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

Issued by the Chief Inspector

Name of designated centre:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	22 September 2025
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0047002

About the designated centre

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

Bridhaven Nursing Home is a designated centre located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 182 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in six suites: on the lower ground floor - (1) Clyda is a dementia-specific unit with 18 bedrooms all single rooms with full en suite facilities of shower, toilet and wash-hand basin); on the ground floor - (2) Lee (33 beds – two twin and 29 single with en suite facilities), (3) Blackwater (37 beds – six twin and 25 single full en suite facilities) 4) Lavender (13 beds - all single full en suite bedrooms); on the first floor - (5) Bandon (currently 12 beds), (6) Awbeg (36 beds – seven twin and 22 single with en suite facilities). Each suite had a day room and dining room and there are additional seating areas located at reception and throughout the centre. There is a large seating area upstairs for resident to relax with views of the enclosed bonsai garden and also the entrance plaza. Residents in Clyda have access to a well-maintained enclosed garden with walkways, garden furniture and shrubbery; there is a second enclosed garden accessible from the Blackwater day room. Bridhaven Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	136

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
Monday 22 September 2025	09:20hrs to 17:45hrs	Breeda Desmond	Lead
Tuesday 23 September 2025	08:30hrs to 14:00hrs	Breeda Desmond	Lead
Monday 22 September 2025	09:20hrs to 17:45hrs	Caroline Connelly	Support
Monday 22 September 2025	09:20hrs to 17:45hrs	Ella Ferriter	Support
Tuesday 23 September 2025	08:30hrs to 14:00hrs	Ella Ferriter	Support
Tuesday 23 September 2025	08:30hrs to 14:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection completed over two days. Inspectors met many residents during the inspection and spoke with 25 residents in more detail, and 15 visitors. Residents gave positive feedback and were complimentary about the staff and the care provided; they reported improvement in the quality of food served and that they enjoyed their meals; a number of residents said they were happy, and one resident said there was always something going on. A resident reported that it was' very good here' and 'comfortable', and 'I can do my own thing', 'get up when I like', 'there is a great team here' and 'the person in charge comes around to meet us'. One resident said that their laundry goes missing at times but they always find their clothes. Visitors spoken with were generally very complimentary of the care provided and said that staff were very attentive to their relative; they said that they only ever had a few issues and these were addressed immediately. One visitor reported that access to the garden was restricted and that they had to wait to gain access to it, and also wait to get back into the building as they were not given the access code. This was addressed by management during the inspection to the satisfaction of the family member. This will be further discussed later in the report.

There were 136 residents residing in Bridhaven at the time of inspection. Bridhaven is a three storey facility with resident accommodation set out in six units over the three floors: Clyda (dementia specific unit) was located on the lower ground floor; Blackwater, Lee Side and Lavender Cottage (dementia specific unit) on the ground floor; Bandon and Awbeg upstairs (Bandon was partially opened and facilitated care of 12 residents with a diagnosis of dementia). Management and HR offices, the main kitchen, maintenance and facilities, staff facilities, laundry, and storage areas were accommodated on the lower ground floor.

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

Throughout the days of inspection, inspectors observed staff interaction with residents. Many of these interactions were respectful and kind with positive engagement, chat and social conversation. Regarding activities, activities staff called to each unit providing one-to-one interaction and explaining the group activities to residents on each unit and inviting them to attend. At 10:30am, residents watched mass live-streamed from Mallow church, on television in dayrooms. This was followed by staff offering residents beverages and snacks including freshly made scones, a selection of pastries as well as tea and soup. The snacks offered to

residents were presented in a very appetising manner. Several residents were seen to make their own coffee in the coffee dock by reception.

Dinner time was observed on different units and inspectors generally observed positive engagement by staff when providing assistance with meals, and meals were served in a normal social manner. Choice was offered for all courses and modified diets were very pleasantly presented to residents.

Staff facilitated a sing-song were seen to gently encourage resident participation while singing and dancing to the music. Children from the local secondary school arrived mid-morning and visited Awbeg and entertained residents there, who were observed to really enjoy the company. Other activities observed included chair exercises facilitated by two staff, and a fit-for-life exercise programme was facilitated by the physiotherapists who were on-site both days of the inspection. They also completed one-to-one assessments as well as group work. Activities observed were very inclusive and staff encouraged residents to participate in group activities as well as respecting those residents who preferred to read the paper for example.

The activities boards were a colourful display with easily accessible information for residents; they were displayed on each unit as reminders for residents of the activities on each unit such as arts and crafts, bingo, 'sit & get fit', games and an array of concerts and movie nights for example. Some other activities were held on weekly basis such as the knitting club every Friday night, the reading club every Thursday night and the gardening club Wednesdays afternoons for example. Two residents spoken with were knitters and were observed to relax, knit and chat with their friends.

Publications and information on display included the monthly Bridhaven news letter, statement of purpose, complaints procedure and advocacy services. The residents' guide was displayed on the wardrobe in each bedroom so residents had access to their individual copy. Bookshelves with a variety of books and games were seen in all dayrooms and the small sitting room on Awbeg; additional reading material was provided by the local community library for residents. There were large colourful displays on each unit regarding 'Safeguarding' and what that means for all service users.

Throughout the inspection, it was noted that the premises was generally very clean. There were hand-wash hubs on all units at different locations at the start and end of corridors. All had advisory signage to explain how to wash hands appropriately and other signs displayed included the 'five moments of hand hygiene' as reminders to staff to wash their hands. Paper towel dispensers, hand soap and pedal bins were alongside each hand-wash sink. Dani centres were wall-mounted throughout the centre which enabled staff to easily access personal protective equipment (PPE) such as disposable hand gloves and aprons. Wall-mounted hand gel dispensers were available throughout the centre.

Painting and redecorating was in progress at the time of inspection and the premises looked clean and fresh. All the carpets were removed from Clyda and

flooring replaced. Some bedrooms had been fully upgraded, and inspectors were informed that three rooms per month were being totally upgraded. Inspectors saw an example of one of the twin bedrooms already fully refurbished, which made a significant improvement on the appearance and facilities within the room. Additional wall-to-wall units were installed in the day room on Lavendar creating a more homely feel to the room. Other improvements noted included the upgrading of soft furnishings in the smaller day rooms on Awbeg. Bandon wing, however, was dark and lacked a homely feel; the corridors were seen to be clinical in nature, inspectors were assured that this had been identified and a project plan was in motion to address this.

Residents personal storage in their bedrooms comprised a double wardrobe and bedside locker; some residents had an additional chest of drawers and an additional single wardrobe. Low low beds, crash mats, specialist mattresses and cushions, and assistive equipment such as hoists were available. Each resident had their own sling for use when being transferred.

The hair salon was located near main reception. Several residents were seen making a cup of coffee at the self-service coffee station beside the hair salon and visitors were seen to avail of the coffee while visiting their relative. A second coffee dock was also available in the main day room on Awbeg.

The smoking shelter was located in the garden in Blackwater; it had seating, fire blanket, fire extinguisher, cigarette butt disposal, and fire retardant aprons. Residents were seen to independently access the outdoors and walk around the garden while having a cigarette. The raised flower beds and walkways were very well maintained. There was a call bell outside to enable residents call for assistance. The access code to enable independent access in and out of the building was displayed here.

There was a separate secure entrance to Clyda so that visitors could access the unit without needing to go through the centre. While there was a large garden outside the day room in Clyda, the access code was painted over during current re-decoration and was not re-instated. This garden was a large well maintained space with walkways, shrubberies, raised flower beds and seating for residents to rest. However, no one was seeing using it on either day of inspection – and both days were dry with sunshine.

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

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

regarding appropriate work-flows and infection control as well as labelling residents' clothing which had resulted in a reduction in missing laundry.

Emergency evacuation plans were displayed throughout the centre with a point of reference to indicate one's location in the centre; primary evacuation routes were detailed in the floor plans. Floor plans were orientated to reflect their relative position in the centre. Stairwells were seen to be free of clutter.

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

Capacity and capability

This inspection was undertaken by inspectors of social services to monitor compliance with the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2013 (as amended), to follow up on the findings of the previous inspection in November 2024 and to follow up on unsolicited information submitted to the Chief Inspector prior to the inspection. The findings of this inspection showed that improvement was noted regarding regulations associated with the premises, staff supervision, the dining experience for residents, infection prevention and control, aspects of staff training, a new call bell system was installed, and wound care management with the implementation of skin care bundles to help prevent pressure damage. Issues that remained outstanding from that inspection included medication management associated with crushing of medications, and residents' care documentation. Areas for improvement identified on this inspection included implementation of recommendations made by allied healthcare professionals such as dietician. These are detailed under the relevant regulations in this report. There were a number of concerns raised as part of unsolicited information submitted to the Chief Inspector prior to the inspection. These concerns included residents' care documentation not being accurately maintained, pre-admission assessments not being completed appropriately to ensure the service can care for the specific needs of people being admitted to the centre, agency staff unsupervised and inadequate staff to facilitate one-to-one resident supervision. Findings associated with these concerns are also discussed throughout the report.

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

The regional director is on site on a weekly basis and came on site to support management and staff during the inspection. The current management structure on site comprised the person in charge, three assistant directors of nursing (ADONs), six clinical nurse managers (CNMs), and senior nurses, staff nurses and healthcare assistants (HCAs). This service was supported by the health-care team, household, catering and administration staff. A human resources (HR) administrator,

maintenance team and facilities manager support the non clinical aspect of the service. Two CNMs rotate on duty at weekends to support the governance structure; on night duty there is a supernumerary CNM or senior nurse cover. The group clinical director provides training on site. A new clinical facilitator was appointed and will facilitate staff training and ensure it is implemented into practice as part of their ongoing quality improvement strategy.

The CEO and COO facilitate weekly meetings providing oversight of the governance, operational management and administration of the service. The person in charge and regional manager facilitate meetings with all staff to provide updates and oversight and these meetings are informed by key performance indicators and audit findings. Weekly meetings are facilitated with the ADONs and CNMs as part of their quality strategy. Staff spoken with said they could raise issues with management, and bring concerns to their attention.

Committees were in place for end of life care, infection prevention and control, wound care management, falls prevention, food and nutrition. Falls prevention champions facilitated best practices to mitigate falls and additional exercise programmes were available, with physiotherapists on site three times a week to support residents and staff. Minutes of the wound care management meetings included an external review by the tissue viability nurse specialist who reported significant improvement in wound management; minutes also demonstrated additional education for staff to enable a high standard of evidence-based care to be delivered.

Quality and safety monitoring systems in place included weekly collection of key performance indicators (KPIs) such as falls, restraints, infection, weights, pressure ulcers and complaints for example. An annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents. Information was trended and this showed improvements in quality care indicators such as a reduction in administration of psychotropic 'as required' medication, moisture lesions, and falls. Management had excellent knowledge of key performance indicators such as oversight of residents' nutritional assessments with associated referrals, infections including multi-drug resistant non-active infections, wounds, catheters, and complaints for example. Other audits included observational tools and these along with audits reflected a true picture of the service. Where issues were identified, performance improvement plans were initiated for staff with clear and simple instructions on how to improve; this was reviewed the following week to facilitate further discussion and assessment, to enable immediate improvement.

Duty rosters on each unit were reviewed and rosters showed adequate staff for the general roster, however, some residents requiring one-to-one supervision did not have this supervision allocated. While others had this supervision, some staff did not actively engage with the resident. In addition, a review of staff allocation was requested to ensure adequate resources during twilight hours. One of the issues raised as part of the unsolicited information was that staff did not always speak in

English when on duty, and this was observed on inspection. Further evidence of this is discussed under Regulation 23: Governance and Management.

A review of training records demonstrated that all nurses had completed syringe-driver training to enhance their end of life care practices. One recently appointed CNM had a post graduate qualification in dementia specific care and one of the HCA had enrolled on a course relating to dementia care and challenging behaviour. Other mandatory training such as fire safety, manual handling and safeguarding was up to date for all staff, nonetheless, 55% of training relating to managing behaviours that challenge was outstanding for staff. As mentioned heretofore, a new clinical facilitator was appointed and would undertake staff training; this was welcomed as deficits in training relating to behaviours that challenge was a concern cognisant that there were three dementia specific units in the centre.

The complaints procedure was displayed at different locations throughout the building; it was in an accessible format for residents. The complaints log was reviewed and issues were recorded in line with current legislation, followed up and investigated.

The annual review for 2024 was available and displayed in the centre. This was a comprehensive publication providing detailed information in accordance with specified regulatory requirements.

Regulation 14: Persons in charge

The person in charge was full time in post and had the necessary qualifications and experiences as required in legislation. She was involved in the operational management and the day-to-day running of the service, and positively engaged with the regulator.

Judgment: Compliant

Regulation 15: Staffing

From a review of staff rosters, feedback of residents and observation on inspection, there were generally adequate staff to the size and layout of the centre and the assessed needs of residents during the day. However evening staffing levels required action on the Bandon unit and Clyda units where residents had higher supervision and care requirements. These units reduced to night time staffing levels at 8pm where further twilight hours are required to meet the assessed needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Action was required as mandatory training was not up to date for all staff as:

- 55% of staff required training relating to responsive behaviours.

Judgment: Substantially compliant

Regulation 21: Records

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

- a sample of staff files were reviewed and while most of the information required in Schedule 2 was in place for all staff, reference confirmation was not completed in records where just a statement of employment dates was issued, and not a reference to demonstrate the ability and competence of the person being employed.

Regarding Schedule 3: Records to be kept in the designated centre in respect of each resident:

- professional guidelines requires that controlled drug are counted and signed by two staff simultaneously to ensure accurate records, however, on one unit, just one staff signed the controlled drug log and there was no count recorded; this practice was not in compliance with the centre policy or professional guidelines.

Judgment: Substantially compliant

Regulation 23: Governance and management

Additional efforts made by the registered provider to further strengthen the management team were acknowledged with the addition of in-house senior management, nonetheless, action was required to ensure that managerial systems were in place to ensure the service was safe, appropriate, consistent and effectively monitored, as follows:

- there was a lack of oversight of care planning as detailed further under Regulation: 5 Individual Assessment and care planning

- there was a lack of oversight of staffing resources for the evening time as identified in Regulation 15: Staffing
- some residents required 1:1 supervision, however, this resource was not consistently available to ensure the care and welfare of residents; in addition, supervision staff did not tend to actively engage with residents such as take them outdoors to the garden for a walk and fresh air.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the incident and accident records showed that while notifications correlated with incidents logged, and were submitted, some were not returned within the regulatory time-frame of two-day notification.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

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

Judgment: Compliant

Quality and safety

Feedback from residents and relatives was mostly positive regarding care and welfare in the centre, and residents access to meaningful activities continued to improve, however, observation and feedback on inspection and as part of the unsolicited information confirmed that access to the outdoors remained poor.

A sample of pre-admission assessments were examined and these showed a thorough review of information to enable decision-making regarding admitting a person to the centre. Validated risk tools were in place to enable appropriate assessments. The daily narrative for both day and night duty was maintained on the

resident's status and progress. A sample of residents' care planning documentation was reviewed and showed mixed findings. Some assessments and care plans were excellent including responsive behaviour care records and informed individualised care, however, others had very little or no detail to inform personalised care. Some residents required weekly weights, however, this was not done consistently in accordance with dietician care recommendations, and in line with the validated nutritional assessment. This and other evidence is further detailed under Regulation 5: Individual assessment and care plan.

The safety pause document was an excellent information-sharing record which included MDROs, challenging behaviours, wounds, fire risk, absconsion risk, falls risk along with clinical oversight such as intake and output, pressure damage risk, and referrals to different specialities.

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

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

Behavioural support charts in place to support the relevant residents were excellent; they included narrative of the resident's normal behaviour, examples of behavioural disturbances and potential triggers, the possible non-pharmacological interventions to support the resident along with the pharmacological interventions.

A sample of controlled drugs records were examined and these were generally maintained in line with professional guidelines, however, on one unit records were not in accordance with professional guidelines and this is detailed in Regulation 21: Records. Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. A record of 'as required' (PRNs) psychotropic medications was maintained as part of medication management; these records showed the rationale for administration of PRNs. Inspectors joined three separate medication rounds where a sample of medication management administration records were examined. Of the sample examined most residents had photographic identification, however, two residents did not have this. While some medications requiring crushing were individually prescribed in line with professional best practice guidelines, others were

not; this and other findings are further detailed under Regulation 29: Medicines and pharmaceutical services.

Improvement was noted regarding oversight of multi-drug resistant organisms (MDROs). An up-to-date record of residents with previously identified MDRO colonisation (surveillance) was maintained. Information regarding MDROS was also part of the daily safety pause as a reminder to staff regarding possible precautions.

Records demonstrated that independent advocacy was accessed for residents in accordance with their wishes. The advocate was on site on a weekly basis and was in the centre during the inspection. Residents availed of this service including residents under 65yrs. Residents meetings were facilitated and issues and queries raised were followed up by the person in charge to ensure requests were addressed such as the addition of more music, shopping and going into Mallow.

Improvement was noted regarding residents' access to meaningful activation. Additional staff were appointed to the activities programme and a review of this programme showed a variety of activities such as The Bridhaven choir comprising residents, family members and staff, music, movie evenings, exercise programmes, newspaper reading and one-to-one time with residents who preferred this to group sessions. Children from the local play school, primary and secondary schools routinely attended the centre with their teachers.

Photographs were displayed of recent events such as the residents' bake-off, Alzheimer's coffee morning, the summer party where staff dressed in their native costume and entertained residents. Photographs of residents enjoying the animals from the pet farm showed they had good fun. Nonetheless, relatives and residents reported to inspectors that access to the outdoor spaces was quite restricted and inspectors observed this on inspection. Even though it was a bright day, there was just one resident seen out walking in the garden with their relative, a few other residents were out in the smoking area; aside from these there was no one else brought to the garden.

In general, the premises was seen to be well maintained. Improvement was noted throughout with new equipment, flooring was upgraded, and painting and decorating was ongoing during the inspection; and inspectors were informed that a complete new call-bell system was being installed at the time of the inspection. Inspectors were informed that an interior designer was due to come to the centre to review Bandon wing and this was welcomed as the unit was dark and required upgrading.

Regulation 11: Visits

Visiting was facilitated in line with the requirements of the regulations. Visitors were welcomed into the centre and inspectors saw that visitors were familiar with the risk management procedures upon entering the centre of signing in and hand hygiene.

There was ample room for residents to meet their relative in private if they wished. Visitors were seen to make coffee at the coffee docks while visiting their relative.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had good access to personal storage space with a double wardrobe, bedside locker and many residents had an additional chest of drawers and single wardrobe. A review of current complaints demonstrated there was no issue with laundry services. The laundry operated over seven days of the week and laundry staff spoken with during the inspection were knowledgeable regarding infection prevention and control protocols.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure the premises was maintained in line with the requirements of Schedule 6 of the regulations as follows:

- the dementia-specific Bandon wing was not suitably decorated as it was dark and corridors were clinical in nature
- privacy screens in twin bedrooms did not adequately enclose the space available to residents to ensure their privacy
- one twin room was well laid out, but the layout of two other twin rooms required attention to ensure it met the needs of both residents occupying the room.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

While improvement was noted in the overall dining experience of residents, care records for some residents showed that food and nutrition care plans were not updated following nutritional assessments and prescribed recommendations made by the dietician, therefore it could not be assured that the specific dietary needs of residents would be met.

Judgment: Substantially compliant

Regulation 27: Infection control

While improvement was noted regarding the implementation of the mandated National Standards for Infection Prevention and Control in Community Services (2018) regarding antimicrobial stewardship governance, issues remained outstanding:

- support bars in some toilets were rusted so effective cleaning could not be assured
- the clinical handwash sink in one sluice room did not comply with HPN10 current guidelines.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The following records required action to ensure residents' medication records were maintained in line with professional guidelines and regulatory requirements:

- Staff were not always administering medications in line with the directions of the prescriber: while some medications requiring crushing were individually prescribed in line with best practice, others were not, and staff were crushing medications even though the instruction to crush was not part of the prescription. Inappropriate crushing of some medications could result in residents receiving sub-optimal effective dosages of medications, and in contravention of manufacturer's guidelines. This was a repeat finding over the last two inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

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

- care plans had not been implemented in accordance with the dietician instructions as a number of residents required weekly and monthly weights were not weighed in accordance with the plan and some showed significant delays in weight monitoring
- one resident’s life story had very little detail of the resident’s family involvement even though their care records showed the family were very involved in the resident’s life in the centre
- a resident with a medical devise did not have this detailed in their care plan to ensure a high standard of nursing care to enable best outcomes for the resident; there was no information in the care plan to direct specific care to ensure the device remained patent,
- some care records were not updated in accordance with regulatory requirements of every four months, or with the changing status of the resident, or when new guidance was provided by the GP
- one resident spoken with wished to self-medicate, however, the appropriate assessment had not been completed to facilitate this
- a spirituality and end of life assessment did not have any information to guide individualised care
- personal emergency evacuation plans (PEEPS) were available for all residents, however, these required review to ensure they reflected the assistance required to safely evacuate a resident during both day and night time, for example, one resident’s care notes stated the resident was bed-bound but their PEEPS said they were a wheelchair evacuation both day and night.

Judgment: Not compliant

Regulation 6: Health care

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

Significant improvement was noted regarding wound care management. The service had access to tissue viability nurse specialist (TVN) who attended the centre on the day of the inspection and attended as required. The TVN had completed an audit of wound care and inspectors saw the report which highlighted the overall improvements in wound care management.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The restrictive practice committee was set up with one of the CNM's championing a restraint-free environment. Alternatives to restraint were trialled to enable best outcomes for residents. A call-bell capacity assessment was completed on residents with restricted movement or cognition, in particular, in the dementia specific units. This was completed to inform individualised care and more frequent supervision of residents as they may not be able to use call bells.

Judgment: Compliant

Regulation 8: Protection

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

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

Residents reported that they felt safe in the centre and were complimentary of staff and their responses to queries.

Judgment: Compliant

Regulation 9: Residents' rights

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

- routinely, going outdoors was not part of the activities schedule or daily routine for residents; residents reported that they normally did not go out into the garden, to enjoy the fresh air,
- occasionally inspectors observed that call bells were not within reach of residents when they were either in bed or by their bedside to enable them to call for assistance should they require help.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0047002

Date of inspection: 23/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Allocation of staff has been reviewed, and this has included the introduction of a twilight shift for Bandon, Clyda and Lavender.

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:

A training schedule has been completed, with a focus on Dementia specific training which will also include responsive behaviours, to ensure compliance in this area.

Regulation Heading	Judgment
Regulation 21: Records	Substantially Compliant

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

All staff files will be reviewed to ensure full compliance with Schedule 2 requirements. Where only statements of employment dates had been provided, additional reference confirmations have been requested from previous employers to verify the individual's ability and competence. Going forward, the recruitment process has been updated to ensure that references explicitly address the candidate's performance, ability, and suitability for the role. The HR department will verify that all required references are in place and satisfactory before any new staff member commences employment.

Compliance checks will be included in routine HR audits to ensure ongoing adherence to Schedule 2's requirements.
Regarding Schedule 3 The issue identified on one unit was addressed immediately following the inspection. All staff have been reminded of the requirement that controlled drugs must be counted and co-signed by two staff members at each handover and when administered, in line with professional guidelines and the center's medication management policy.
A review of current medication management practices has been completed. CNM/ADON carry out twice weekly audits of the controlled drug register to ensure compliance, and any non-compliance will be addressed promptly through supervision and re-training.

Regulation 23: Governance and management	Substantially Compliant

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

• All care plans are currently being reviewed to ensure compliance under regulation 5. Our ADON/CNM will continue their monitoring with monthly feedback to the PIC/RP.
• A twilight shift has been introduced to Lavender, Clyda and Bandon.
• Residents who required 1:1 supervision have always had this resourse in place.
• An initiative called "Move and Connect" has been introduced into the centre. This initiative encourages residents to mobilise to different areas within the centre including the garden. The access code to the garden will also be removed to encourage free access to the garden for walks and fresh air.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

All staff responsible for incident reporting have been reminded of the regulatory requirement to submit notifications within two working days. The notification process has been reviewed and strengthened. Three staff now have access to the portal to assist in the submission of notifications.
Management will monitor notification timelines through monthly audits to ensure all future incidents are reported within the required period.

Regulation 17: Premises	Substantially Compliant

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

We had recognized that the décor and environment in the dementia-specific Bandon Wing did not fully meet the standards of a homely, dementia-friendly setting.
A refurbishment plan has already been initiated to enhance the environment and promote comfort and orientation for residents. This includes adding artefacts to assist with reminisce, adding appropriate signage, artwork, and memory cues, and introducing soft furnishings to create a warmer, more homely atmosphere.
Where possible, residents and families will be consulted to ensure that the décor reflects residents' preferences and promotes familiarity.

A review of all twin bedrooms has been completed, currently privacy curtains have been ordered for two bedrooms. Staff have also been reminded on maintaining privacy and dignity for residents.

Twin rooms have now been upgraded to a standard to ensure it meets the needs of the residents occupying the room.

Regulation 18: Food and nutrition	Substantially Compliant

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

All food and nutrition care plans have been reviewed to ensure that all updates following on from a nutritional review have been recorded and implemented.

Regulation 27: Infection control	Substantially Compliant

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

Support bars identified with rust will be actioned to ensure adequate cleaning can be assured.

All sluice rooms in the centre have HPN10 sinks in place, these were all completed by September 2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

A review of all residents' medication has been completed. This included a review of all medication that requires to be crushed. Currently the center is compliant regarding this compliance.

Regulation 5: Individual assessment and care plan	Not Compliant

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

• care plans that required updating regarding dietary instructions or residents that required weekly or monthly weights have had their care plans updated. A monitoring system has been introduced by the CNM/ADON, to ensure delays do not occur.
• The residents life story will now be obtained prior to admission and on admission a Key to Me will be completed by the team. A review of the residents care plans will be undertaken to ensure it is reflective of the residents life story/Key to me. This will be undertaken with the resident and or family.
• A review of all care plans of residents with a medical devise has been completed to ensure a high standard of nursing care to enable best outcomes for the resident with a medical device.
• A review of all care plans is currently in place to ensure they are updated every four months or if there is a change to the residents condition, or when new guidance was provided by the GP. This is been monitored by the ADON team.
• One resident who expressed an initial desire to self medicate has not fully decided. However a self assessment form is available aswell as appropiate locked storage for her bedroom.
• A current review of all care plans is been undertaken to ensure assessment and End of Life care plans reflect guidance to the residents preferances and care.
• All PEEPS in the centre have been updated to reflect each residents ability in the event of evacuation. This includes both day and night.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: An initiative called “move and connect” was introduced into the centre. This initiative encourages staff and residents to take walk`s outside. The access code to the garden will be removed thereby allowing free access to the garden area. Living with purpose is encouraged within the garden and an initiative to introduce a poly tunnel will commence in 2026. Residents are also actively involved in maintain indoor plants through regular watering and feeding. The garden has been fully risk-assessed by the Physiotherapist to ensure it is safe for resident use. Comfort and safety checks are completed hourly within the centre staff have been reminded as was already in place to complete of the position of the call bell to ensure easy access for each 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 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.	Substantially Compliant	Yellow	10/11/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2025

Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	03/11/2025
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	31/01/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and	Substantially Compliant	Yellow	31/12/2025

	control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
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	11/11/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Substantially Compliant	Yellow	03/11/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a	Not Compliant	Orange	31/01/2026

	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.	Not Compliant	Orange	03/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/01/2026
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and	Substantially Compliant	Yellow	03/11/2025

	ability of each resident.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	21/11/2025