies were stored adjacent to residents' windows and this impacted on the light entering residents rooms.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not 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	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bushy Park Nursing Home OSV-0000410

Inspection ID: MON-0041236

Date of inspection: 25/02/2025

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**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: Buildings • Updated original floor plans were forwarded on 2/5/25 • Updated floor plans include fire zones/compartments that have been realigned with Fire Panel on 20/4/25 Fire Impact Assessment. • Full impact Fire assessment carried out on 5/3/25 by competent practitioners. • Assessment forwarded to HIQA on 21/3/2 • FD60 kitchen door replacement ordered on 7/5/25 – will be in place by 13/06/25 • Fire exit double door (between room 9 and 11) ordered on 7/5/25 – will be in place by 18/06/25 Going forward; Regulation 7 will be integrated into Monthly Governance Report, and will be monitored at QIM (Quality Improvement Meeting) where issues requiring corrective action will be addressed as part of Risk Management Reviews	
Regulation 23: Governance and management	Not Compliant

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

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

• There is a clearly defined Management structure in place.
• The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)

1. The Fire Risk Impact Assessment completed on 5/3/25 all identified gaps were integrated into Compliance Action Plan. Reports were forwarded to HIQA on 16/4/25 with updated action plan on compliance on 2/5/25
2. FD60 replacement kitchen door on order from 7/5/25
• Exit double door (between room 9 and 11) on order from 7/5/25
3. 100% of staff have been upskilled with further training from competent practitioners, the training included use of evacuation aids, and evacuation procedures.
4. 100% staff have had on site evacuation drill – night and day evacuation and highest risk compartments, facilitated and audited by Competent Practitioners.
5. Audits strengthened to reflect impact of new building on residents lived experiences; privacy and light. Net curtains placed on windows of rooms overlooking the building area.
6. Monthly Resident Forum in place to elicit residents experience of new building
7. Maintenance log strengthened to reflect identified gaps in environmental Audit – in place
8. Safeguarding plan for known Safeguarding Risk strengthened. Arrangements for mitigating measures as outlined in risk assessment in place over weekends and evenings – in place
9. Gas boiler removed and replaced with immersion.
Gas slam shut [automatic gas shut off valves] for laundry and kitchen .
Installation on 15/06/25.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• There is a clearly defined Management structure in place.
• The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)
• Premises and environmental audits are integral to Monthly Governance Report.

1. Call bell system completely upgraded and additional call bells placed smoking area and all bathrooms – completed on 22/4/25
2. All staff have received training on Call Bell system.
3. Call bell response Audits integrated into Monthly Governance Review and on agenda for monthly QIM
4. Bed pan washer has been replaced and is on a scheduled preventative maintenance Plan.
5. Heating boilers have been serviced on 26/3/25 and certificates in place
6. Roof gutter has a down pipe in place 14/4/25
7. Residents personal storage has been addressed by purchase of further wardrobes on 1/4/25

Regulation 27: Infection control	Substantially Compliant

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

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

• There is a clearly defined Management structure in place, including a designated IPC lead who is integral to QIM
• The QIM (Quality Improvement Meeting) includes GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)

1. Audit plan in place which includes monthly audit of dirty Utility Room
2. Bi Monthly Audits of residents rooms which includes hand basins.
3. Feedback will be given to staff at end of each Audit, which will ensure that corrective actions are implemented immediately
4. Communication book in place to enhance communication with staff on Audit findings and IPC information
5. Audit findings and corrective actions reported monthly as part of Governance Report and discussed at QIM
6. Malodor from sluice room addressed by purchase of new bedpan washer with a scheduled preventative maintenance.
1. All inappropriate items have been removed from housekeeping rooms
2. Wash hand basin installed in laundry and housekeeping room
3. Urinal storage and cleaning has been strengthened and will be audited integral to

Monthly IPC audits.
4. Staff changing room has been decommissioned for health care staff – staff changing room is situated in staff toilet with adequate lockers in place.

Regulation 28: Fire precautions	Not Compliant

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

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

• There is a clearly defined Management structure in place.
• The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)
• Fire prevention and Precautions will be a standing agenda item as part of QIM.
• All identified gaps in compliance with Regulation 28 will be integral to QIP and SMART Compliance Plan

1. Full Fire Risk and Impact Assessment carried out by Competent Practitioner on 5/3/25 – all identified gaps have been addressed and report forwarded to HIQA on 2/5/25
2. There is a clearly defined Management structure in place.
3. The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
4. Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)
5. Outstanding actions:
• FD60 replacement kitchen door on order from7/5/25 and
• Fire exit double doors (between room 9 and 11) on order from 7/5/25
6. Furniture in smoking shelter changed to metal
7. Non spark lighter purchased and awaiting delivery and installation.
8. Smoking policy updated to reflect safety measures and supervision
9. Extension cords no longer in use from 18/3/25
10. Means of escape uneven surface addressed on 23/4/25
11. All PAT certificates in place and available 1/4/25
12. Residents electrical equipment will be checked by electrician prior to use. Updated in Fire Prevention Policy and Risk Register - In place
13. All PEEPS have been reviewed and template strengthened as part of updated documentation – in place
14. Fire Panel has been realigned to reflect current fire compartments and 6 compartments added to Fire panel which includes Boiler Rooms, Stairs, Attic space completed on 15/4/25

15. Additional smoke alarms in place in dining room and under stairs
16. 100% of staff including management have had additional training from Competent practitioner on Fire prevention/use of evacuation aids/evacuation drill experience.
17. Two additional Ski mats have been purchased and training on their use given to all staff.
18. An additional staff member has been added to night time roster to facilitate safe evacuation of Bariatric resident – 4 staff on night duty - in place
19. Kitchen door FD60 ordered on 7/5/25
20. External emergency lighting in place – 25/4/25
21. All floor plans have been realigned with zones and compartments – this is reflected in fire panel and all floor map signage and exit instructions updated on 20/4/25
22. Kitchen fire containment;
• All hoods and ducts cleaned in line with FR19 on 7/4/25.
• Gas boiler removed and replaced with Immersion
Kitchen gas slam shut for installation on 15/06/25.
23. Laundry room fire doors coded and cold sealed on 23/4/25
24. All fire doors are compliant from 23/4/25
25. Breaches in fire rated ceiling addressed
26. Fire containment between first floor areas and attic space – there is a fire wall between office and Zone 12
27. Sealing up service penetrations through fire resistant construction – Plant room slapped with fire resistant materials and all areas sealed off

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• There is a clearly defined Management structure in place.
• The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)
• Health care clinical Audits and KPIs are reported on in monthly Governance Report

1. Falls management unwitnessed GCS monitoring reinforced with Nursing Staff – Falls Clinical Audit is carried out monthly and corrective actions reported to QIM
2. Routine blood glucose monitoring scheduled for twice weekly and individual monitoring is in line with Care plan
3. All nursing staff have had upskilling on Diabetic Management 1/4/25
4. Nurses reminded of importance of recording observations in line with best practice
5. CNM 1 and 2 in place going forward with responsibility for monitoring best practice in health care through a raft of clinical audits
6. Clinical Audit identified gaps and corrective actions will continue to be shared at monthly staff meetings.
7. Continued appraisal will identify gaps in training and practice development - ongoing

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• There is a clearly defined Management structure in place.
• The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)
• Safeguarding is a standing agenda item on Monthly Governance Report and QIM

1. Known Safeguarding risk assessment reviewed and actions addressing mitigating circumstances at weekends and evenings put in place. 1/4/25
2. Care plan in place for Safeguarding risk 1/4/25
3. 100% staff have had in house Safeguarding Training
4. Residents have had a Safeguarding Forum which outlined the new HIQA Guidelines – Jan 2025
5. Safeguarding discussed monthly in Governance Review and standing agenda item in QIM
6. Monthly QUIS audits in place – Predominantly connective positive interactions noted - ongoing

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• There is a clearly defined Management structure in place.
• The QIM (Quality Improvement Meeting) will include GM, PIC,PDN, IPC Lead.
• Going forward, the Monthly Governance Report will be shared in detail at monthly QIM (Quality Improvement Meeting) where all corrective actions will be risk rated and addressed as part of the QIP (Quality Improvement Plan)
• The Governance Report will include Residents Surveys (four monthly and Residents Forums (Monthly) all emerging themes and identified gaps/corrective actions will be integrated into QIP at the QIM
• All action plans on corrective actions will be SMART

1. Construction materials with possibility to restrict light to residents rooms have been re located

2. Privacy net curtains have been added to residents rooms facing the building area.
3. Quarterly Residents Survey and Monthly Residents forum seek to elicit residents lived experience and impact of new build
4. All residents and families kept informed of Building progress in monthly News Bytes – a monthly newsletter that highlights activities and maintains communication with residents families.

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
Registration Regulation 7 (3)	A registered provider must provide the chief inspector with any additional information the chief inspector reasonably requires in considering the application.	Not Compliant	Orange	20/05/2025
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.	Not Compliant	Orange	20/05/2025
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	Not Compliant	Orange	16/04/2025

	effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	16/04/2025
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	20/06/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	20/05/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	20/06/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate	Not Compliant	Orange	20/05/2025

	arrangements for reviewing fire precautions.			
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	16/04/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	16/04/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable,	Substantially Compliant	Yellow	16/04/2025

	residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/04/2025
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	16/04/2025
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	16/04/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional	Not Compliant	Orange	16/04/2025

	guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	16/04/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	16/04/2025