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:	Breffni Care Centre
Name of provider:	Health Service Executive
Address of centre:	Ballyconnell, Cavan
Type of inspection:	Unannounced
Date of inspection:	12 January 2023
Centre ID:	OSV-0000489
Fieldwork ID:	MON-0037149

About the designated centre

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

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The designated centre provides 24-hour nursing care to 18 residents over 65 years of age, male and female who require long-term and short-term care including dementia care, convalescence, palliative care and psychiatry of old age. The centre is a single story building opened in 2001. Accommodation consists of four three bedded rooms, one twin bedroom and four single bedrooms. An additional bedroom is designated for the provision of end of life care. Communal facilities include Dining/day room, an oratory, visitors' room, hairdressing salon, smoking room and a safe internal courtyard. Residents have access to three assisted showers and a bathroom. The philosophy of care is to embrace ageing and place the older person at the centre of all decisions in relation to the provision of the residential service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 12 January 2023	10:15hrs to 17:00hrs	Catherine Rose Connolly Gargan	Lead
Thursday 12 January 2023	10:15hrs to 17:00hrs	Lorraine Wall	Support

What residents told us and what inspectors observed

On arrival to the centre, the inspectors met with the person in charge. Following an introductory meeting, inspectors walked around the centre with the management team which gave them an opportunity to meet with residents and staff as they prepared for the day. A small number of residents in assistive chairs were being assisted to the sitting room area by staff. The centre was warm, bright and had there was a relaxed atmosphere. The inspectors spoke with a number of residents and a small number of resident's visitors. Overall, feedback from residents was mostly positive and inspectors observed that although a number of residents could not participate in the social activities in the sitting room due to space limitations, they accepted this and other than going to the dining room for their meals, the majority remained in their bedrooms.

Breffni Care Centre is located in a residential area on the periphery of the town. Residents' accommodation was arranged on ground floor level throughout. The centre premises was designed in a square design with one side dedicated to primary care services and two general practitioner (GP) surgeries. Access was controlled between the two facilities to ensure residents' safety.

A traditional fireplace had been installed in the centre's reception area since the last inspection. An electric fire was lighted in the fireplace and this created a welcoming and warm ambiance on entering the centre. Residents were seen to enjoy this area and to spend time with their visitors sitting around the fireplace in the comfortable chairs provided. One resident told the inspectors he spent time sitting in this area every morning after his walk and he loved to "watch people coming and going."

Residents told inspectors that they were well cared for, complimented the food they received and the staff caring for them. Inspectors observed interactions between residents and staff and found that staff were warm, empathetic and respectful in their interactions with residents. Residents comments to inspectors regarding the staff included that staff "could not do enough for you", "hard to beat the kindness of the staff here" and that they were "the best in the world". Residents knew the person in charge and the management team and they told the inspectors that they would talk to "any of the staff" if they were worried about anything or were not satisfied with any aspect of the service. Residents said that they were always listened to and any issues they ever raised were addressed to their satisfaction.

The dining room was airy and spacious and overlooked the outdoor courtyard which could be accessed from the dining room. A specially adapted table was available to enable residents in comfort chairs and wheelchairs to eat their meals at a dining table. A large door and glass wall had been fitted between the dining room and the circulating corridor since the last inspection and inspectors saw that this improved the dining environment for residents as the room was now separated from the corridor. An area adjacent to the dining room was laid out with domestic style kitchen furniture around the wall and was registered as a sitting room for residents.

No residents were observed using this area outside of mealtimes even though it is registered as a second sitting room. This was of particular concern as the main sitting room could only seat nine residents comfortably. Inspectors observed that many of the residents returned from the dining room to their bedrooms and spent most of their time in their bedrooms**.** One of these residents told inspectors that were not aware that there was a sitting room that they could rest in and another resident asked inspectors 'where else can I go'.

Residents were seen to enjoy the activities facilitated by the activity coordinator in this sitting room, including music and word games. The residents in the sitting room were also observed praying a rosary together led by the activities coordinator. Residents in the sitting room told the inspectors that they enjoyed other activities too, such as bingo, pet therapy, baking and their day trips out together. The centre was recovering from a COVID-19 outbreak and residents were looking forward to going out on day trips again. These observations of residents' quality of life in the sitting room were in stark contrast to the inspectors' observations regarding the experience of residents who spent the day in their bedrooms. Residents who remained in their bedrooms during the day had limited opportunities to participate in meaningful social activities and they watched television and spent time sleeping and sitting quietly in or by their beds.

There was a small alcove at the end of most of the three bedded bedrooms. These alcoves were laid out with comfortable chairs so that residents in these bedrooms could rest and relax in the comfortable chairs provided. Although inspectors were told that residents used these sitting areas, no residents were observed to use these areas on the day of inspection and chose to rest on their beds. One resident told the inspectors that they did not use the sitting area in their bedroom and stayed by their bed so they could watch the television.

Overall, the general environment including residents' bedrooms, communal areas and toilets were clean. A post outbreak deep clean was in progress on the day of the inspection. Alcohol hand gel dispensers were available for use on the corridors and the majority of staff were seen to use good hand hygiene techniques however, there was some evidence of inappropriate use of gloves. This was addressed and corrected by the centre's management team at the time of the inspection.

The designated centre had been painted and refurbished in a number of areas since the last inspection. Inspectors observed that there was adequate storage space available for equipment including residents' assistive equipment.

The inspectors observed that the centre's oratory was not accessible to residents as it was being used as a temporary storage for Christmas decorations. This had a significant impact on one resident who told inspectors that she really liked to visit the oratory on a regular basis and was not able to do so.

The inspectors saw that many of the residents had personalised their bed spaces and bedrooms with their photographs and artwork. Each resident's bedroom door had the residents name along with a picture of the resident and some pictures to reflect their interests. Efforts had been made in the bedrooms with three beds to

define each resident's bed space with a wardrobe and dressing table unit and the placement of their privacy screens. However, inspectors observed that one resident's wardrobe was very narrow and did not provided them with sufficient space for their clothing. This resident's wardrobe was also not accessible to them as it was in another bedroom. The inspectors' were told that this was a temporary arrangement during their recent COVID-19 outbreak and the resident's wardrobe. The inspectors observed that this resident's wardrobe was returned to their bedroom on the day of inspection.

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

Capacity and capability

This was an unannounced inspection completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors followed up on progress with completion of the compliance plan from the last inspection and found that a number of the compliance actions relating to twelve regulations had been completed. However further non compliances were found in these regulations on this inspection including actions to bring Regulations, 9: Residents' Rights, 15: Staffing, 17: Premises and 23: Governance and Management into compliance. The inspectors' findings are described under the relevant regulations in this report.

The registered provider of Breffni Care Centre is the Health Service Executive (HSE), and a service manager was assigned to represent the provider and oversee the operation of the designated centre. As a national provider involved in operating residential services for older people, this designated centre benefits from access to and support from centralised departments such as human resources, information technology, staff training and finance.

Although, there was an established governance and management structure in place, the inspectors found that the oversight and management of the service was not robust and did not ensure that the service was safe and consistent and that adequate resources were provided to ensure residents' needs were met. This inspection also found that the provider had breached the conditions of their registration by changing the purpose of a resident's sitting room to a dining area which meant that there was not sufficient communal space available for residents to sit together or to sit quietly outside of their bedrooms. The provider had also failed to submit an application to the Chief inspector for this variation of room usage which was not in line with the designated centre's registration conditions.

The systems in place to monitor the quality and safety of the service and residents' quality of life were not effective as these systems were not comprehensively identifying service deficits or informing actions needed to mitigate the impact of

these deficits on residents. For example, the negative impacts on some residents' quality of life in the centre by not being facilitated to participate in meaningful social activities and not having adequate sitting room facilities had not been identified and addressed.

This inspection found that the provider had not ensured that there was adequate staffing resources available to meet residents' social care needs. This was a finding from the last inspection in January 2022 and is a repeated non compliance on this inspection. The inspectors' findings are discussed under Regulation 15 in this report. Staff were not appropriately supervised according to their roles and as a result, the inspectors found that residents' social care needs were not adequately met.

All staff working in the centre had received up-to-date mandatory training which included fire safety training, safe moving and handling and safeguarding training. Staff were also facilitated to attend training including infection prevention and control to ensure they had the necessary skills and competencies to meet residents' needs. Most staff had been facilitated to attend professional management of aggression and violence (PMAV) training. Two staff members had attended a Focused Intervention Training and Support (FITS) programme and were trained as Dementia Care Coaches. However, there was no evidence available that other staff had been facilitated to attend training to ensure they had up-to-date skills and knowledge to manage and support residents' who experienced responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Inspectors found that all notifiable incidents that had occurred in the centre had been reported in writing to the chief inspector, as required under Regulation 31: Notification of Incidents.

An annual review of the quality and safety of care had been completed from 2022. Resident feedback was used to inform the review.

The centre's complaints procedure was available and while inspectors were assured that all complaints received were managed in line with the complaints policy, documentation was limited and did not contain adequate information to reference that all steps of the complaint management process were completed and that the complainants' satisfaction with how the complaint was resolved was obtained and recorded.

A sample of staff files were examined and they contained all of the requirements as listed in Schedule 2 of the regulations. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff.

Regulation 15: Staffing

The provider had failed to ensure that the number of staff available was appropriate to meet the needs of residents and the size and layout of the centre. The inspectors found that staffing resources were not adequate and these findings were repeated from the last inspection in January 2022 as follows;

- The staff rosters reviewed on the day of this inspection for weeks commencing 02 and 09 January 2023 showed that the numbers of care staff available varied from day to day in the absence of any evidence of a change in residents' dependency or care needs. For example, the number of care staff available to meet residents' direct care needs from 08:00 to 17:00hrs varied from three to four staff and the number of care staff from 17:00 - 20:00hrs varied from two to three staff each day. The number of care staff on night duty also varied from two to three staff. The majority of the seventeen residents in the centre had high care and support needs and were assessed as needing two staff to meet these needs including their emergency evacuation needs at night.
- The allocation of staff available did not ensure residents could choose to spend time in the second sitting area off the dining room. The inspectors observed that this second area was now furnished as a dining area.
- There was not enough staff available to ensure residents who spent most of their day in their bedrooms had opportunities to engage in meaningful social activities that interested them and met their capability needs. This meant that these residents watched television or slept.
- Inspectors were told that an additional care staff member was assigned at weekends and bank holidays with responsibility for facilitating residents' social activities. However, the staff rosters reviewed by inspectors showed that no additional care staff were rostered at the weekends and bank holidays to carry out this role. This meant either that that there were no staff available to provide activities for the residents at weekends or if care staff were redirected to provide activities then the number of care staff available to meet residents' direct care needs was reduced although there was no evidence of a reduction in the residents' dependency needs.
- The centre's hairdresser vacancy had not been replaced and one of the staff responsible for providing activities was allocated to hairdressing duties for residents. This impacted on the availability of this staff member to ensure the social activity needs of residents were met and is a repeated finding from the last inspection in January 2022.

Judgment: Not compliant

Regulation 16: Training and staff development

While, there were residents with dementia who experienced responsive behaviours, not all staff had not been facilitated to attend suitable training to ensure they had

up-to-date skills and knowledge to support them with managing residents' responsive behaviours.

Staff were not appropriately supervised according to their roles and as a result, the inspectors found the following;

- Many of the residents' individual social activity care plans developed to meet their interests and capacities were not being implemented.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The centre had established and maintained a directory of residents containing all information as required by the regulations. This documentation was made available to inspectors for review.

Judgment: Compliant

Regulation 21: Records

Records as set out in Schedules 2,3 and 4 were kept in the centre and were made available for inspection. Records were stored safely and the policy on the retention of records was in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

Although, improvements had been made since the last inspection in January 2022, management and oversight of the service was not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013 and ensuring the service were delivered in line with the centre's statement of purpose. This was evidenced by the following finding;

- Systems to ensure adequate staffing resources were provided were not being implemented effectively. As a result, this was impacting on residents' access to meaningful social activities that met their interests and capabilities and their quality of life in the centre.
- The provider had changed the purpose of a second sitting room to a dining

area for residents. This action was not in compliance with the Condition 1 of the centre's registration and statement of purpose and had a negative impact on the comfort and choices afforded to residents in where they spent their time. Non-compliance with the conditions of the designated centre's compliance registration was also found on the last inspection in January 2022.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Notifications and quarterly reports were submitted within the specified time frames and as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Four complaints were recorded in the complaints record for 2022 and all were closed. While inspectors were given assurances that these complaints were being managed in line with the centre's policy, there was limited information recorded in the records made available to the inspectors regarding;

- the complaint investigation process
- that the outcome of the investigation was consistently communicated with complainants.
- The complainant's level of satisfaction with the outcome of the complaint investigation. This information is necessary to ensure that complainants are informed of the appeals procedure if necessary
- Any learning from the complaint investigation including any improvement actions that needed to be implemented.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures were up-to-date and were made available to the inspectors for review. The centre's policies and procedures as outlined in Schedule 5 of the regulations were reviewed and updated within the previous three

years. Policies and procedures in place regarding the COVID-19 pandemic were updated to reflect evolving public health guidance.

Judgment: Compliant

Quality and safety

Overall, residents were provided with a high standard of nursing and medical care, however, inspectors found that their social care needs were not adequately met and this impacted on the quality of life of residents, particularly those resident who spent most of their day in their bedrooms. While residents' privacy was respected, resident rights regarding their choices in where they spent their time in the centre had been impacted by a reduction in communal seating areas and the re-purposing of the oratory room about which residents had not been adequately consulted.

Works were completed since the last inspection to ensure the premises was maintained to a good standard and residents had improved the look of the living environment for residents.

Measures were in place to ensure residents were protected from risk of fire. However, further actions by the provider were necessary to ensure the effective containment of fire and smoke in a fire emergency. Actions were also required to ensure that residents could be evacuated to a place of safety in a timely manner and that the fire safety checks in the centre were carried out in line with the centre's own procedures.

There was an up to date infection prevention and control policy that provided guidance to staff regarding the standards of practice required to ensure that residents were adequately protected from infection. The centre was recovering following an outbreak of COVID-19 infection and deep cleaning was in process on the day of inspection. Inspectors found that this process was well managed to reduce the risk of transmission of infection. While, improvements in relation to infection prevention and control processes and procedures had been made since the last inspection, this inspection identified some further actions were required to ensure risk of infection to residents was effectively mitigated and the designated centre was compliant with Regulation 27, Infection control.

There were no restrictions on residents meeting their visitors. Residents had access to religious services and were supported to practice their religious faiths in the centre. However, at the time of this inspection residents were not able to access the oratory to say prayers or for quiet reflection.

Staff were familiar with the residents' needs and residents received good standards of nursing care and support. Resident's care plan documentation clearly guided staff with providing person-centred care in line with residents' individual preferences and wishes. The provider ensured that residents had timely access to their general

practitioners (GPs) and specialist medical and allied health professional services who were located on the the same site. Residents were supported to attend out-patient appointments as scheduled. Staff had made a particularly special effort for one resident who was losing weight, ensuring that this resident had the food they liked. This included staff driving to Derry to get this resident's favourite fish and chips. This had a positive impact on this resident's well being and health.

No residents had developed pressure related skin wounds in the centre over the past 12 months. However the inspectors reviewed the management of two resident's chronic wounds and found that some improvement in documentation of wound assessment was necessary to reflect evidence based practice and to inform treatment plans. There was a low incidence of residents falling in the centre and actions were put in place to mitigate residents' risk of further falls.

Residents who had opportunities to attend the sitting room were supported to participate in a variety of social activities that met their interests and capabilities. However, due to limitations on space available in the sitting room, not all residents could attend the sitting room. Those residents who did not attend the sitting room spent much of their day in their bedrooms and did not have opportunities to participate in meaningful social activities that met their interests and capabilities. This finding was negatively impacting on their well being and quality of life. The inspectors' observations and residents' feedback is discussed in section 1 of this report. This was also a finding from the last inspection in January 2022 which had not been effectively addressed by the provider and person in charge.

Residents' accommodation was provided in four single bedrooms, one twin bedroom and four bedrooms with three beds in each. The twin bedroom and the four bedrooms with three beds had en-suite toilet and wash basin facilities available. Communal shower and toilet facilities were provided to meet the needs of the other residents. There was adequate storage facilities for residents' assistive equipment.

There were measures in place to ensure residents were safeguarded from abuse. The provider had taken adequate measures to ensure that any risk of unauthorised access by members of the public attending the adjacent primary care centre was mitigated by controlled access which had been put in place by the provider since the last inspection.

A minimal restraint environment was promoted in the centre and procedures in place were in line with local and national policies. A restraint register was maintained and reviewed on a regular basis. Records showed that restraints were only used following a comprehensive risk assessment and there was evidence of alternatives trialled prior to their use.

Residents' meetings were regularly convened and issues raised for areas needing improvement were addressed. However, inspectors found that residents had not been adequately consulted about the changes to the sitting room and the re-purposing of the oratory room.

Residents had access to local and national newspapers and radios.

Regulation 11: Visits

Visits by residents' families were encouraged and practical precautions were in place to manage any associated risks. Residents access to their visitors was not restricted and facilities were available to ensure residents were protected from risk of infection.

Judgment: Compliant

Regulation 12: Personal possessions

Not all residents had access to sufficient storage space to retain control over their personal possessions. This was evidenced by;

- One resident did not have sufficient wardrobe space. The wardrobe provided was narrow with limited space available to them for their clothing and other possessions. In addition, this resident's wardrobe was in another resident's bedroom as there was not sufficient room in their own bedroom and as such was not accessible to them. This resident's wardrobe was relocated to their own bedroom on the day of the inspection and a new wardrobe was ordered for the resident.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. This was evidenced by:

- The surface of on the sides of a splash-back panel behind a sink in one bedroom with three beds was peeling and damaged behind one sink was damaged and could not be effectively cleaned.
- Part of the surface was uneven in an area of the floor in one bedroom with three beds. Inspectors were told that repair was already scheduled.
- There was not adequate sitting space available outside of the residents' bedrooms for the number of residents accommodated in the centre. This was because the second sitting room had been laid out as an extension to the dining space for residents.This meant the majority of the residents in the centre spent their day in their bedrooms.
- The oratory was not accessible to residents as it was being used as a storage

room on the day of this inspection.

Judgment: Not compliant

Regulation 27: Infection control

A number of infection prevention and control measures had been implemented, but further actions were necessary to ensure residents were protected from risk of infection and in line with national standards. For example;

- While a sink was available in the clinical/treatment room, it did not comply with current recommended specifications for clinical hand hygiene sinks. However, the inspectors were told that replacement was scheduled to take place in the week following this inspection.
- The area immediately around the water outlets in sinks in some residents' en suite facilities and in some communal toilets and shower rooms was stained. This finding did not give assurances that these areas had been thoroughly cleaned and this posed a risk of cross infection.
- There was no facility available in the cleaner's room for filling water for cleaning purposes or for disposal of waste water following cleaning.
- There was no hand wash basin and hand drying facilities in the cleaner's room to support cleaning staff with hand hygiene.
- A staff changing area was provided, but an item of outdoor clothing belonging to staff was inappropriately stored in the cleaner's room which posed a risk of cross infection.
- Boxes of personal protective equipment (PPE) and other items were stored directly on the floor in one storeroom and as such hindered effective floor cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Although, measures were in place to protect residents from risk of fire, the following findings required further actions to ensure residents' safety and compliance with Regulation 28: Fire safety,

- The door to the residents' smoking room did not close fully and remained partially open. This posed a risk of cigarette smoke entering the rest of the centre and did not ensure effective containment of fire and smoke would be achieved in the event of a fire in this room.

The oversight of the fire equipment checks was not robust and did not ensure that

where faults were identified that these were reported and addressed in a timely manner. For example;

- At the time of this inspection, weekly checks of fire doors were taking place. However, the weekly check of the fire doors in the centre was confirmed with a tick. This did not give assurances that a comprehensive check was completed on the operation and condition of each individual fire door and to track actions necessary to address any deficits in their effective operation.
- The checks to ensure the fire alarm system was operational at all times did not include a daily check that faults were not registering on the fire alarm panel.

While, a floor plan was displayed by the fire alarm panel to inform evacuation procedures in the centre, the fire compartment boundaries were not clearly displayed and as agency staff regularly worked in the centre, there was a risk that this information would not be clearly communicated to staff working in the centre in the event of a fire emergency.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While, each residents' needs were regularly assessed, actions were necessary to ensure that the care interventions that staff must complete to meet each resident's assessed needs are met. For example

- one resident with diabetes and receiving insulin therapy did not have a care in place. Although, this resident's health needs were met, there was no information to inform the frequency of blood glucose level monitoring, the parameters that this resident's blood glucose levels should be maintained within and the actions staff should take if this resident's blood glucose measurements were outside these parameters.
- A wound assessment was not recorded since 22 December 2022 for one resident's wound each time a dressing procedure was done. This did not inform progress with wound healing or treatment reviews by the multidisciplinary team.
- Although one resident had a care plan in place to inform the care interventions that needed to ensure their pain was appropriately managed, there was no documentation to support that assessment of this resident's pain was completed each time they received pain relief medication so that the effect of the medication was monitored and any changes could be referred to the resident's general practitioner (GP) for medical review if required.
- While, residents' social activity needs were assessed and a social programme was developed in consultation with them to ensure they could continue to pursue their interests in line with their capabilities, there was limited evidence

available that the majority of residents' social activity needs were met. For example, no records were available referencing that these residents had been offered meaningful social activities that met their interests and capacities.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to a general practitioner (GP), allied health professionals, specialist medical and nursing services including psychiatry of older age, community palliative care and tissue viability specialists as necessary. An on-call medical service was accessible to residents out-of-hours as needed. Residents were supported to safely attend out-patient and other appointments in line with public health guidance.

Staff were monitoring residents for symptoms of COVID-19 on an ongoing basis including twice daily temperature checks.

Judgment: Compliant

Regulation 8: Protection

The centre had policies and procedures in place to protect residents from abuse. Staff spoken with were knowledgeable in recognizing and responding to all forms of abuse. Staff were aware of the reporting procedures and clearly articulated knowledge of their responsibility to report any concerns regarding residents' safety. Residents confirmed with inspectors that they felt safe in the centre and would be comfortable to speak with staff if they had concerns.

Training records reviewed showed that all members of staff had up to date training in safeguarding residents from abuse.

The centre acted as pension-agent for some residents' pensions and arrangements were in place to ensure the procedures in place were in line with the legislation.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights were generally respected, however, actions were necessary to ensure residents had access to meaningful activities that met their interests and

capabilities. The inspectors observed that due to the limitations on space available in the sitting room, only nine residents could be accommodated in this room where a member of staff coordinated residents' social activities. The majority of the other residents spent their day in their bedrooms watching television, sleeping or sitting quietly in their chairs with little or no access to meaningful activities.

Inspectors' were unable to get a rationale for a key-code locking system in place on one set of cross corridor doors midway down one corridor used by residents to access the communal dining room, the centre's oratory and the outdoor courtyard. One leaf of these doors was held open with a magnet while, the other door leaf was locked. This meant that there was a risk that both doors would be locked and residents would be restricted from accessing the communal areas provided.

Residents in bedrooms with three beds shared two televisions. This did not ensure that each resident had choice of television viewing and listening. One resident was unable to comfortably view the television on a wall adjacent to their bed in one of the three bedded rooms due to it's location.

Residents could not choose to access the oratory as their access was obstructed due to temporary storage of Christmas decorations in this room.

Residents were not adequately consulted about the changes that had been made to the layout of the sitting and dining facilities in the designated centre. There was no evidence in the resident meeting records that residents had been consulted and had agreed to these changes.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Breffni Care Centre OSV-0000489

Inspection ID: MON-0037149

Date of inspection: 12/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Breffni Care Centre have in place a planned set roster for the Management team, Staff Nurses, Health Care Assistants, Activity Coordinator, Chef's, Catering and Cleaning staff. As part of this planned roster cover for planned annual leave, sick leave etc. is included. In the event of an emergency, where sick leave exceeds the built in cover allocation, the management team contact staff who are not rostered for duty to request their presence at work to provide cover. In a situation where there is no staff available to provide this cover the A/Don and or CNM II will provide cover in the provision of direct care to our residents. Going forward this will be clearly identified on the roster. Each day there are two staff Nurses rostered from 8:00hrs – 17:00hrs (seven days per week) and one staff Nurse from 17:00- 20:15hrs. The Staff Nurses are supported in the provision of direct care to our residents by four Healthcare Assistants from 08:00-17:00hrs and two Healthcare Assistants from 17:00-00hrs- 20:00hrs. There is also a diversional activities coordinator rostered for duty each day 08:00- 17:00 hrs. Monday to Friday. Weekend cover Saturday and Sunday, there are four Healthcare Assistants 08:00-17:00hrs, Two Healthcare Assistant form 17:00- 20:00hrs. One 08:00—17:00hrs Healthcare Assistant is nominated on the roster to provide meaningful activities to the Residents. From 20:00hrs – 08:00hrs there is one Staff Nurse and two Health Care Assistants on duty each night to meet the identified need of the Residents in our care. Each morning the management team carry out risk assessments in relation to Resident: Staff ratios, taking into account resident dependency, Health Status, appointments and a record of this is maintained within the Centre. Dynamic risk assessments are carried out throughout the day and night. To ensure that our residents can choose to spend in the sitting room and or dining/day room, staff will be clearly identified on the roster to provide supervision in both areas.	

Arrangements are in place in the Centre to ensure hair care / hairdressing service is provided to our residents. Residents have the option of inviting a professional hairdresser of their choice to attend the Centre or they may choose to book an appointment in the Local Hairdressing Salon. This will be facilitated by the Care Team in Breffni Care Centre. The Activities Coordinator is a qualified hairdresser and provides a service to the residents also if required. If allocated as a hairdresser, healthcare staff will provide the activities of the residents.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
91% of staff working in Breffni Care Centre have completed a training programme in the Professional Management of Aggression and Violence (PMAV), which clearly provides staff with the skills and knowledge to recognise and support residents who experience responsive behaviors associated with their dementia diagnosis. Residents who display responsive behaviours have positive behaviours support plans in place, which are reviewed regularly as required in accordance to the resident identified needs. The PMAV instructor have a post graduate diploma in managing complex behaviours in the clinical setting and is also available to support staff and management.

Two staff, including the ADON have completed the Focused Intervention Training and Support (FITS) programme and are trained as Dementia Care Coaches. They are available to advise staff in relation to responsive behaviour management. They will also deliver in house training to all staff on identifying and meeting our resident's specific identified needs. The Enriched Model of Care planning will be implemented to support individual residents as required. Management and Staff have access to our Advanced Nurse Practitioner within Older Persons Services with special interest in Dementia Care for support and referral to other member of the MDT as required.

Within Breffni Care Centre residents are supported to self-determine in choosing their activities on a daily basis. Staff supervision structures within Breffni Care Centre are as follows; A/Don supervises CNM II, CMN II, supervises Nursing Staff and Nursing Staff supervise Health care Assistants with overall governance is the responsibility of the Person in Charge. The daily staff allocation sheet clearly identifies the two teams working within the Centre comprising of the Staff Nurse and Healthcare Assistants with responsibility for: Person Centered Care delivery, meaningful activities, appointments, birthday celebrations, and Safety champion and toolbox talks. Staff break times are also identified on the allocation sheet. The CNM II carries out audits of all entries on the EpicCare system, of which meaningful activities are a vital component.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
As outlined above, Breffni Care Centre have in place a planned set roster for the Management team, Staff Nurses, Health Care Assistants, Activity Coordinator, Chef's, Catering and Cleaning staff. As part of this planned roster cover for planned annual leave, sick leave etc. is included. In the event of an emergency, where sick leave exceeds the built in cover allocation, the management team contact staff who are not rostered for duty to request their presence at work to provide cover. In a situation where there is no staff available to provide this cover the A/DON and or CNM II will provide cover in the provision of direct care to our residents. Going forward this will be clearly identified on the roster.

Each day there are two staff Nurses rostered from 8:00hrs – 17:00hrs (seven days per week) and one staff Nurse from 17:00- 20:15hrs. The Staff Nurses are supported in the provision of direct care to our residents by four Healthcare Assistants from 08:00-17:00hrs and two Healthcare Assistants from 17:00-00hrs- 20:00hrs. There is also a diversional activities coordinator rostered for duty each day 08:00- 17:00 hrs. Monday to Friday.

Weekend cover Saturday and Sunday, there are four Healthcare Assistants 08:00-17:00hrs, Two Healthcare Assistant form 17:00- 20:00hrs. One 08:00—17:00hrs Healthcare Assistant is nominated on the roster to provide meaningful activities to the Residents. From 20:00hrs – 08:00hrs there is one Staff Nurse and two Health Care Assistants on duty each night to meet the identified need of the Residents in our care.

Each morning the management team carry out risk assessments in relation to Resident: Staff ratios, taking into account resident dependency, Health Status, appointments and a record of this is maintained within the Centre. Dynamic risk assessments are carried out throughout the day and night. The staffing complement had been reviewed and changed to incorporate one additional Healthcare Assistant from 08:00 -17:00hrs Monday-Sunday inclusive, and one additional Healthcare Assistant from 20:00-08:00hrs (night duty) following recommendations from HIQA on our January 2022 inspection.

Room 56 within the Centre is registered as a dining/day room with access to additional open dining/dayroom area. No application to vary the usage of this room has never been submitted. Room 56 is used by our residents for group activities such as; Baking, music, card games, parties, celebrations, mass and any other activity which enhances our residents well-being. Room 56- sitting/dining-room will be available to all our residents to use as they wish to ensure adequate communal sitting room facilities and this will be monitored on an ongoing basis by the CNM and / or PIC. A checklist has been developed for the monitoring of same and will be available to the inspectorate on request.

Room 62- Oratory has been cleared of all inappropriately stored items 13/01/2023 and is

now clean and available for use by our residents day and night as they wish. This will be monitored on an ongoing basis by the CNM and the PIC. A checklist has been developed for the monitoring of same and will be available to the inspectorate on request.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints records log has been updated on 13/03/2023 to include; Date complaint received, type of complaint, Name of complainant, details of the complaint, complaint investigation process, and learning, outcome of process / level of satisfaction. This log will be will be reviewed on a weekly basis going forward.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The new double wardrobe was received for the resident 16/01/2023. Resident's wardrobe which was located in the wrong bedroom, and was removed on the day of inspection.

The new double wardrobe was received for the resident 16/01/2023, following consultation with the resident in accordance with their will and preference.
Going forward any changes to the resident's personal possessions will be discussed and agreed with the resident and a record of this will be maintained in the resident's notes on the resident information system.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The IPC panel behind the sink in the three bedded room has been replaced with a new panel which complies with IPC guidelines and can be effectively cleaned. All IPC panels in the resident's bedrooms have been replaced and meet IPC guidelines. Works have been completed 03/03/2023. The uneven floor in bedroom with the three beds will be

repaired by an external contractor on 13//03/2023.
There is also a comfortable seating area in the front foyer with traditional fireplace where residents and their families can use at any time.
Room 56 is also available at any time for residents use. Room-62 the Oratory has been de- cluttered 13/01/2023 and is now accessible to all residents.

Room 56 is available at any time for residents use. The PIC/and or CNM will ensure that residents will be given a choice to stay or not stay post dining and a staff member will be assigned to supervise/carry out activities. This will be monitored daily.

Room 56 within the Centre is registered as a dining/day room with access to additional open dining/dayroom area. No application to vary the usage of this room has never been submitted. Room 56 is used by our residents for group activities such as; Baking, music, card games, parties, celebrations, mass and any other activity which enhances our residents well-being. Room 56- sitting/dining-room will be available to all our residents to use as they wish to ensure adequate communal sitting room facilities and this will be monitored on an ongoing basis by the CNM and / or PIC. A checklist has been developed for the monitoring of same and will be available to the inspectorate on request.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A new IPC panel and replacement clinical sink has been fitted in the clinical treatment room which meets current recommended specifications for clinical hand hygiene sinks. New IPC panels and sinks have been fitted in resident's bedrooms and en-suite facilities.

A small sluice room is available (room16) for cleaning staff to fill clean water and dispose of waste water. This room is only used by the cleaning staff. Hand gel is provided in the room for cleaning staff for hand hygiene purposes. Following a scoping exercise by HSE maintenance department in relation to the provision of hand wash facilities in room 64 cleaning room, this room was not deemed suitable as there is no water system servicing this room. The management team is reviewing the purpose and function of room 55 as an alternative cleaner's room and if deemed suitable an application to vary will be submitted to the authority, this will be completed by 31/03/2023.

All staff have been reminded of the correct storage of personal belongings i.e. outdoor clothing in designated changing rooms whilst at work. The CNM /and or PIC will carry out ad hoc observational inspections to ensure the correct storage of personal belongings.

All excess PPE has been removed to an alternative off site storage location to facilitate effective cleaning of the floor areas. It was identified that the extra PPE is no longer required. In the event that circumstances change, the extra PPE which is stored offsite, can be delivered on site within 1 hour of request for same.

All stained water outlets have been replaced with new sinks, daily cleaning is monitored by PIC/CNM. A record of same has been maintained and is available to the inspectorate on request.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The door to the resident's smoking room was checked by the PIC on the day of the inspection and the switch on the door closure was reactivated as it had been turned off in error. Smoking room door, now closing automatically, this will be continually monitored by the PIC and or CNM.
Emergency evacuation records were reviewed and they clearly state the compartment for evacuation, room names and numbers and the area to where the residents were safely evacuated to.
The oversight of fire equipment weekly checks was reviewed by the PIC and CNM, the weekly check of the fire doors now includes a comprehensive check on the operation and condition of each individual fire door and tracks actions required to address any defects, records of same are available to the inspectorate upon request. The checks to ensure that the fire alarms system is operational at all times now includes: a daily check that faults are not registering on the fire alarm panel. Breffni Care Centre have now updated floor plans which clearly identify fire compartment boundaries within the Centre, records of same are available to the inspectorate upon request.

Any issues or concerns identified are discussed during the daily Safety Pause and a maintenance request will be sent to local maintenance and or external contractor as required- records are available to the inspectorate upon request.

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:
The resident who has diabetes and receiving full insulin therapy care plan has been reviewed and update and now includes information to inform staff of the frequency of blood glucose level monitoring, the parameters that this residents blood glucose levels should be maintained within and the actions to be taken if the residents blood glucose measurements were outside these parameters.

A wound assessment is carried out each time a residents dressing procedure is completed, which informs the progress of the wound healing. Wound reviewed by the Medical Officer and or changes in treatment are recorded in the residents medical notes. A pain assessment chart has been implemented for each resident requiring pain relief, which assesses the residents level of pain, each time they are receiving pain relief medication, the effectiveness of the pain relief administered and any changes are referred to the Medical Officer for review.
Records are now available on the resident information system demonstrating residents being offered meaningful social activities that meet their interests and capacity.

Audits of resident's Care plans are undertaken by CNM2 each month through the Test Your Care-Quality Care Metrics. Areas requiring improvements are brought to the attention of the staff nurse responsible for the residents Care Plan and are addressed in a timely manner. All admissions/discharges documentations and care plans will be audited within 48 hours post admission, any gaps will be highlighted to staff immediately. Records of these actions are available to the inspectorate on request.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In addition to the sitting room (room12), room 56 within the Centre is registered as a dining/day room with access to additional open dining/dayroom area. This room is used by our residents for group activities such as; Baking, music, card games, parties, celebrations, mass and any other activity which enhances our residents well-being.

There are four alcoves with comfortable seating and soft furnishings for residents use anytime during the day or night. These alcoves can also be used for quiet reflection or for smaller group activities. There is also a comfortable seating area in the front foyer with traditional fireplace where residents and their families can use at any time. Room 108 is also available to residents for family visits, for imagine gym, movie experiences and reminiscence therapy.

Key code locking system on cross corridor doors used by residents to access communal areas, has been deactivated- completed on 13/01/2023. A mobile communication device with internet access is available for entertainment purposes to facilitate individual choices for viewing. In relation to the resident who was unable to comfortably view the television, an adjustable wall bracket has been sourced and fitted to facilitate same.

The Oratory has been de- cluttered and is now accessible to all residents.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	16/01/2023
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	16/01/2023

	and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	16/01/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/03/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	31/01/2023

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	16/01/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	16/01/2023

Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/01/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	16/01/2023
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	31/01/2023
Regulation 34(1)(e)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall assist a complainant to understand the complaints procedure.	Substantially Compliant	Yellow	13/01/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints	Substantially Compliant	Yellow	13/01/2023

	procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Substantially Compliant	Yellow	13/01/2023
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	13/01/2023
Regulation 5(2)	The person in charge shall	Substantially Compliant	Yellow	16/01/2023

	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.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	16/01/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/01/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with	Not Compliant	Orange	31/01/2023

	the rights of other residents.			