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:	Brabazon House
Name of provider:	The Brabazon Trust
Address of centre:	2 Gilford Road, Sandymount, Dublin 4
Type of inspection:	Unannounced
Date of inspection:	02 November 2023
Centre ID:	OSV-0000017
Fieldwork ID:	MON-0039744

About the designated centre

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

Brabazon House Nursing Home is a 51-bed centre providing residential and convalescent care services to males and females over the age of 18 years. The service is nurse-led by the person in charge and delivers 24-hour care to residents with a range of low to maximum dependency needs. Admissions are primarily accepted from people living in the sheltered accommodation apartments in Brabazon Court and Strand Road, although direct admissions to the centre are accepted, in exceptional circumstances, subject to bed availability. The building is an original Edwardian House (circa 1902) that has been extended and refurbished while retaining some of its older features. It is located in a quiet road just off the Strand Road close to the strand and Dublin Bay. Local amenities include nearby shopping centres, restaurants, libraries and parks and also the strand. Accommodation for residents is across two floors. The centre contains 40 single bedrooms of which 34 have en-suite facilities. There are also three twin and two three bedded rooms. Communal facilities include assisted shower bathroom and toilets, dining room, two sitting rooms, an activity room, sensory room and a library. There are small rest areas situated on the ground floor at reception and on the first floor outside the hairdressing room which residents and visitors can enjoy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 2 November 2023	08:45hrs to 18:40hrs	Bairbre Moynihan	Lead
Thursday 2 November 2023	08:45hrs to 18:40hrs	Frank Barrett	Support

What residents told us and what inspectors observed

From the inspector's observations and from speaking to residents, it was clear residents received good care from staff that were kind and caring. Residents were complimentary about the care they received and informed inspectors that they felt safe in the centre.

Inspectors were greeted by the person in charge and general manager. Following an introductory meeting inspectors were guided on a tour of the premises. The centre had a relaxed atmosphere and residents were observed freely mobilising around the centre and chatting to other residents and staff.

Brabazon House is registered to accommodate 51 residents with 2 vacancies on the day of inspection. The centre is laid out over two floors divided into seven different areas - Pax, Lower Brabazon and Lower Kerr on the ground floor and Upper Pax, Upper Brabazon, Upper Albert and Upper Kerr on the first floor. The centre had 39 single rooms with 34 en-suite rooms, three twin rooms and two triple rooms. Not all rooms were en-suite and not all en-suites contained a shower. Three rooms included a separate sitting room in their layout and one room contained a walk-in wardrobe. Residents' rooms were personalised with pictures of family and friends on display and belongings from home. Communal showering and bathing facilities were available for residents. The ground floor contained a dining room, day room, sitting room, library and snoezelen. In addition, the centre had a dedicated hairdressing salon.

The activities schedule was on display. When inspectors arrived in the centre, there was a "men's breakfast" ongoing in the dining room which is held every Thursday where male residents get a traditional Irish breakfast. A member of the board attended the mens' breakfast. A small number of residents were observed doing art in the day room in the morning. In the afternoon, an old movie was on the television with a number of residents watching it. Residents informed the inspector about a recent trip to a hotel for lunch. In addition, residents informed the inspector how they liked going out into the garden to mobilise and that they had a route around the garden that they completed and a small number of residents played bowling in the bowling green on the grounds. Doors to the enclosed garden were open on the day of inspection.

Inspectors were informed that residents' meetings had commenced since the inspection in March 2023. Documentation reviewed identified that there are three meetings per year. Meeting minutes for one residents' meeting were submitted to the Office of the Chief Inspector following inspection. The meeting was held in October 2023 with 39 residents attending. The plans for the extension of the centre were discussed with the residents with residents querying whether there will be a space for quiet activity and if there will be adequate toilet facilities in the extension. The responses to these queries were not included in the meeting minutes provided. The survey results were also shared with residents and the complaints procedure

was discussed. A food survey was completed since the inspection in March 2023 and included an action for each comment from residents.

The dining experience was observed. The majority of residents ate in the dining room with residents requiring assistance in the day room. The menu was on display at the entrance to the dining room on a notice board. Lunchtime was a sociable occasion with residents chatting amongst themselves. Residents informed the inspector that the food had improved in recent months but that the variety of food still required improvement. Residents had access to snacks and drinks in between meal times.

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

Capacity and capability

This was an unannounced inspection to assess the overall governance of Brabazon House and to identify if actions outlined in the compliance plan from the inspection in March 2023 were completed and sustained. In addition, the inspection had a particular focus on Regulation 28: Fire Precautions. Overall, inspectors identified that a number of actions were completed and sustained. For example; significant improvements were identified in fire training. In addition, staff meetings had commenced, and monthly and quarterly meetings with the catering provider. However, non compliances were identified in Regulations 31: Notification of incidents, 4: Written policies and procedures, 23: Governance and management and 28: Fire Precautions. Additional improvements required are detailed under the regulations below.

The registered provider had submitted an application to renew the registration of the centre. A small number of areas for action were identified in the statement of purpose and in the floor plans. These were discussed with management on the day.

The Brabazon Trust is the registered provider for Brabazon House. The person in charge reported to the Chief Executive Officer. Brabazon House had a general manager on site who worked alongside the person in charge. These roles also include the oversight of residents in sheltered housing onsite which had a further 55 residents. Inspectors were informed that one healthcare assistant was assigned daily to the residents in the sheltered housing and the staff nurse administers medications to the residents in the morning. The person in charge was supported in the role by two clinical nurse managers who were supernumery and who generally worked opposite each other, staff nurses, healthcare assistants, activities co-ordinators and maintenance staff. The registered provider had outsourced housekeeping and the catering to external providers.

Staff had access to mandatory training including fire training and manual handling. Improvements were identified in training since the inspection in March 2023, however, a number of staff were outstanding in safeguarding training and infection control.

Inspectors requested a sample of staff records. Garda vetting was in place and up to date in records reviewed. There was evidence that Garda vetting was in place prior to the commencement of employment. The professional registration of staff, where applicable, was in place and up to date. An inspector followed up on the employment history of staff following an action from the inspection in March 2023. The inspector identified that three out of the four records reviewed had no gaps in the employment history however, the employment history of one staff member was not on file and staff were unable to locate it while inspectors were on site.

The annual review was completed for 2022 and was aligned to the National Standards for Residential Care Settings in Older People. Areas for improvement in 2023 included a review of falls and a plan to reduce them accordingly as well as to liaise with the catering company in order to improve the dining experience. The registered provider had an audit schedule in place. Audits completed included a medication management audit and a falls audit. The audits were identifying issues and an action plan was devised. Systems of communication were in place. Staff nurse meetings were held monthly. Issues identified on inspection in relation to medication management were discussed at the staff nurse meeting but were also a finding on inspection. Key quality indicators were discussed and complaints received. Meeting minutes were accompanied by a time bound action plan. Monthly committee meetings were held with the management team of The Brabazon Trust. The person in charge provided a monthly report at this meeting. The structure of the committee meetings had changed since the inspection in March 2023 to provide greater oversight of key performance indicators, staff training, breakdown of falls and the number of multi-drug resistant organisms.

The registered provider maintained a log of incidents. The majority of incidents reported were falls. No medication incidents were observed in the sample reviewed. Given the actions identified in medication audits, discussed at meetings and identified on inspection, it was difficult for staff to identify trends in relation to medication incidents and put actions in place to prevent them occurring again. The majority of incidents reviewed were reported to the Office of the Chief Inspector. However, one incident was not reported. This is discussed under the regulation.

The complaints log was reviewed by an inspector. A small number of complaints were received since the last inspection. The detail of the complaint, outcome and the satisfaction or otherwise of the complainant were logged. The complaints policy was not available for review on the day of inspection and was submitted following inspection.

Fire safety policy and procedures were reviewed by Inspectors. It was found that the provider had made significant improvement in staff training in fire safety as well as ensuring that fire safety systems were improved and serviced up to date. A marquee erected on the grounds of the centre to facilitate dining for residents in an

adjoining independent living arrangement, was impacting on fire safety for residents and staff in the centre. The overall impact of this structure had not been identified by the provider as a risk. This is discussed further under Regulation 23: Governance and management. A Fire Safety Risk assessment was completed by the provider in October 2022, had identified items as being of high, medium and low risks. Some of the high and medium risk items were not completed at the time of the inspection, and were outside of the timelines associated with the fire safety risk assessment (FSRA). Some of these issues were in relation to fire safety in the marquee for example, it was noted that there was no fire detection in the marquee, and this required action within one week on the FSRA. On the inspection day, this had not been resolved. Further fire safety issues are discussed under Regulation 28: Fire Precautions.

A number of policies and procedures required under Schedule 5 of the regulations were not available for review on the day of inspection. This is detailed under Regulation 4: Written Policies and Procedures.

Registration Regulation 4: Application for registration or renewal of registration

A completed application had been submitted within the required time frame for the renewal of the registration of the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the number and skill-mix of staff was appropriate having regards to the needs of the residents and given the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps in training in staff development were identified:

- 10 staff had not completed training in managing behaviours that challenge.
- 21 staff had not completed safeguarding training.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors followed up on the actions required from the inspection in March 2023. One staff file reviewed contained no employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

The assurance systems in place in the centre required strengthening to ensure the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c). This was evidenced by:

- Incidents in relation to medications, while identified by staff and discussed at the staff nurse meeting were not reported as incidents. Therefore no trending of these incidents was taking place in order to identify actions and drive learning.
- A review of a fall where a resident sustained injuries requiring medical treatment was not completed to identify the cause of the fall and contributory factors to identify learning.
- Residents from sheltered housing had access to the centre through the laundry. Inspectors observed a sheltered housing resident with a key exiting the centre through this door and was informed that all sheltered housing residents had access to the centre. The systems of access required review to ensure that residents in the designated centre were protected at all times and that their rights to dignity and privacy were ensured at all times.
- A marquee erected on the grounds, was positioned at the exit of the dining room. The risk associated with the obstruction this structure presented to the emergency exit route, was not appropriately assessed by the provider. Furthermore, inspectors could not be assured that appropriate fire safety systems were in place in the marquee, or that they were linked to the centre's fire safety systems for example, the Fire Detection and Alarm System (FDAS).
- Issues raised in a Fire Safety Risk Assessment (FRSA) conducted at the centre in October 2022, did not have satisfactory resolution of high and medium risk items, in line with the time lines proposed on the FSRA for example:
    - Compartmentation issues around electrical distribution boards, identified as medium risk requiring action within one week had not been completed.

- A lack of fire detection, was noted within the adjoining Marquee on the FSRA as a high risk item with action required within one week. This had not been completed.

Judgment: Not compliant

Regulation 3: Statement of purpose

Discrepancies were observed in the statement of purpose (SOP) and function and floor plans. For example:

- Some rooms did not contain measurements on the both the statement of purpose and the floor plans such as the the kitchen and laundry.
- The measurements of a bedroom were different on the statement of purpose and floor plans.

In addition, the time lines for the investigation of complaints and the completion of a review were not included in the statement of purpose.

These along with additional changes required were discussed with management during the course of the inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Two incidents that met the criteria for notification to the Chief Inspector of Social Services were not notified within the required timelines. These were submitted following inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in the centre but it required review to meet the amendments to the regulations that had come into effect in March 2023 (S.I. 298 2023).

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Not all policies required by schedule 5 were available for review on the day of inspection in line with regulatory requirements. For example; the admissions policy, residents' personal property and finance, staff training and development, provision of information for residents, complaints and the temporary absence and discharge of residents.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulations. They had the appropriate experience and qualifications.

Judgment: Compliant

Quality and safety

Inspectors found that residents' had a good quality of life in Brabazon House. Residents were observed to be living their lives in an unrestricted manner, according to their own capabilities. Staff were committed to promoting an approach to care and service delivery that understood and respected the residents' rights, including the right to dignity, privacy and choice.

Maintenance and upkeep of the premises, was well managed overall. There were a number of issues identified on the day of inspection, which impacted on the premises for example, damaged furniture, and light shafts in enclosed rooms, which were not kept clean. It was noted that people from the adjacent independent living facility had access keys to enter some areas of the centre. Inspectors also noted that some areas of the centre did not match details in the centres' floor plans under which the centre was registered. This meant that some spaces were not used as per the registered statement of purpose, and associated registered floor plans. These issues are discussed further under Regulation 17: Premises. Assistive handrails were in place throughout all circulating corridors. Carpets were in place in all corridors and sitting rooms. The registered provider had commenced replacing carpets in bedrooms.

Excessive staining was identified in a number of the carpets and soft furnishings. The exposed wiring in the assisted bathroom (021) was fixed and the walls were

replaced with a washable surface. Overall, the centre was generally clean on the day of inspection. The registered provider had engaged with an infection control specialist who had completed a review of the centre on the week prior to inspection and the registered provider was awaiting a report. Management stated that they were informed that improvements in infection control training were required. The registered provider had identified an infection control link practitioner who was a clinical nurse manager who was undertaking audits in infection control. A second nurse was identified who was training for the role at the time of inspection and management stated that protected hours would be provided for the role.

The laundry was unchanged since the last inspection with a dirty to clean flow. An environmental audit action plan was submitted following inspection. Issues identified included spill kits were expired at the nurse's station and some hoists slings were unlabelled. Each finding had an action and who the action was escalated to. The centre had two COVID-19 outbreaks since the inspection in March 2023. The outbreaks were contained to a small number of residents. Outbreak reports were completed following the outbreak with learning identified.

The registered provider had engaged with the catering company on a monthly basis in order to improve the food for residents. Residents had mixed views on the improvements but generally residents stated that the food had improved but the variety of food required improving. Kitchen staff were knowledgeable about how to correctly modify diets and were able to describe the process in place for identifying residents on a modified diet.

Inspectors reviewed arrangements at the centre to manage the risk of fire. While it was noted that the centre was fitted with a serviced sprinkler system, this sprinkler system did not cover all areas of the centre. There was no evidence that the lack of total coverage of the sprinkler system, influenced the fire safety arrangements in those areas of the centre which were not covered by the sprinkler, for example, the upper Pax area. Issues relating to containment of fires was identified on inspection. These issues ranged from deficiencies in fire sealing around service penetrations through fire rated compartment walls, to containment within storage areas under stairs, to damaged fire doors. An attic hatch in the upper Pax unit did not appear to be fire rated. This area also had a single means of escape internally, and had an external escape stairs installed at the end of the corridor. Inspectors could not be assured that staff had practiced evacuation drills using this escape stairs, or that it would be suitable for use with evacuation aids in use on the unit. A shutter used to close of the kitchen did not appear to be fire rated. This would impact on residents in the dining room in the event of a fire in the kitchen. Furthermore, the most appropriate means of escape from the dining room was through the Marquee erected to extend dining facilities. These issues and other fire safety concerns are discussed under regulation 28 Fire Precautions.

The registered provider had an up-to-date medicines policy in place which included the transcribing of medications. Medications, including medications that required strict control measures were stored securely. A sample of these was checked with a staff nurse and were correct. The inspector was informed that a pharmacist was onsite once monthly and was available to speak to residents if they requested it,

however, management stated that this had never been requested. Notwithstanding the good practices in place, improvements were required which are detailed under Regulation 29: Medicines and pharmaceutical services.

Inspectors found that residents needs were routinely and appropriately assessed and this information incorporated into resident-specific plans of care. While care plans were generally up to date and person-centred, some improvements were required. Residents were provided with a good level of evidence-based healthcare in the centre. There was good access to general practitioners and other healthcare professionals including speech and language therapy and physiotherapy.

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Responsive behaviours were well managed in the centre by a person centred approach to care. Improvements were identified in the completion of behavioural trigger charts and these were regularly completed. The registered provider had a restraint register in place. Eight residents had bedrails at the time of inspection, however, there was no evidence from a review of documentation that less restrictive options were trialled.

The registered provider had two wholetime equivalents (WTE) of activities co-ordinators. This was a reduction of one since the inspection in March 2023. Inspectors were informed that the registered provider was recruiting into the position at the time of inspection and this was confirmed in documentation reviewed.

Overall, residents' right to privacy and dignity was well respected. Residents were afforded choice in the their daily routines and had access to newspapers, radios, and television. Independent advocacy services were available to residents and the contact details for these were on display. There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents, meeting minutes and satisfaction surveys.

Regulation 17: Premises

The registered provider did not ensure that the premises of the designated centre was in accordance with the statement of purpose prepared under Regulation 3. For example:

- Changes were required to the floor plans to reflect the layout on the ground;
    - The inclusion of a linen store room within the laundry was not on the plans.
    - A cross-corridor door near room 47 was not in place.
- The snoezelen room was used as an activities store room.

Improvements were required, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Some furniture required repair/replacement. Damaged furniture can result in difficulty in cleaning, and can pose an infection control risk as well as a safety risk.
    - A table in the library had sections of the veneer peeling off.
    - There was water damage to some wardrobes in room 11.
    - A rusted metal rack was found in an assisted shower room.
    - A water damaged radiator cover was found in an assisted bathroom.
- The blinds in the sky light in the snoezelen were in a poor state of repair.
- An assisted bathroom was out of order. The bath was leaking onto the floor, and the floor was wet as a result posing a falls risk to residents.
- There were boxes stored on the floor in some storage rooms. This can pose difficulties for cleaning and stock control.
- Two light shafts in the kitchen ceiling were very dirty, and debris was observed above them.
- Damage was identified on some walls, and ceilings in the centre. For example, the assisted bathrooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The registered provider had continuous engagement with the catering team and were endeavouring to improve the food for residents. Residents were provided with a choice at mealtimes including residents on a modified diet. Food, fluids and snacks were provided at times outside of regular mealtimes. Support was available from a dietitian for residents who required specialist assessment with regard to their dietary needs. There was adequate numbers of staff available to assist residents with nutritional intake.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required in order to ensure procedures are consistent with the national standards for infection control in community services: For example;

- A number of upholstered chairs and a small number of carpets were observed to be excessively stained. Management stated that they were steam cleaned six monthly, however, a review of this schedule was required.

- A number of vents in bathrooms contained excessive dust.
- The ground floor did not have any clinical hand wash sinks. Furthermore, no sinks in the centre were compliant with the required specifications.
- The cleaning trolley containing cleaning products with chemicals, was not lockable and posed a risk to residents if the trolley was left unattended.
- 13 staff had not completed training in standard and transmission based precautions.
- 31 staff had not completed hand hygiene training.
- The housekeeping room on the first floor did not contain a janitorial sink.
- Not all hoist slings were single resident use. Inspectors were informed that they were cleaned after each use and washed once weekly. This practice posed a risk of cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While it was noted that there were robust fire safety systems including a sprinkler system in the centre, fire safety action was required at the centre.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example:

- Inspectors could not be assured that staff on duty at times of low staff numbers had appropriate training. Some staff members rostered for night duty had not completed fire safety training
- There was no record of staff having trialled the use of an external metal stairs in the Upper Pax area. In the event of a fire in this unit, this stairs would be required to move some of the residents immediately to a place of relative safety. There was insufficient space at the top of this stairs to manoeuvre a resident safely.
- The fire safety procedure in the centre did not reflect the differing nature of some areas of the building. A sprinkler system was installed in most areas of the building, but was not in place in all areas for example the upper Pax unit. Staff spoken to were not aware of this change, and the impact of not having the sprinkler system in those areas of the centre.

The registered provider did not make adequate arrangements for containing fires. For example:

- Service penetrations were found in the walls and ceilings in the centre. These services were not fire sealed, and there were large gaps around their perimeter. This would impact on the containment of fire and smoke in the event of a fire. For example:

- Service penetrations through walls and floors in store room 130.
- A store room under the stairs identified as store 045. This was not fire sealed to protect the stairwell evacuation route.
- An unsealed store area under the stairs was in the Lower Pax/Lower Albert ground floor. The storage space was not sealed from the protected stairwell in this case.
- Extensive service penetrations in the hoist store room on the ground floor. This room was also an electrical cabinet and a place of higher fire risk.
- An electrical riser in the corridor at the entrance lobby did not have fire sealing around the frames above the doors. This area was used for charging hoist batteries also, and would be a high fire risk area.

- Issue were identified with fire doors throughout the centre, for example:
  - No smoke seals on library doors. This door opens onto the escape route.
  - Non fire-rated ironmongery including hinges and handles were observed to fire doors in many areas in the centre.
  - A fire door was not in place to close the corridor near a Laundry.
  - Some door closers were identified as not working or disengaged. For example; male staff changing room door.
  - Inspectors could not be assured that all doors opening onto the protected escape route were fire doors, for example, sluice room 133, tank room door, under stairs toilet area 045 on ground floor, a fire exit door across from laundry 046.
- There was an attic hatch in the upper Pax area, which was not fire rated. Assurances were required that containment measures are in place above the ceiling in this area.
- Inspectors could not be assured that the shutter in the kitchen, beside the main entrance door from the dining area, was a fire rated shutter. This shutter was in the open position, with catering serving equipment underneath it for most of the inspection day. Inspectors could not be assured that this would close in the event of a fire, or that it would contain fires in the kitchen if it did close.
- Wooden (plywood) cabinets were fitted around electrical distribution boxes on some escape routes. Inspectors could not be assured that these cabinets would contain fire or smoke/fumes on the escape route, in the event of a fire.

The registered provider did not make adequate arrangements for evacuating where necessary in the event of a fire, of all persons in the designated centre. For example:

- Inspectors could not be assured that staff could evacuate residents to a place of safety externally in the event of a fire. There was no record of "vertical evacuation" being trialled at the centre. This could impact on residents on level two who would need to be evacuated down the stairs in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

While overall medication management procedures were good, the inspector identified the following which required action:

- The inspector observed 4 topical creams, stored in the fridge which were either no longer is use or opened for a longer period than manufactures would recommend. These were removed from the fridge while the inspector was onsite.
- Transcribing of medications was taking place from a prescription to an electronic system. One instance was identified where the incorrect route was transcribed onto the electronic system. This posed a risk of an error taking place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example;

- A newly admitted resident did not have the care plans completed within 48 hours of admission.
- Care plans and validated assessment tools on one resident had not been updated four monthly in line with regulations.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to general practitioners and health and social care providers as required. Residents who resided in the rooms outlined in the condition on the centres' registration were assessed four monthly by a physiotherapist to ensure they could safely use the steps and chair lift leading to their bedrooms.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While bedrail assessments and consent was documented there was no evidence from records reviewed that less restrictive alternatives were trialled. This was not in line with the national policy on promoting a restraint free environment.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required by the registered provider to ensure the registered provider is in compliance with Regulation 9. For example;

- Inspectors were informed that there was one vacancy for an activities co-ordinator. In line with findings from the inspection in March 2023, improvements were required in resident activities to ensure that all residents had an opportunity to participate in activities in accordance with their interests and capabilities.

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
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brabazon House OSV-0000017

Inspection ID: MON-0039744

Date of inspection: 02/11/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Brabazon House has organized the required training and additional trainings. An efficient training matrix has been developed to carefully track and record the trainings that staff members have finished, as well as those that are still pending. A training certificate folder is available to securely store all completed certificates as evidence. Management ensure that all staff have successfully completed their mandatory and accessory trainings through both online and onsite programs. • The Person in charge (PIC) and the administration staff have worked together to efficiently manage trainings and keep a thorough record in an Electronic System. Brabazon management place a high value on staff development and ensures that trainings are current. Furthermore, a comprehensive list of trainings and participants who need to attend is prominently displayed on the staff notice board. A new system and process has been implemented for staff members to submit their HSE online certificates to the designated person within a specific time frame.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • PIC / Director of Nursing along with the administration staff ensures that a CV which has no gaps is received from every staff prior to joining on duty. • The checklist is thoroughly checked and the required documents are available on file and is complete.	

Regulation 23: Governance and management	Not Compliant

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

• CNM assigned for Medication Audit will pick up on all medication errors and an error report form is filled by the concerned staff. All errors are audited and reported monthly and an audit report is filed every 3 months. Reporting of all medication errors are treated individually and ensured that learnings are made from such errors. All serious medication errors will be reported to GPs and followed up. HIQA will be notified when necessary.

• All incidences and falls are reported and documented. Staff have been asked to fill in the incidence form on EPIC system with all contributory factors and a lesson learnt before closing an incident report.

• All audit reports will be discussed in the Nurses meeting, risks assessed and action plans put in place to reduce such incidences. Recommendations are documented and put out by the CNMs for all staff to read and sign. All tracking and trending of incidences will be reported at the staff meetings and outcomes discussed to see if there has been an improvement with new plans in place.

• PIC / Director of Nursing makes the report of all incidences and reports to the Committee in the monthly committee meeting. All KQIs are discussed in a brief summary and presented in the Committee meeting by PIC / DON.

• Sheltered Housing Residents Accessing through the Laundry door:

Access to Brabazon House Nursing Home by Sheltered Housing residents through 046A (Laundry) has been discontinued. There is now a secure lock in place and there is no access to the centre by sheltered housing residents through this route.

• Marque -FIRE RATING

The marquee area has been connected to the Fire Detection and Alarm System. Two smoke alarm heads have been installed in the marquee and two emergency break glass units at exit doors. Additional emergency lighting has been installed in the marquee. We are awaiting delivery of the alarm sounder for the marquee; the specific part was significantly delayed beyond our control. All wiring for this device has already been put in place and it will be installed as soon as it arrives on-site. It is worth noting that the smoke detection system within the marquee is live and functional.

The sounder for the marquee remains on order with Siemens and can be connected as soon as it arrives, all cabling is in place to facilitate this.

This will be connected to the existing system as soon as it arrives on site.

Emergency Exit route is free from obstruction through the Marque.

• FSRA Report:

The eight ESB meter and all high Voltage fuse units located between Lower Kerr & Lower Albert which were the subject of compartmentation on the FSRA Report had been

removed by July 2023 and two new fuse board were put in place to mitigate any risk. Our Fire Safety consultant has mentioned that as these fuse boards are controlled by an enclosed main distribution board elsewhere which has an ELCB and for this reason may not be required to have a fire proof enclosure. Never the less Fire Doors Ireland have been tasked with fitting a fire rated enclosure to prevent any spread of smoke or fire in the unlikely event of an incident. This will be prioritised in the February works commencing 5/02/24.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Floor Plans:
• A Geospatial survey of the entire Brabazon House and grounds was carried out in March 2023 and these drawings will be used for any future presentations and registration.
• Floor plans with measurements are attached now.
Statement of Purpose:
• Reviewed and revised with new floor plans
• The time lines for investigation of complaints and the completion of review is now included in the statement of purpose.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All notifiable incidents as per Regulation 31 are known to the PIC and Management team. All incidents are received by the PIC and CNM and are reported through the HIQA portal as required. In the absence of PIC the CNMs are trained to review each incident and have access to the HIQA portal.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaint's procedure was amended and replaced with the current one which meets the current requirement (in March 2023). The Complaint's procedure is now displayed near the lift.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• All policies were made available to all staff in clinical and non-clinical folders.

• As per the requirement all Schedule 5 Policies will be available in a separate folder and the remaining in a Non schedule Folder.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The New Floor plans reflects the layout of the ground floor with the inclusion of a linen store within the Laundry and a cross corridor near room 47. The Snoezelen room 023 is now called 'Activity Room' – residents have access to this room and there is no loss of communal resident space. This name change has been reflected in the statement of purpose.
• All damaged furniture has now been replaced; the wardrobes repaired; the metal rack from an assisted shower room removed and radiator cover replaced.
• The blinds in the skylight in the Activities Store room has been removed.
• The Assisted bathtub which was leaking is being repaired and awaiting parts to be installed by the company.
• All storerooms cleared of clutter and place on high grounds for easy cleaning and avoiding contamination from the ground level.
• Shaft lights in the kitchen ceiling were cleaned, all other ceilings were replaced and tidied.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The carpets and upholsteries in the center are steam cleaned twice a year in June and December. The upholsteries in the rooms and carpets were also cleaned by an external company (on 7th and 8th December) and records are available.
• The cleaning supervisor is in-charge of keeping all documents for cleaning and any upholsteries or carpet that is dirty is cleaned immediately with the carpet cleaning machine available at the center.
• The vents in the bathrooms were also cleaned and made sure that they are kept cleaned at all times.
• A clinical hand wash sink is being sourced for the ground floor.
• Two new cleaning trolleys were ordered and the chemicals and dirty mops will be kept locked in the trolley and not exposed, in order to avoid risks.
• A janitorial sink will be provided in the upstairs housekeeping room.
• New slings were ordered and labelled for each resident use to prevent cross contamination.
• All staff training certificates are now on file for Hand Hygiene and Standard and transmission-based precautions.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All new staff were trained in Fire procedures and no staff will be rostered to do night shifts without a fire training.
• Upper Kerr area- Upper Kerr exit -for evacuation through fire door- Evacuation drill done on 11/12/2023 and recorded.
• All staff are made aware of areas not covered by the Sprinkler system in the Lower and Upper Pax.
• The external stairs are located at the end of Upper Kerr (not Upper Pax) which is an area protected by both the sprinkler system and the fire detection system. This external stairwell serves only four single rooms in this area and while the top platform area is not as big as it might be comfortable for evacuation it is however possible to evacuate. The next nearest internal escape stairwell is less than 12 meters from the furthest room of the landing, this distance to the nearest internal stairwell if further strengthened by the fact that there is a sprinkler system in this area. it is also noteworthy that this external stairwell would be a route of last resort under evacuation guidelines which advocates the need to follow horizontal evacuation within the building and only to exit the building as a refuge of last resort.
• The penetration of heating pipes is fire sealed on the other side of this solid wall. This inner side of the wall will be included in fire seal work to be carried out as soon as possible. All areas identified in the report and some others have now been sealed by Fire Seal

• All under stairs areas identified as store rooms have been cleared and all storage removed, as they were never intended to be used for storage - this includes store 045 and the area under the stairs at Lower Pax/Lower Albert ground floor. They have been designated 'not for storage use'. The ground floor hoist store room mentioned above (room 27) has been fire-sealed. The electrical riser in the entrance lobby corridor has been fire-sealed.
• 30 doors have been replaced or brought up to standard by Fire doors Ireland over a period of June to August of 2023. This work was completed over a number of weeks by Fire Doors Ireland. Doors requiring ironmongery upgrades have been brought in line with Section 11 of BS 8214:2016. Doors with glazing requiring upgrades have been brought in line with Section 10 of BS 8214:2016. Where brand new doors were required, they were constructed to BS 476: Part 22:1987, Section 7 of BS 8214:2016.
• While there is a door frame in this location there has not been a door here for a considerable time. It is also worth noting that there is vertical compartmentation at the two adjacent doors at the bottom of the stairs. This door was removed many years ago when the compartmentation was deemed to be at both sides of the stairwell where two fire doors do exist. There is also a fire door leading from the laundry to corridor E. This is being further examined by our fire safety consultants and any advice given will be actioned.
• This closer and any other malfunctioning closers have been replaced by Maintenance staff or in the case of automatic closer our electricians. These doors & door closers have all been attended to and are in good working order.
• Fire Doors Ireland will be carrying out upgrade, and replacement where necessary,,and maintenance to all doors leading onto the protected escape routes. This work will commence on February 5th. Expected completion date before 30/06/2024
• While this door (133) did pass the standard in 2008 for fire safety with its intumescent strip, smoke seal re-enforced glass & 3 hinges. Fire Doors Ireland have been tasked to replace this door.
• This plywood hatch was replaced with an air tight 1 hour fire rated hatch (Supplied by Trade Craft|) in March 2023 and a data sheet is available for inspection of same. The old attic hatch in the Upper Pax area has been replaced by a brand-new Air Test Compliant Door supplied by Tradecraft Building Products with product code PFFD-AT900-600. This is 1 Hour Fire Rated to the following specifications; robust steel panel certified to BS EN 1634-1:2008 and BS EN 1364-2:1999. It is also smoke tested to 1634-3:2004.
• Fire Doors Ireland have been tasked with fitting a fire rated enclosure to prevent any spread of smoke or fire. This will be prioritised in the February works. Expected completion date 30/06/2024
• At the time of inspection, the shutter was not obstructed by any catering equipment and could close to the floor if required. This shutter will now be linked to the fire detection system and will close automatically when the fire alarm is activated. The component to allow this to happen is known as an IO (Input/output) unit and this has been ordered from the supplier and will be installed as soon as possible. This shutter was acceptable for fire safety at the time of installation.
• The eight ESB meters located between Lower Kerr & Lower Albert had been removed by July 2023. Eight electrical meter units have been removed from the area in question, they were removed in their entirety from the centre by ESB Networks. Large mains fuses were also removed from the area at this time by ESB Networks. These have been replaced in the same area by two new small fuse boards, installed by C Fortune Electrical. These actions have ensured that the risk in the area has been significantly

reduced. Fire Doors Ireland have been contracted to carry out all necessary works to bring the fire doors up to standard, this will include replacement of some doors where necessary and the upgrading of other doors where deficiencies are found. This work is to commence on February 5th and continue until completion. Expected completion date before 30/06/2024
• The fire safety contractor carries out vertical evacuation with all staff annually.
• The CNM in charge of Fire drills and evacuation drills make sure that a vertical and Horizontal evacuation drills are done every month, so that the staff are familiar with safe evacuation procedures.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All stock of medications and dressing materials are checked for expiry dates monthly and recorded (Including the fridge items)
• Pharmacist comes to the centre to audit every month; checks stock and supplies to make sure that we do not over stock medications; all unused medications of those deceased are returned back to the Pharmacy. All disposal of medications is done through the Pharmacy.
• In order to avoid all documentation errors while transcribing a prescription on to a computerized system, two nurses check the prescription and save documentation after been checked thoroughly. The two nurses sign and countersign on the prescription and save document in the given folder.
• The pharmacist assistance in transcribing prescriptions has been sorted to avoid errors in future.

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:
• All new admissions will be assigned to a staff Nurse and specific time allocated to do the assessment and care plans in order to complete within 48 hours.

• Allocated time will be given to all staff to review and complete the due assessments and care plans assigned to them.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• All care plans were reviewed and if bed side rail is used, all less alternatives trailed before using the bedside rails as a restraint will be assessed and documented in the care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Assessments and care plans will be reviewed by the Activities coordinator and plan the activities according to the resident's interest and made it a meaningful activity for each resident.
• A part time Care assistant is assigned to participate in assisting the Activities coordinators with the activities for resident.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	05/01/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Orange	30/01/2024

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	30/11/2023
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	29/02/2024
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	29/02/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Not Compliant	Orange	30/06/2024

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2024
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	30/06/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30/01/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of	Substantially Compliant	Yellow	31/01/2024

	date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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	05/01/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	03/11/2023
Regulation 34(2)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/01/2024

	complaints procedure provides for the nomination of a complaints officer to investigate complaints.			
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	30/11/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	05/01/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	06/11/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph	Substantially Compliant	Yellow	20/12/2023

	(3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/11/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/01/2024