Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	12 May 2026
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0041660

About the designated centre

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

Bridhaven Nursing Home is a designated centre located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 182 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in six suites: on the lower ground floor - (1) Clyda is a dementia-specific unit with 18 bedrooms all single rooms with full en suite facilities of shower, toilet and wash-hand basin); on the ground floor - (2) Lee (33 beds – two twin and 29 single with en suite facilities), (3) Blackwater (37 beds – six twin and 25 single full en suite facilities) 4) Lavender (13 beds - all single full en suite bedrooms); on the first floor - (5) Bandon (currently 21 beds open), (6) Awbeg (36 beds – seven twin and 22 single with en suite facilities). Each suite had a day room and dining room and there are additional seating areas located at reception and throughout the centre. There is a large seating area upstairs for resident to relax with views of the enclosed bonsai garden and also the entrance plaza. Residents in Clyda have access to a well-maintained enclosed garden with walkways, garden furniture and shrubbery; there is a second enclosed garden accessible from the Blackwater day room. Bridhaven Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	149

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 12 May 2026	09:30hrs to 17:30hrs	Breeda Desmond	Lead
Wednesday 13 May 2026	09:15hrs to 18:00hrs	Breeda Desmond	Lead
Tuesday 12 May 2026	09:30hrs to 17:30hrs	Louise O'Hare	Support
Tuesday 12 May 2026	09:30hrs to 16:30hrs	Paul Dunbar	Support
Wednesday 13 May 2026	09:15hrs to 18:00hrs	Louise O'Hare	Support

What residents told us and what inspectors observed

This was an unannounced inspection completed over two days. Inspectors met many residents during the inspection and spoke with 25 residents in more detail, and five visitors. Residents gave positive feedback and were complimentary about the staff and the care provided; they enjoyed their meals and said there was lots of choice. One resident reported that staff were very quick to respond to requests and queries. One resident said that they had been in a few different nursing homes and 'this was by far the best'. A resident reported that it was 'very good here' and 'comfortable', and said 'I can do my own thing' and choose not to be 'involved in the activities'. Visitors spoken with were generally very complimentary of the care provided and said that staff were very attentive to their relative; they said that they only ever had a few issues and these were addressed immediately. Two visitors spoken with said that the care was excellent, but relayed that their relatives were unsettled with the move from Lavender to Bandon unit because of refurbishment of Lavender. One visitor gave feedback and said that while some healthcare assistants (HCAs) were excellent, others did not engage, they were 'on their mobile phones' and did not 'interact' with residents. These issues had been raised to management and were detailed in the complaints log. Complaints' records examined showed that these were addressed by the person in charge; advocacy services were also involved to assist in the process.

There were 149 residents residing in Bridhaven at the time of inspection. Bridhaven is a three storey facility with resident accommodation set out in six units over the three floors: Clyda (dementia specific unit) is located on the lower ground floor; Blackwater, Lee Side and Lavender Cottage (dementia specific unit) are on the ground floor; Awbeg and Bandon (dementia specific unit) are upstairs on the first floor. Management and HR offices, the main kitchen, maintenance and facilities, staff facilities, laundry, and storage areas are accommodated on the lower ground floor.

Initially, inspectors visited all the units and saw that some residents were receiving personal care, others were being escorted to the different day rooms, while others were still in bed. Some residents remained in bed throughout the day and inspectors saw residents were relaxed in their environment. Residents on all the units were seen to mainly have their breakfast in the dining rooms, while others had their breakfast either in bed or in their bedrooms. All residents in Clyda were seen to enjoy their breakfast in the dining room.

Throughout the days of inspection, inspectors observed staff interaction with residents. Many of these interactions were respectful and kind with positive engagement, chat and social conversation, however, a few staff did not engage with residents. Regarding activities, activities staff called to each unit providing one-to-one interaction and explaining the group activities to residents on each unit and inviting them to attend. At 10:30am, residents watched mass live-streamed on

television in dayrooms. This was followed by staff offering residents beverages and snacks including freshly made scones, a selection of pastries as well as tea, juice and soup. The snacks offered to residents were presented in a very appetising manner.

Menus were displayed on tables, on the large boards in each dining room as well as a pictorial display to enable easy access to menu choice. Residents were seen to have choice of cereals as well as hot options. Dinner time was observed on different units and inspectors generally observed positive engagement by staff when providing assistance with meals, and meals were served in a normal social manner. Choice was offered for all courses and modified diets were very pleasantly presented to residents. While most interactions were seen to be positive, some staff did not engage with residents while serving them their main meal. Two other staff were observed to stand while providing assistance to residents with their meal rather than sit with them, and did not engage with residents. Residents began to arrive in the dining room from 12:40pm, however, they were not served their meal until 13:15pm. Dining rooms were not supervised by a senior member of staff to ensure residents would have a pleasant dining experience. On another unit, when residents were finished their dinner but having their desert, staff cleaned the dinner plates with metal cutlery and then threw the plates into a basin: this noise in the dining room was abrasive and unpleasant.

Activities varied on each unit. Staff facilitating a sing-song were seen to gently encourage resident participation while singing and dancing to the music. Other activities observed included chair exercises, games to promote hand-eye co-ordination, and a fit-for-life exercise programme. The quiz was a very interactive session and residents actively participated in this; this was interspersed with story-telling and sharing life experiences. While most interactions observed were very inclusive, other were not. For example, one lady arrived into the day room and appeared confused, there were two staff standing chatting with each other and did not engage with the resident, who left the room as she did not know where she should sit. Another member of staff came and actively engaged with the resident and allayed her confusion and gently showed her where she could sit. Music on another unit was very loud and not age appropriate, to enable residents to engage and enjoy.

The activities boards were a colourful display with easily accessible information for residents; they were displayed on each unit as reminders for residents of the activities on each unit such as arts and crafts, bingo, 'sit & get fit', games, and an array of concerts, live music and movie nights for example. Some other activities were held on weekly basis such as the knitting club every Friday night, the reading club every Thursday night and the gardening club Wednesdays afternoons for example. One resident spoken with was knitting and said she found it very relaxing.

Publications and information on display included the monthly Bridhaven news letter, statement of purpose, annual review report, complaints procedure and advocacy services. The residents' guide was displayed on the wardrobe in each bedroom so residents had access to their individual copy. Bookshelves with a variety of books and games were seen in all dayrooms and the small sitting room on Awbeg;

additional reading material was provided by the local community library for residents. There were large colourful displays on each unit regarding 'Safeguarding' and what that means for all service users.

Throughout the inspection, it was noted that the premises was generally very clean. There were hand-wash hubs on all units at different locations at the start and end of corridors. All had advisory signage to explain how to wash hands appropriately and other signs displayed included the 'five moments of hand hygiene' as reminders to staff to wash their hands. Paper towel dispensers, hand soap and pedal bins were alongside each hand-wash sink. Dani centres were wall-mounted throughout the centre which enabled staff to easily access personal protective equipment (PPE) such as disposable hand gloves and aprons. Some staff donned face masks even though there was no clinical indication for this; and were observed to routinely wear them incorrectly. Wall-mounted hand gel dispensers were available throughout the centre. Flushing records were seen in rooms that were infrequently used as part of legionella protocols.

Painting and redecorating was in progress at the time of inspection and the premises looked clean and fresh. Some bedrooms had been fully upgraded, and inspectors were informed that three rooms per month were being totally upgraded. Lavender was temporarily closed at the time of inspection for refurbishment.

Residents personal storage in their bedrooms comprised a double wardrobe and bedside locker; some residents had an additional chest of drawers and an additional single or double wardrobe. Bedroom televisions were also being upgraded to larger TVs to enable resident view the screen from their bed. Low low beds, crash mats, specialist mattresses and cushions, and assistive equipment such as hoists were available. Each resident had their own sling for use when being transferred.

The hair salon was located near main reception. There were two coffee docs available to residents and visitors; one was located beside the hairdressers salon at main reception, and the second was in the main day room on Awbeg upstairs.

The smoking shelter was located in the garden in Blackwater; it had seating, fire blanket, fire extinguisher, heater, and fire retardant aprons. A second smoking shelter was available in the garden off Clyda with similar equipment. While there were cigarette butt disposal receptacles, these were not fit for purpose and were seen to contain cigarette boxes which posed a fire hazard; new appropriate fire-retardant receptacles were ordered immediately on the first morning of inspection. Residents were seen to independently access the outdoors and walk around the garden while having a cigarette. The raised flower beds had been painted and looked really well; walkways were very well maintained with spring planting. There was a call bell outside to enable residents call for assistance. The access code to enable independent access in and out of the building was displayed.

There was a separate secure entrance to Clyda so that visitors could access the unit without needing to go through the centre. There was a large garden outside the day room in Clyda. This was very well maintained space with walkways, shrubberies, raised flower beds and seating for residents to rest.

Alarm bells were wall mounted at the end of each corridor for easy access by staff and residents to call for help; they were also available in communal rooms should the need arise. Residents using oxygen had signage indicating oxygen in use in their bedrooms.

Laundry was segregated at source and laundry trolleys had pedal-operated function. There was a separate entry and exit to the laundry to prevent cross-over of dirty and clean laundry as well as specialist washing machines with a one-way operating system. Directional work-flow signage was seen within the laundry to mitigate the risk associated with cross infection. The laundry was very neat and tidy and devoid of clutter.

Emergency evacuation floor plans were displayed throughout the centre with a point of reference to indicate one's location in the centre; primary evacuation routes were detailed in the floor plans. However, these were very small and difficult to read; some floor plans were not orientated to reflect their relative position in the centre, so evacuation routes were confusing.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangement impact the quality and safety of the service being delivered.

Capacity and capability

This inspection was undertaken by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, to follow up on the findings of the previous inspection in September 2025, to follow up on unsolicited information submitted to the Chief Inspector prior to the inspection, and to inform the renew of registration process.

The findings of this inspection showed that improvement was noted regarding regulations associated with the premises, staffing, staff training, medication management regarding crushing of medications, notifications relating to the care and welfare regulations, and residents' care documentation. Issues that remained outstanding from that inspection included Schedule 2 Staff records documentation. Areas for improvement identified on this inspection were staff supervision, the dining experience for residents, fire safety precautions including resident personal emergency evacuation plans (repeat finding). These are detailed under the relevant regulations in this report.

There were concerns raised as part of unsolicited information submitted to the Chief Inspector prior to the inspection relating to deficits in middle management, as five clinical nurse managers (CNMs), two assistant directors of nursing (ADONs) and one senior staff nurse had resigned their posts. Deficits were acknowledged as part of

the governance and management senior management meetings; recruitment was in progress and to date, two new assistant directors of nursing were appointed and due to commence employment by end of May; four new CNMs had commenced and were on the duty roster at the time of inspection, and a further two had been recruited and were completing the recruitment process. This will bring the total number of CNMs to six. In addition, the Chief Operations Officer (COO) was now the person representing the provider for registration purposes. The person in charge was appointed as the new Director of Operations in April and was awaiting to take up that post. Recruitment was in progress for a person in charge for the centre, and when appointed, the current person in charge would take up the post of Director of Operations. There was a newly appointed person participating in management (PPIM) Clinical Operations Manager for the group. Overall, there was significant middle and senior management turn-over since the last inspection creating an overall unstable governance structure. The associated registration notification 6 (1) (a) was not submitted to the office of the Chief Inspector regarding the intended change in the person in charge of the designated centre, with the planned departure of the person in charge to their appointed as Director of Operations, as well as the appointment of the PPIM as mentioned heretofore.

Bridhaven Nursing Home is a designated centre for older adults and is registered to accommodate 182 residents. The provider is part of the Virtue group; the company has four directors' with one of the directors acting on behalf of the registered provider.

The current management structure on site comprised the person in charge, one assistant director of nursing (ADON), and four clinical nurse managers (CNMs). The service is supported by the health-care team that included a clinical facilitator, senior nurses, staff nurses and healthcare assistants (HCAs), household, catering and administration staff. A human resources (HR) administrator, maintenance team and facilities manager support the non clinical aspect of the service.

Currently, the COO facilitates weekly meetings providing oversight of the governance, operational management and administration of the service. While many key issues are discussed to provide oversight, infection prevention and control (IPC) was not a set item on the agenda, as mandated in the national standards; IPC was added to the agenda as a standing item during the inspection. The person in charge facilitates meetings with all staff to provide updates and oversight and these meetings are informed by key performance indicators and audit findings. Actions agreed with responsibilities assigned formed part of the meeting minutes; minutes demonstrated that issues were followed up on subsequent meetings to ensure completion.

Quality and safety monitoring systems in place included weekly collection of key performance indicators (KPIs) such as falls, restraints, infection, weights, pressure ulcers and complaints for example. An annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents. Information was trended and this showed improvements in quality care indicators such as a reduction in administration of psychotropic ‘as required’ medication, moisture lesions, and falls. The person in charge had excellent

knowledge of key performance indicators such as oversight of residents' nutritional assessments with associated referrals, infections including multi-drug resistant non-active infections, wounds, catheters, and complaints for example. Other audits included observational tools and these along with audits reflected a true picture of the service. Many of the issues identified on inspection had been recognised in audits, such as deficits in wound care management and residents' personal evacuation plans for example. However, due to staff turn-over, including CNMs, these issues remained outstanding.

Duty rosters on each unit were reviewed and rosters showed adequate staff to support the duty roster. A review of training records demonstrated that all mandatory staff training was up to date. The clinical facilitator had just completed their moving and handling training to facilitate in-house training. One CNM had a postgraduate qualification in dementia specific care and provided training in this field. Other training completed by staff included dementia care with challenging behaviour and virtual reality dementia live, and this was provided to staff as well as family members. A QQI level 6 programme was being facilitated in-house to further train staff in leadership; an external facilitator was scheduled to provide wound care management training.

The complaints procedure was displayed at different locations throughout the building; it was in an accessible format for residents. The complaints log was reviewed and issues were recorded in line with current legislation, followed up and thoroughly investigated. A current insurance certificate was in place. Schedule 5 policies and procedures were in place and easily accessible to staff. The directory of residents had the requirements as specified as part of Schedule 3. The statement of purpose required updating to include the specified regulatory requirements.

The annual review for 2025 was available and displayed in the centre. This was a comprehensive publication providing detailed information in accordance with specified regulatory requirements. The risk management overview was very detailed and provided information to inform their quality improvement strategy plans.

A human resources person was recently appointed; she had introduced very positive initiatives such as a staff well-being programme; in addition, she visited residents regularly to obtain their feedback and from this was developing resident-specific well-being programme. One resident asked her to do an interview with them, so she went through the whole interview process including CV appraisal and interview, and the resident was so pleased with the experience.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew registration of Bridhaven Nursing Home. Appropriate fees were paid; prescribed documentation was submitted including floor plans and statement of purpose.

Judgment: Compliant

Registration Regulation 6: Changes to information supplied for registration purposes

The post of person in charge was advertised in April 2026 as the current person in charge was appointed as Director of Operations in March, however, the required notification was not submitted in accordance with this regulation which states:

Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015, 6 (1) (a) - 'give notice in writing to the Chief Inspector of any intended change in the identity of the person in charge of a designated centre'.

A second person was appointed as PPIM Clinical Operations Manager, however, the associated notification was not submitted to the regulator:

Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015, 7 (3) - shall notify the Chief Inspector in writing of any change in the identity of any person participating in management of a designated centre'.

Judgment: Not compliant

Regulation 15: Staffing

From a review of staff rosters, feedback of residents and observation on inspection, there were adequate staff to the size and layout of the centre and the assessed needs of residents. The roster was updated following the findings of the previous inspection and included additional staffing levels for twilight hours.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required to ensure that staff were appropriately supervised; evidence of lack of supervision is detailed throughout the report including during mealtimes and activities, for example:

- staff were observed to stand over residents while assisting them with their meal rather than sit down facing residents to enable active engagement
- on another unit, when residents were finished their dinner but having their desert, staff cleaned the dinner plates with metal cutlery and then threw the

plates into a basin creating an unpleasant noise while residents were still having their meal
- one lady arrived into the day room and appeared confused, there were two activity staff standing chatting with each other and did not engage with the resident, who left the room as she did not know where she should sit.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained and this contained the requirements as specified in paragraph 3 of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Action was required to ensure records were maintained in accordance with specified regulatory requirements, as follows:

Schedule 2: Documents to be held in respect for each member of staff:

- a sample of staff files were reviewed and while most of the information required in Schedule 2 was in place for staff, reference confirmation was not completed in records where just a statement of employment dates was issued; these statements of employment do not demonstrate the ability and competence of the person being employed,
- there were gaps in employment histories in two files examined.

Judgment: Substantially compliant

Regulation 22: Insurance

A valid insurance certificate was in place and had the specified regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

While it is acknowledged that recruitment was in progress, the governance structure was unstable to ensure the service was safe, appropriate, consistent and effectively monitored, as follows:

- oversight of submission of registration notifications, as changes to senior management roles were not notified to the Chief Inspector as outlined under Registration Regulation 6: Changes to information supplied for registration purposes,
- the turnover of middle and senior management included the change of person representing the registered provider, appointment of a PPIM, two assistant directors of nursing and six CNMs, along with recruitment in progress for replacement of the current person in charge,
- there was a lack of oversight of staff supervision to ensure and enable effective care as outlined under Regulation16: Training and staff development
- minutes of committee meetings did not provide assurance that the service relating to IPC was effectively monitored; this is further detailed under Regulation 27: Infection control.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to ensure it complied with specified regulatory requirements as follows:

- to include the organisational structure
- whole-time equivalent staffing numbers
- the specific care needs being provided.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the incident and accident records showed that notifications correlated with incidents logged, and were submitted in accordance with specified regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed throughout the centre and the information reflected changes in legislation. A review of complaints logged showed that records were maintained in line with current legislation, issues were followed up in a timely manner, actions taken on foot of complaints to mitigate recurrence and the outcome of complaints were recorded. The person in charge liaised with the complainant throughout, and records showed minutes of meetings and phone calls to complainants to enable satisfactory outcomes. Advocacy services expertise was sought to enable best outcomes.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were available to staff. They were updated in accordance with regulatory requirements.

Judgment: Compliant

Quality and safety

Feedback from residents and relatives was mostly positive regarding care and welfare in the centre, and while some issues were raised by one relative, these were seen to be comprehensively addressed as part of the complaints process.

A sample of pre-admission assessments were examined and these showed a thorough review of information to enable decision-making regarding admitting a person to the centre. Validated risk tools were in place to enable appropriate assessments. The daily narrative for both day and night duty was maintained on the resident's status and progress. A sample of residents' care planning documentation was reviewed and showed mixed findings. Some assessments and care plans were excellent including responsive behaviour care records that informed individualised care, however, others had very little detail or the information in care plans did not correlate with information reported in residents' assessments. This is further detailed under Regulation 5: Individual assessment and care plan.

Personal emergency evacuation plans (PEEPS) were available for all residents, however, these required updating to ensure they reflected the assistance required to safely evacuate a resident during both day and night time.

The GP was on-site Monday – Friday, and out-of-hours GP cover was provided by South Doc. Residents were seen to have good access to health and social care professionals such as a dietician, dental, physiotherapist, occupational therapist (OT), speech and language therapist (SALT), tissue viability nurse specialist, as well as support from a consultant geriatrician, psychiatry community services and palliative care, to enable better outcomes for residents. Access to the mobile diagnostic unit enabled residents to have x rays within the centre and negated the requirement to go to an emergency department with the associated anxiety and upset. Exercise programmes were held on a weekly basis as part of their positive aging programme to help residents maintain their level of muscle tone and mobility.

Behavioural support charts in place to support the relevant residents were comprehensive; they included narrative of the resident's normal behaviour, examples of behavioural disturbances and potential triggers, the possible non-pharmacological interventions to support the resident along with the pharmacological interventions. Staff spoken with demonstrated good knowledge of residents in their care.

A sample of controlled drugs records were examined and these were maintained in line with professional guidelines. Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. A record of 'as required' (PRNs) psychotropic medications was maintained as part of medication management; these records showed the rationale for administration of PRNs. Inspectors joined two separate medication rounds where a sample of medication management administration records were examined and these were maintained in accordance with professional guidelines.

Records demonstrated that independent advocacy was accessed for residents in accordance with their wishes. The advocate was on site on a weekly basis and residents availed of this service including residents under 65yrs. Residents meetings were facilitated and issues and queries raised were followed up by the person in charge; relatives meetings had commenced providing an opportunity for information sharing such as proposed improvements, KPIs, and complaints management, and receipt of feedback from relatives was encouraged to enable quality improvement.

Regarding residents' access to meaningful activation; the activities programme was varied and included group and one-to-one engagement as well as an array of clubs such as the indoors equivalent of the mens' shed, knitting, and book club for example. Children from the local play school, primary and secondary schools regularly attended the centre with their teachers.

In general, the premises was seen to be well maintained. Improvement was noted throughout with new equipment, flooring was upgraded, and painting and decorating was ongoing during the inspection; a complete new call-bell system was installed. While planned upgrades were in progress to refurbish Lavender [dementia

specific unit], this was taking a protracted time to complete; residents were relocated to Bandon unit and out of their familiar surroundings. The unit was closed on 23 March and the proposed time for completion was hoped to be July 2026.

The centre was visibly clean and household staff were rostered on each unit throughout the day, and one staff rostered on night duty. Notwithstanding this, minutes of IPC meeting in January and March 2026 did not include discussion on key items such as surveillance, antibiotic usage, wound infections or other infections for example, to enable oversight and trending of information to inform effective monitoring. While these were discussed in February's meeting, minutes of IPC meetings demonstrated that there was no set agenda items to enable consistency and effective oversight of IPC in the centre.

Service records relating to fire safety precautions were in place including annual and quarterly certifications. Fire drills and simulated evacuations were routinely completed monthly and undertaken cognisant of night time staff levels. Nonetheless, action was required regarding emergency evacuation floor plans and residents' personal emergency evacuation plans to ensur they could be safely evacuated.

Regulation 11: Visits

An open visiting policy was seen throughout the inspection. Visitors were welcomed into the centre and inspectors saw that visitors were familiar with the risk management procedures upon entering the centre of signing in and hand hygiene. There was ample room for residents to meet their relative in private if they wished. The person in charge and staff were familiar with visitors, greeted them by name and provided updates on their relative's well-being.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had good access to personal storage space with a double wardrobe, bedside locker and many residents had an additional chest of drawers and single or double wardrobe. A review of current complaints demonstrated there was no issue with laundry services. The laundry operated over seven days of the week. The laundry was inspected and seen to be meticulous.

Judgment: Compliant

Regulation 17: Premises

A programme of works was ongoing in the centre to ensure it was in compliance with Schedule 6 of the regulations. Three bedrooms per month were completely refurbished; this included new furniture of bed, locker, chest of drawers, armchair and wardrobe. Flooring had been upgraded and other flooring was scheduled to be replaced.

Judgment: Compliant

Regulation 18: Food and nutrition

Action was required to ensure residents were served appropriately, as follows:

- there were delays in serving residents their main meal; some residents waited 30 minutes before being served in the dining room
- the noise level in one dining room was loud and abrasive; while some residents were still eating their dinner or being served their desert, staff cleaned off plates with cutlery and then threw plates into a dish creating an unpleasant noise.

Judgment: Substantially compliant

Regulation 26: Risk management

A current risk policy was available; it had the specified risks as detailed in the regulations, and had been updated with the change in legislation.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure the implementation of the mandated National Standards for Infection Prevention and Control in Community Services (2018) as follows:

- due to staff attrition, there was no IPC lead currently [the ADON recruited has completed a lead practitioner course in IPC and they will be in post shortly]

- antimicrobial stewardship, infections, wound infections and MDROs were not set items on the IPC meeting minutes to provide oversight of IPC in the centre
- some staff were wearing masks with no clinical indication for donning them; others wore masks with a clinical indication, however, they were seen to routinely wear them incorrectly
- one staff member reported that they decanted dirty water from cleaning into hand-wash basins which would cause a risk of cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required to ensure adequate fire precautions as follows:

- the print in emergency evacuation floor plans was very small and could not be read to enable access to evacuation information
- some floor plans were not orientated to reflect their relative position so evacuation route information was confusing
- personal emergency evacuation plans (PEEPS) were available for all residents, however, these required review to ensure they reflected the assistance required to safely evacuate a resident during both day and night time, for example, one resident's care notes stated the resident had moderate pain and used a walking frame to mobilise, however, their PEEP said they would mobilise with a walking frame in an evacuation.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvement was noted regarding medication management. Medications requiring crushing were individually prescribed to ensure best outcomes for residents. Controlled drugs were maintained in accordance with professional guidelines. There were separate fridges on each unit to safely store medications; medications were seen to be dated with the date of opening.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were examined and while some had personalised information to inform individualised care, many others did not have this detail or were not updated in accordance with regulatory requirements. For example:

- assessments and care plan information did not correlate to enable and ensure residents was cared for in accordance with their current needs. For example, the pain assessment reported that the resident did not have pain, however, their care plan gave specific details of location of pain along with details of regular and as required pain medication prescribed,
- one resident's life story had very little detail of the resident's family involvement even though their care records showed the family were very involved in the resident's life in the centre
- while records were updated in accordance with regulatory requirements of every four months, they were not routinely updated with the changing needs of residents to ensure individualised care
- a spirituality and end of life assessment did not have any information to guide personalised care
- while one resident's skin assessment stated they had wounds, there were no further descriptors to indicate the type or location of these wounds; there were no associated plans of care to inform wound care management. [Deficits in wound care management had been identified as part of the audit process; additional wound care training was scheduled in-house for nursing staff to address this.]

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to GP services with a GP attending the centre on a daily basis. The physiotherapist was on site weekly and residents had access to allied health professionals as well as specialist consultant services, tissue viability nurse specialist (TVN), psychiatry and palliative care including community services to enable best outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Responsive behaviour and restraint registers were maintained to provide oversight of restrictive practices within the centre. Care plans examined showed in-depth knowledge of residents and their specific care needs to enable individualised care. Staff spoken with were very familiar with residents, possible triggers which may

cause upset, and individualised de-escalation methods to enable their comfort and safety.

Judgment: Compliant

Regulation 8: Protection

Safeguarding posters were displayed throughout the centre informing residents and visitors about their rights and actions taken to safeguard people.

Allegations of inappropriate behaviours were notified to the Chief Inspector in accordance with specified regulatory requirement. Records showed that these were investigated thoroughly, followed up, and action plans developed to mitigate possible recurrence of such incidents.

Residents reported that they felt safe in the centre and were complimentary of staff; residents reported that they could raise issues and their concerns were addressed.

This service was a pension agent for 13 residents. Robust systems were in place to safeguard residents with a separate residents account with individual resident accounts. Monthly statements were issued to each resident; and advocacy services were availed of when residents required assistance with their financial matters.

Judgment: Compliant

Regulation 9: Residents' rights

Notwithstanding improvements noted regarding activities in the centre, action was required to ensure residents rights and independence were promoted:

- observation throughout the inspection showed delays in answering call bells on some units
- observation on inspection showed that some staff did not engage with residents when providing assistance at mealtimes, during activities in day rooms or when providing personal care
- while TVs in bedrooms were being upgraded, some remained small and would be difficult to view.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0041660

Date of inspection: 12/05/2026

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 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: • The required notifications have been submitted to the regulator and the COO/RPR has provided reassurance to the regulator for ongoing compliance with this regulation. In progress	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A CNM is allocated to the dining room for mealtimes each day to ensure that the training provided to staff is implemented in daily practice. The CNM team are accountable for including their feedback on their mealtime observations and any actions completed in the daily report to their colleagues: CNM, ADON & DON. Ongoing • Induction for new staff as well as daily huddles include reminders on preventing noise levels in the dining rooms at mealtimes. Ongoing • Staff are no longer use cutlery to clear plates, and desert is placed after the residents have finished their main meal. Ongoing • The Clinical facilitator and CNS in Dementia complete hands-on training and support staff on a daily basis to enhance the resident experience with increased focus on mealtimes and meaningful engagement. Ongoing	

• Training has commenced on HSE "Safeguarding starts at the table" and will continue to be rolled out for all staff in the coming months. Ongoing
• All staff have been reminded of the importance of meaningful engagement and acknowledgement of residents; this is overseen by the nursing & clinical management team. Ongoing

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

An audit of employee files has commenced to ensure that
• reference confirmation is completed for all staff where statement of employment has been received and gaps are being addressed. This is ongoing and will be complete by 01/08/2026
• any gaps in employment histories have been rectified. Completed

Regulation 23: Governance and management	Not Compliant

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

• The registration notifications have been submitted to the chief inspector. Completed
• The COO/RPR continues to facilitate weekly Governance & Management meetings with PIC and PPIM. Ongoing
• Whilst the current PIC has been appointed as RDO, this post will not be in effect until a suitable candidate is secured and satisfactorily inducted into the DON/PIC post of the center. Ongoing
• To enhance stability and ensure continuity in the centre's G&M the current PIC/RDO will complete a robust handover and induction when a new DON/PIC commences. This will include continued oversight and leadership of the centre with onsite presence of a minimum 2 days per week and will be reviewed at 3 month and 6-month intervals. Ongoing
• The Governance and Management in the center has been restored with ADONx3 & CNMx4 in place resulting in increased oversight of staff supervision to ensure and enable effective care of residents. CompletedCNMx2 are on boarding and due to commence in July and August 2026 respectfully. This will result in a team of ADONx1 and CNMx2

allocated to each area of the home as part of the Governance and Management structure. Completed by 10/08/2026
• ADON who has worked previously in the center is the lead IPC link nurse completed an IPC committee meeting in June 2026. The agenda included antimicrobial stewardship, infections, MDRO, appropriate PPE wearing and oversight to ensure that IPC is effectively monitored. Meetings will continue monthly with clear terms of reference in place and oversight by the PIC. Ongoing
Ongoing educational assistance is provided to staff by the center to support the professional development for the clinical management team and increase the stability of the clinical management team. Ongoing

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

• The SOP has been reviewed and the organizational structure updated to reflect change in RPR, PPIM, WTE staffing numbers and the specific care needs provided to residents in each area. Completed

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• There is daily oversight of the dining experience by the CNM team in each area with improvements noted by PIC. Ongoing
• The clinical facilitator, ADON and CNS continue to complete QUiS observational assessments on mealtime experience for residents with findings shared with staff as part of QIP's with PIC oversight. Ongoing
• Additional lead HCA's have been interviewed and appointed to each area, provided with training and allocated accountability to ensure the mealtime experience is effective and enjoyable for all residents. Ongoing

Regulation 27: Infection control	Substantially Compliant

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

• ADON x1 who has returned to work in the center is the Lead trained IPC link nurse trained and completed IPC committee meeting in June 2026, the agenda included antimicrobial stewardship, infections, MDRO, appropriate PPE wearing and oversight to ensure that IPC is effectively monitored. Completed
• Monthly IPC committee meetings will continue and actions/learnings shared with the wider team with clear terms of reference and oversight by the PIC. Ongoing
• There are 2x trained Link nurses in the centre and an additional staff x 3 have been allocated to complete the IPC link nurse training in October 2026.
• Oversight of wearing of masks has increased with guidance provided to all staff on the appropriate wearing of PPE. Ongoing
• A new sink has been ordered and there is an appropriate IPC process in place for housekeeping to decant dirty water in the area identified. This will be completed by 01-07-2026

Regulation 28: Fire precautions	Substantially Compliant

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

• The emergency evacuation floor plans have been reviewed and are in the process of being printed in a larger scale and due to be completed by 01-08-2026
• The floor plans have been orientated to reflect the correct position to avoid any confusion. Completed
• All residents PEEP's have been audited and updated to ensure they include the correct information and reflect what is in the residents nursing assessments. These will continue to be reviewed 4 monthly and/or if and when the residents' condition changes. Ongoing

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

• Residents care plans have been reviewed and updated with any discrepancies identified rectified with ongoing monthly audits in place. Ongoing
• Social care manager has reviewed and updated as necessary all residents' life story records in line with the resident's care records. Ongoing
• The CNM team reviews each resident's assessments and care plan post MDT review, admission to the centre and upon the resident returning from OPD/Hospital. Ongoing
• The assessments and care plans are routinely spot checked by ADON/DON as part of the weekly KPI monitoring with feedback shared with the relevant nursing team. Ongoing
• There is a trained CARU team in place to support the quality of spirituality and end of life assessment and care planning. Ongoing
• Wound care training to include the quality of related assessments, documentation and follow-up requirements was completed at the end of May with 50 staff(Nursing & HCA's) attending. Additional wound care training is scheduled on 2nd of July for 30 staff (Nursing &HCA's).
• Care plan Audits will continue monthly as part of the audit schedule completed by the clinical management team and findings/learnings shared with the nursing team. Ongoing

Regulation 9: Residents' rights	Substantially Compliant

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

• The call bell system in place enables automatic audit of the call bell answering times for May, demonstrates that >92% of call bells are answered within a good or normal response time of 3.5mins. Continued monitoring and auditing of call bell answer times is completed by the clinical management team. Monthly audits will continue. Ongoing
• Increased oversight & additional hands-on training has improved staff engagement with residents at mealtimes, during personal care and activities. This is overseen and monitored by the CNM, ADON, Clinical facilitator and CNS. Ongoing
• The PIC continues to provide a welcome induction to all new staff which includes the significance of meaningful engagement on residents quality of life and how this can be applied to support residents. Ongoing
• All residents have TV in their room. A review of the size of TV's in each resident's room has been completed and a plan implemented to swap out smaller TV's with larger TV's has commenced. This will continue as part of the fit out of 3 rooms each month. Ongoing

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 6 (1) (a)	The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre for older people.	Not Compliant	Orange	25/06/2026
Registration Regulation 6 (3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the centre) within 28 days of the change and supply full and satisfactory information in regard to the	Not Compliant	Orange	25/06/2026

	matters set out in Schedule 2 in respect of any new person participating in the management of the designated centre.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	25/06/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	25/06/2026
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	01/08/2026
Regulation 23(1)(d)	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	01/08/2026

Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	01/07/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	01/08/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	25/06/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	25/06/2026
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	01/08/2026

	formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Substantially Compliant	Yellow	25/06/2026
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	25/06/2026