Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	07 November 2023
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0041799

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 (45 beds – four twin and 37 single with en suite facilities), (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:	127

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 7 November 2023	18:15hrs to 22:00hrs	Breeda Desmond	Lead
Wednesday 8 November 2023	09:00hrs to 18:15hrs	Breeda Desmond	Lead
Tuesday 7 November 2023	18:15hrs to 22:00hrs	Caroline Connelly	Support
Wednesday 8 November 2023	09:00hrs to 18:15hrs	Caroline Connelly	Support
Wednesday 8 November 2023	09:00hrs to 18:15hrs	Catherine O'Shea	Support

What residents told us and what inspectors observed

Overall, inspectors saw significant improvement in care practices during this inspection. Inspectors met many residents on both days of the inspection and spoke with 22 residents in more detail, and six sets of 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. They were very complimentary of the range of activities and the lovely atmosphere in the centre. Visitors were generally complimentary about the care and said there had been a lot of recent improvements, however one family member felt that communication could be better. Others said that clothing sometimes went missing.

This was a two-day inspection, with the first day commencing at 6:15pm. Inspectors were welcomed to the centre by the senior nurse and completed the risk management procedure of signing in and hand hygiene. A brief introductory meeting was held on the first evening of inspection and an information-sharing meeting was facilitated with the management team on the second day of the inspection.

There were 127 residents residing in Bridhaven at the time of inspection. Bridhaven was 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. Management and HR offices, the main kitchen, maintenance and facilities, staff facilities, laundry, storage areas, and hairdressers' room were accommodated on the lower ground floor.

Initially upon arrival to the centre, inspectors visited all the units and saw that residents were enjoying various activities on each unit. In the day room on Blackwater, residents were enjoying a music concert on the large screen and staff were actively engaged with residents encouraging them to be involved with singing, clapping and staff dancing to the music. Both residents and staff enjoyed the music and craic. Upstairs, residents were enjoying music on the television; snacks and beverages were offered to residents and the care staff sat and actively engaged with residents chatting about the events of the day, the music on TV while at the same time encouraging residents with their fluids. Later in the evening, inspectors saw residents chatting with their friends on corridors as they went about their business, and upon their return to the day room, residents went and sat with their friends and chatted in a normal social manner. On Lavender, inspectors saw staff sitting with residents and actively engaging with them, chatting and drawing, with lovely music on in the background. The inspectors observed supper time on Clyda unit, where most residents enjoyed a hot drink and cake in the day or dining room. A couple of residents were very complimentary of the food and supper and requested seconds which were promptly served. One resident told the inspector that

the staff were fantastic and were lovely to all the residents.

Inspectors spoke with staff who were completing medication rounds. Nurses were observed to complete the medication round in a calm and relaxed manner. Inspectors asked about medication rounds and were informed that approximately five-to-seven residents on each unit get their medications at 07:30pm, all other medications were given by the night duty staff and that round started after the hand-over report.

There was a household cleaning staff on night duty seen cleaning and emptying waste bins. Throughout both days of inspection, it was noted that while many areas were generally clean, other areas were unclean. Two of the handwash sinks were replaced since the last inspection, but many of the clinical hand-wash sinks with metal outlets, remained in place. Some bedroom furniture had been replaced, however, surfaces of some furniture such as bed frames, lockers and chest of drawers were worn. Some flooring was replaced but other floor surfaces were worn and stained and looked unsightly. Nonetheless, painting and re-decorating was in progress; corridors were being painted and hand rails were sanded and ready for varnishing.

On the second day of inspection, the activities co-ordinator explained the days' activities to residents and the choice available to them. Residents were seen to watch mass on television in dayrooms at 10am. This was followed by staff offering resident beverages and snacks. As part of the inter-generational programme introduced, children from the near-by primary school visited residents in the dayroom on Blackwater wing; children sang and danced for residents and they really enjoyed the entertainment. In the afternoon, children from the secondary school came and offered hand massage, nail painting and manicures; this was a very relaxed experience and residents were seen to enjoy this very much. One resident told the inspectors how they really enjoyed the activities and added ''everything is so good here that it would be very difficult to find fault with anything''. Three residents were outside, having their cup of tea and cigarette. They had independently accessed the outdoors and knew the key-code to re-enter the building. Inspectors spoke with the three residents who reported they were happy with the service and could raise issues if needed. They did query when the sheltered smoking cabin would be available and this query was brought to management who explained that the cabin was on-site but needed to arrange a fork-lift to transport it to the garden as well as agree a suitable location.

The inspectors observed very positive and person centered interactions between residents and staff and it was obvious that staff knew residents well. While most residents were very complimentary about staff a few residents reported some delays in staff answering call bells, with one resident reporting delays in staff attending to their needs in the morning resulting in a later getting up than they would wish.

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. Other publications and information on display included the monthly Bridhaven news letter, statement of purpose, residents' guide, complaints

procedure and advocacy services. The advocate was on site on a weekly basis to support residents, including seven residents under 65yrs.

Staff on the dementia specific units of Clyda and Lavender facilitated activities there. Staff on Lavender were asked about meal-times and they explained that meal-time was resident-led. Breakfast time was observed here; five residents were seen to have their breakfast at 10:15hrs; some residents had a cooked breakfast, others cereal and toast; the remainder of residents were asleep in bed and would be given their breakfast when they awoke.

Upgrading work to the premises was in progress with the space to the right of main reception being re-configured to accommodate the hairdressers room and this was welcomed, as currently, the hairdressers was located in the lower ground floor and away from the main thoroughfare. The ongoing works to the main garden was completed and this enabled greater outdoor space for residents to walkabout and sit and enjoy the outdoors. Other re-configuration works included the installation of custom-built kitchenette units in the dining rooms on Awbeg and Bandon; the conference room on Awbeg was converted to a day room. The expansive connecting corridor between Awbeg and Bandon was re-configured with the creation of a quiet day room. This was a bright room with windows on either side with views of the gardens.

The display table in this space had the framed words of a song composed by one of the residents called 'A song for Bridhaven'. The resident's new book was being launched in the centre at the end of November. Another resident was also a published author and their works were also celebrated. Bookshelves with a variety of books and games were seen in all dayrooms; additional reading material was provided by the local community library for residents.

The laundry was inspected on the morning of the second day of inspection. Emergency evacuation routes remained clear of obstruction. There was no laundry awaiting washing as there was dedicated night duty staff as well as day duty for the laundry. The laundry staff were knowledgeable regarding infection prevent and control protocols and explained the sequence of cleaning dirty laundry, appropriate temperatures for different items of clothing and chemicals to be added as part of the computer programme operation of the machines. 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.

There was a separate secure entrance to Clyda so that visitors could access the unit without needing to go through the centre. The reception area here had infection control precautionary facilities along with a sign-in sheet. The complaints procedure was displayed at the entrance. Memory aids such as large pictures were displayed to orientate residents to rooms such as toilets, bathrooms and the dining room. Large clocks were displayed in the day room and dining room. An open-shelved unit in the day room displayed the colourful memory boxes with each resident's name on the

front of their box; these contained items of reminiscence for residents such as photographs and other memorabilia. Access to the enclosed garden in Clyda was via patio doors in the day room. This was a large well maintained space with walkways, shrubberies, raised flower beds and seating for residents to rest.

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. Previously there was a specialist bath available to residents in the centre, and this was removed by the previous provider as it did not comply with infection control precautions and was not replaced.

Alarm bells were wall mounted at the end of each corridor for easy access by staff and residents to call for help. Residents using oxygen had signage indicating oxygen in use in their bedrooms.

Throughout both days of inspection, appropriate hand hygiene including hand washing and hand sanitisation was observed. 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.

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. All stairwells were seen to be free of clutter. The inspectors observed that the fire doors to the main kitchen were not closing fully. The inspectors observed that a number of the clinical rooms and nurses station were not securely maintained, allowing for unauthorised access. One of the nurses stations had the medication fridge there and this was also unsecured.

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 arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This inspection was undertaken as part of ongoing regulatory monitoring of the service and to follow up on the findings of the previous inspection in April 2023. Significant improvement was noted in the quality of life initiatives started following the previous inspection. The findings of this inspection demonstrated that action

was taken relating to residents' rights and protection, food and nutrition regarding the dining experience for residents, staffing; and some improvement was noted in resident care documentation. Repeat findings were identified relating to fire safety precautions, infection control and aspects of residents' care planning documentation. Additional areas of concern identified on this inspection included regulations relating to staff supervision, features of medication management. An immediate action was issued to the provider on inspection relating to fire safety, and this was remedied immediately following the inspection.

Bridhaven Nursing Home was a designated centre for older adults and was registered to accommodate 182 residents. The provider was part of the Virtue group and the company had four directors. One of the directors acted on behalf of the provider. The management team had changed since the last inspection with the appointment of a new person in charge, two new assistant directors of nursing (ADONs) and new clinical nurse managers (CNMs). The person in charge at the time of inspection, was appropriately qualified and had the necessary experience in line with regulatory requirements. At the time of inspection, the regulator had received a regulatory notification advising of a change in person in charge, with a new person in charge due to take up post following the inspection.

The current management structure on site comprised the person in charge, two ADONs, five CNMs, and senior nurses. This service was supported by the health-care team, household, catering and administration staff. A human resources (HR) administrator, maintenance team and facilities manager supported the non clinical aspect of service. Two CNMs rotated on duty at weekends to support the governance structure; on night duty there was supernumerary CNM or Senior nurse cover. The group clinical director for training provided training on site.

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. The annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents. Nonetheless, all the senior management team on site had changed, with further changes relating to the person in charge following this inspection, so these quality initiatives would take time to become embedded in the culture of the centre. CNMs were assigned quality leads roles in October 2023 for areas such as infection control, food and nutrition, tissue viability and restrictive practice for example, which again, would take time to embed. While audits completed had comprehensive action plans and initiatives undertaken to remedy the deficits identified, the depth of some audits were not sufficiently robust to ensure effective monitoring; evidence of this was discussed throughout the report and detailed under Regulation 23, Governance and Management.

The regional director of operations facilitated weekly teams meetings with the persons in charge of the five centre associated with the registered provider; this provided good support as well as information sharing amongst the persons in charge. Regional 'Quality Safety and Risk' meetings were facilitated and chaired by the director of quality safety and risk. Monthly 'Social, Clinical and Transition' meetings were convened. Agenda items for these meetings comprised quality

improvement plans, key performance indicators, transitional management of residents, risk management and attendees included the on-site senior management.

The duty rosters were reviewed and showed planned and worked rosters. These demonstrated there was adequate care staff to the size and layout of the centre. While recruitment was ongoing for posts such as activities co-ordinators, staff rosters did not reflect staff allocation to activities for days when there was limited or no activities co-ordinator on duty.

The complaints procedure was updated on inspection to ensure it reflected the recent change in legislation, and that it was in an accessible format for residents. The complaints log was reviewed and many issues were recorded in line with current legislation, nonetheless, other issues identified regarding complaints were further discussed under Regulation 34, Complaints.

Registration Regulation 6: Changes to information supplied for registration purposes

Appropriate notification was timely submitted regarding change to the person in charge. Specified documentation was submitted. The incumbent person in charge had the necessary experience and qualifications as specified in the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge at the time of inspection 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.

Judgment: Compliant

Regulation 15: Staffing

Improvement was noted regarding staffing levels on all units. Duty rosters examined showed there were adequate staff to the size and layout of the centre and the assessed needs of residents; and this was observed on inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Although there was a comprehension training matrix in place for all staff, there were a large number of staff who did not have up-to date training in responsive behaviour as per the centers policy.

Supervision of staff required review as the inspectors observed that on occasions residents were not being responded to in a timely manner, particularly in relation to delays in answering call bells.

Judgment: Substantially compliant

Regulation 21: Records

Records were made available for inspection as required. Records were generally stored appropriately, however, some records were not stored securely,as actioned under Regulation 23 relating to access to nursing offices.

Judgment: Compliant

Regulation 23: Governance and management

It was acknowledged the efforts made by the registered provider to strengthen the management team in the centre, nonetheless, this would take time to embed and for the quality improvement initiatives to become routine and part of the quality culture of the service. Action was required to ensure the service was safe, appropriate, consistent and effectively monitored as follows:

- a review of the duty roster was necessary as inspectors observed in some units, there was insufficient time for staff handovers to enable all staff to attend this important information-sharing
- the auditing process was not sufficiently robust to ensure and enable learning to inform quality improvement, for example, complaints and activities; many of the issues identified on inspection had not been recognised or identified as part of their auditing process
- many rooms were not securely maintained to prevent unauthorised access, for example, clinical treatment rooms, nurses stations and sluice room with clinical waste.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications submitted to the regulator correlated with the incidents logged as part of the risk management in the centre, however, some of these were submitted late and not within the time-lines specified in the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Action was necessary to ensure complaints were responded to in line with legislation, as follows:

- some complaints were not followed up
- other complaints were not followed up in line with their policy of responding within 20 days
- learning from complaints were not documented to prevent recurrence of issues, such as missing laundry
- three allegations of omissions of care or neglect by staff were reported as complaints. While they were appropriately dealt with as part of safeguarding, confusion and misunderstanding could occur if such allegations were treated as complaints and not followed up appropriately.

Judgment: Substantially compliant

Quality and safety

Overall inspectors found that residents were enabled to have a good quality of life. Significant improvement was noted on this inspection regarding the programme of activities and the overall atmosphere in the centre.

The newly appointed ADON was responsible for completing the pre-admission assessment of residents to ensure the service could care for the resident in accordance with their assessed needs. Personal emergency evacuation forms were in place for residents. A sample of residents' care planning documentation was reviewed. The daily narrative for both day and night duty was maintained on the resident's status and progress. Touch-screen devises were displayed on corridors to enable staff record care delivered to residents. Validated risk assessments were in place to enable staff to assess residents care needs, however, sometimes these were not comprehensively completed to adequately inform the care planning process. This was further discussed under Regulation 5, Individual assessment and

care planning. While the service actively monitored restrictive practices, the associated risk assessment for restraint did not support decision-making or could not effectively assess the related risk.

Residents were seen to have good access to health and social care professionals such as a dietician, dental, occupational therapist (OT), speech and language therapist (SALT) and tissue viability nurse (TVN) 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. Residents notes demonstrated that they had access to tissue viability nurse specialist to support wound care. Residents had access to palliative care services. To support residents, nurses were training up in the administration of subcutaneous fluids to enable better outcomes to support their comfort. Fit-for-life physiotherapy group was held on a weekly basis as part of their positive aging programme to help residents maintain their level of muscle tone and mobility.

Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. As part of the medication oversight, additional information was included such as the requirement for blood profile or heart monitoring (ECG) to be completed to enable the GP to monitor residents' response and suitability of certain medications, to ensure best outcomes for them. Inspectors joined four separate medication rounds where a sample of medication management administration records were examined. Residents had photographic identification and allergy status details. Medications requiring crushing were individually prescribed in line with best practice. Behavioural support charts were in place to support the relevant residents; these included narrative of the residents normal behaviour, examples of behavioural disturbances and potential triggers, the possible non-pharmacological interventions to support the resident along with the pharmacological interventions. Signage was displayed in areas where oxygen was stored or in use. Controlled drugs were maintained in line with professional guidelines. Nonetheless, issues were identified in the medication documentation and these were further discussed under Regulation 29, Medicines and pharmaceutical services.

A review of the dining experience was undertaken following the findings of the last inspection and improvement was noted regarding food and nutrition, meal choices and the overall dining experience for residents. The head chef facilitated regular meetings with residents to enable quality improvement in their dining experience including meal choices offered.

The advocate was on site on a weekly basis and residents availed of this service including residents under 65yrs. External agency support was sought to provide personal assistant (PA) service for residents and funding was sanctioned for PA support, however, they were awaiting personnel to be recruited to these positions. While residents' meetings were facilitated and were well attended, minutes of these meetings did not provide assurance that thee meetings were interactive; issues raised were not followed up on subsequent meetings to assure residents that their

voice was heard and their request or suggestions were taken on board.

Dedicated hand hygiene hubs were available throughout the centre, however, some did not comply with current recommended specifications for clinical hand wash sinks as specified in document HBN-09 infection control in the built environment (DoH 2013).

Daily and weekly fire safety checks were comprehensively maintained. Several of the bedroom fire doorstops were replaced since the last inspection, and a daily check was put in place to ensure better oversight of these; batteries were replaced as required, and doorstops replaced as necessary. The senior nurses and CNMs on each unit were trained as fire marshals. Staff induction training on fire precautions was comprehensive. Simulated fire drills and evacuations were undertaken on a regular basis, however, evacuation of full compartments had not occurred to be assured that staff were competent regarding fire safety precautions. Two fire blankets were replaced on inspection when it was highlighted to maintenance. An immediate action was issued on inspection regarding the fire doors at the entrance to the main kitchen; this was remedied on the day following the inspection and further detailed under Regulation 28, Fire Precautions.

Regulation 10: Communication difficulties

Residents with communication difficulties were seen to have theses needs documented in their care plans and the interventions to deal with issues were outlined. Communication aids were made available to residents to ensure residents were all able to communicate as freely as possible.

Judgment: Compliant

Regulation 11: Visits

Visiting was facilitated in line with the requirements of regulations. Visitors were welcomed into the centre and staff guided them through the risk management precautions. There was ample room for residents to meet their relative in private if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Several complaints logged reported missing laundry and items not returned to

residents. An action plan was not developed or responsibility was not assigned to mitigate recurrence of such issues and help streamline the process to prevent clothes going missing.

Judgment: Substantially compliant

Regulation 17: Premises

Notwithstanding the three-phase programme of works underway to upgrade the premises work remained incomplete regarding:

- the specialist bath that was previously in-situ was removed by the previous registered provider due to it's non-compliance with infection control guidelines, however, this had not been replaced to facilitate resident choice and to ensure compliance with Schedule 6 of the regulations.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

A review of the dining experience was undertaken following the findings of the last inspection and improvement was noted regarding food and nutrition, meal choices and the dining experience for residents. The head chef facilitated meetings with residents to enable quality improvement in their dining experience regarding quality and choice. Mealtimes were observed, including serving of meals and snacks to residents in their bedrooms and improvement was noted here as well.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Documentation was maintained on site of information provided upon residents' transfer to another health-care facility. This included residents' infection status and history, antibiotic treatment and multi-drug resistant (MDRO) status. Discharge letters for when residents returned to the centre were seen as part of residents' documentation which enabled residents to be cared for in accordance with their current needs.

Judgment: Compliant

Regulation 27: Infection control

Notwithstanding the capital project plan in place to address the environment and equipment concerns, the following issues remained outstanding which had the potential to impact the effectiveness of infection prevention and control with the associated risk of transmitting a healthcare-associated infection within the centre:

- surfaces to furniture such as hand rails, bed frames, lockers, and bed tables were worn so effective cleaning could not be assured
- some of the hand-wash sinks did not comply with the Dept of Health clinical wash-hand basin guidance
- one handwash sink in a sluice room was rusted and could not be cleaned effectively
- oversight and monitoring of cleaning throughout the centre as some areas were visibly unclean
- staff were observed to use pre made up disposable wipes for all cleaning in one area despite having access to cleaning chemicals
- some store rooms had inappropriate storage on the ground impeding effective cleaning.

While a CNM was appointed IPC lead for the service, the national IPC guidelines for community services and antimicrobial stewardship guidelines would take time to implement and embed to ensure compliance with regulatory requirements.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was necessary to ensure fire safety precautions as follows:

- there was no call bell available to residents and staff at the smoking area in the enclosed garden of Blackwater Lee Side
- while fire blankets were replaced during the inspection, better oversight was necessary of such fire safety equipment to ensure it was fit for it's intended purpose
- full compartment simulated evacuations had not been completed, these are required to be assured that a full compartment evacuation could be completed in a timely manner by all staff.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Action was necessary to ensure medication records were appropriately maintained in line with professional guidelines as the following were identified:

- one resident was prescribed a medication every three months, while they had received it in June 2023, it was not administered in September 2023
- as part of medication records, residents on daily insulin had their blood sugar recorded, however, this was not comprehensively completed to be assured of the resident's sugar/insulin ratio, or that insulin was administered in line with the needs of the resident and the directions of the prescriber, and in accordance with any advise provided by the pharmacist regarding the appropriate use of the product.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were examined and these showed mixed findings. Some had personalised information to inform individualised care while many others did not have this detail and required action to enable staff provide individualised care. For example:

- some assessments such as mobility and activities were blank, others had generic information that could apply to any resident and could not inform individualised care
- while it was reported that residents were at risk of infection, it was not reported where or the type of infection the resident was prone to developing
- one residents 'missing person's profile' indicated 'no' regarding confusion, even though the resident had 'severe' cognitive impairment
- one resident was deemed to have no risk regarding a safe environment even though they were a high falls risk and had several falls
- while the food and nutrition assessment detailed the resident's choice for breakfast, 'menu choice' was written for their dinner and tea, and did not have their likes or dislikes to inform individualised care
- aside from residents religion and resuscitation status, there was no other detail to inform their end-of-life care wishes and preferences
- the comprehensive assessment was last completed in December 2022.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to GP services who visited the centre on a daily basis and when required. The service had the support of a consultant geriatrician which enabled better outcomes for residents, including residents in the dementia units. Residents notes showed they had timely access to specialist services such as psychiatry and palliative care.

To support residents food and nutrition, they had access to speech and language and dietician specialities. Tissue viability nurse specialist support residents regarding their wound management when indicated; scientific measurements were used when monitoring wound status. Regular monitoring of bloods was facilitated in line with residents' diagnosis such as diabetes, cardiac disease, and poly pharmacy.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restraint in the centre was not always in accordance with the national policy as published on the website of the Department of Health as required by the regulations:

- the assessment for the use of bedrails was not sufficiently robust and a checking mechanism was not in place to ensure the correct application of bedrails to ensure residents safety
- there was not evidence in all residents files if alternatives to bedrails had been trialled and that the restraint in place was the least restrictive alternative.

Judgment: Substantially compliant

Regulation 8: Protection

Significant improvement was observed on inspection regarding protection of residents from institutional practices. As described heretofore, staff actively engaged with residents; activities were facilitated throughout the day with a varied activities calendar seen and observed on each unit. The 'after 5pm club' was a new initiative to enable residents be actively involved in developing their evening programme. Activities were facilitated over seven days. Work routines no longer dictated the daily activities and this was especially noteworthy in Lavender and Clyda where residents had more freedom to get up and go to bed at later times, routines were dictated more by residents welfare and rights.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure residents rights were upheld, as follows:

- residents' meetings were facilitated and well attended, however, the minutes did not assure that residents' voices were heard, and that issues raised were followed up in subsequent meetings, or that information reported back to residents
- while a smoking shed was on site, it was not installed in the garden for residents to access, this was especially relevant cognisant of the inclement weather over the last several weeks
- while it was reported that additional activities staff were being recruited at the time of inspection, duty rostered showed that staff were not allocated to facilitate activities when there was limited or no activities co-ordinators rostered on duty, so assurances were not provided that residents would have access activities and recreation in accordance with their interests and capacities.

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 6: Changes to information supplied for registration purposes	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially 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 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0041799

Date of inspection: 08/11/2023

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: Responsive behaviour training is scheduled on the monthly training plan and all staff will have their responsive behaviour training completed by 30th March 2023. A review of staff breaks, supervision of each house has been completed on 16th November 2023, ensuring that there is an increased monitoring and supervision of delivery of care.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of duty rosters was undertaken thus facilitating adequate time and staff are present at all handovers. Completed 16.11.23. Training for all management team in the completion of audits and actions required with associated findings was completed by 30th November 2023. All Clinical rooms and sluice rooms are secured at all times which is monitored at different times during the day by the Senior Management team to ensure compliance with the above. (Complete and ongoing since 28.11.2023)	

Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All required notifications will be submitted within the required regulatory time frame.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Following the inspection any complaints received are consistently and accurately recorded and followed up in accordance with Bridhaven management of Complaints policy. Quality improvement plans are now created and disseminated to all team members identifying all learnings from any complaints. Any suspected or alleged safeguarding concerns that may initially be raised as a complaint are managed as per Brid haven's safeguarding policy and procedure. 20.11.23 and ongoing.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: A Quality improvement plan was completed post inspection in relation to the missing of personal possessions which includes actions and a Standard operating procedure which was communicated with staff, residents and the residents designated contact person which was completed on 11.12.2023. The above action plan will be audited by 30th January 2024.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

All Resident are informed at the pre-admission assessment stage that Bridhaven does not have a bath. The Residents make an informed decision regarding their choice of home based on their preference prior to admission.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
An ongoing capital project plan in place to address the environment and equipment concerns,
• All handrails surfaces have been repaired .30th November 2023.
• Audit was completed on lockers and bed tables on 17th of October 2023 and a replacement programme has commenced on lockers and bedtables .To date 102 tables and 34 lockers have been replaced.
• An audit of existing hand wash sinks was completed to identify the hand wash sinks that require replacement . Since the inspection an additional three Clinical Hand wash sinks were installed in accordance with the HBN guidance.
• The handwash sink in the Sluice Room was replaced on 21st of November 2023
• The rusted hand washing basin in the sluice room is now removed and replaced with a new hand washing basin.
• Monitoring and oversight of all cleaning processes and procedures including items on the Housekeeping trolley is completed weekly with an associated Quality Improvement plan which is shared with all staff and disucssed at team meetings. Commenced on 27th of November 2023.
• All pre made up disposable wipes has removed from all cleaning trollies and the compliance of this is been monitored by Facilities manager. (10/11/2023)
• New shelving has been provided to ensure that the items are stored off the floor to ensure proper cleaning.Completed on 17/11/23.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A call bell is available to residents and staff at the smoking area in the enclosed garden of Blackwater Lee Side.Completed on 16th November 2023.
• A review of fireblankets is now included as part of monthly Health and safety Audits of fire extinguishers.
• Full compartment simulated evacuations are completed and recorded.Completed on 6th of November 2023 and is ongoing.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Included in the Bridhaven the Quality improvement plan is the introduction of the electronic medication management system will be implemented by Jan2024. Post incident quality improvement plan implemented that a medication administration chart for residents who are on three monthly and six-monthly medications will be completed. A residents list and the next due date to be maintained in nursing station for injections such as Neo-Cytamen, Prolia or Decapeptyl for the safe administering and monitoring. CNMs with overall monitoring from Senior Management team in Bridhaven are assigned responsibility of Kardex audit monthly commencing 15th December 2023.
An audit of Blood sugar monitoring records was completed, 15th of November 2023, An outcome of this audit included that all blood sugar level readings are now recorded electronically . Completed 01st December 2023.

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:
Training has been arranged for all nurses including the completion and prescription of Care planning. Commenced in October 2023 and is ongoing.
A full review and audit of all care plans was completed in October and the Quality Improvement documentation project is ongoing to improve the quality-of-care plan whilst ensuring that the care plan is resident focused.
All comprehensive assessments are now detailed, updated and within date.
Post admission audits are completed within 48 hours of admission to Bridhaven which identifies any gaps in all clinical risk assessments and comprehensive assessments.
All comprehensive assessments are reviewed and updated in conjunction with all care plans and clinical risk assessments at a minimum of 4 monthly intervals which are now scheduled.
Care plan audits are now scheduled monthly and include questions relating to "End of life Care wishes and preferences", residents' religion and resuscitation status, residents likes and dislikes.

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:
A comprehensive restraint audit was completed post inspection in all the households and a quality improvement plan was created. The progress to date are discussed weekly in the weekly Governance meeting with the RPR. An ADON is assigned as the lead for the Restrictive practice.
• There is a comprehensive assessment for the use of bedrails to ensure the correct application of bedrails to ensure residents safety.Completed on 16/11/2023.
• All residents have a record of alternatives trialled before the use of bedrails

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A revised resident's Meeting minute template is in place and will come into effect on the December 18th meeting which ensures that the resident's opinions and contributions are evidenced, and any issues raised in the meeting will be followed up. A Quality improvement plan will be developed by DON and will be shared with the residents as a follow-up to each meeting.

A second smoking shed is now installed in the garden which is accessible to the residents. Completed on 16th November 2023.

Staff are rostered as part of the activities team to ensure that staff are available over the 7 days to ensure activities are facilitated for our residents.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly and returned to that resident.	Substantially Compliant	Yellow	30/01/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/03/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	16/11/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the	Substantially Compliant	Yellow	10/11/2023

	residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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.	Substantially Compliant	Yellow	30/11/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/03/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	16/11/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	16/11/2023

Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	10/11/2023
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	30/11/2023
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.	Substantially Compliant	Yellow	20/11/2023
Regulation	The registered	Substantially	Yellow	20/11/2023

34(2)(b)	provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Compliant		
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	20/11/2023
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.	Substantially Compliant	Yellow	20/11/2023
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any	Substantially Compliant	Yellow	20/11/2023

	investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	28/11/2023
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	28/11/2023
Regulation 7(3)	The registered provider shall	Substantially Compliant	Yellow	16/11/2023

	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.			
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	10/11/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	18/11/2023