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:	Bushfield Care Centre
Name of provider:	Health Service Executive
Address of centre:	Bushfield, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	26 May 2025
Centre ID:	OSV-0005242
Fieldwork ID:	MON-0047222

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

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 26 May 2025	09:00hrs to 16:50hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in Bushfield Care Centre reported significant improvements in the quality of care they received. They described the care and support they received as person-centred and delivered by a team of staff who were familiar with their individual needs and preferences. Residents spoke positively about the improvements made, particularly in how they are kept informed about changes within the centre and that this made them feel safe.

The inspector was met by a director of nursing on arrival at the centre. Following an introductory meeting, the inspector walked though the centre and met with the residents and also engaged with staff across various departments. The person in charge attended the centre following the commencement of the inspection and a brief introductory meeting was held.

Residents were observed to be content and relaxed in various communal areas. Some residents were seated in the dining room enjoying breakfast, while others were reading the newspaper. Residents reported a high level of satisfaction with the quality of care and support they received from staff. Residents told the inspector that staff were prompt to answer their call bells, and did not make them feel rushed when they came to assist them with their care needs. Residents were familiar with the staff that provided them with care and support, and this made them feel safe and comfortable in their care.

The inspector spent time in the different areas of the centre chatting with residents and observing the quality of staff interactions with residents. Staff interactions with residents were respectful, polite, and person-centred. Staff assisted residents in a discrete and supportive manner. Staff that spoke with the inspector demonstrated a good knowledge of residents, and their individual needs and preferences.

The premises was appropriately decorated, well-lit, clean, and warm for residents. There were appropriately placed hand rails to support residents to walk independently around the centre. There was an enclosed garden accessible to residents. The garden area was appropriately furnished and maintained to a satisfactory standard.

Residents were complimentary of the dining experience and the quality of the food they received. The dining experience was observed to be a social and enjoyable experience for residents. Staff were available to provide discrete assistance and support to residents, if required. Food was freshly prepared and met residents individual nutritional requirements. Residents confirmed the availability of snacks and refreshments outside of scheduled meal times.

Residents spoke about how they raised issued or concerns with the staff, and described how they would always tell staff if there was an aspect of the service they were not happy with.

Throughout the day, residents were actively engaged in a variety of meaningful activities. There was a detailed activity schedule developed in consultation with the residents. Residents were observed enjoying music and engaged in games and other activities during the morning. Staff were observed to engage in activities with residents and this added to the social experience of the activities.

The following sections of this report detail the findings in relation to the capacity and capability of the provider and describes how these arrangements support the quality and safety of the service provided to the residents.

Capacity and capability

This was an unannounced inspection carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).

The Health Service Executive (HSE) took control of this designated centre under Section 64 of the Health Act 2007 (as amended) in December 2024, following the cancellation of the registration of a previous registered provider.

The findings of this inspection were that the Health Service Executive had ensured that the service was adequately resourced to support the safe and effective delivery of care to residents. This included ensuring the service had appropriate staffing levels, financial support, and necessary equipment to deliver consistent care to the residents. However, this inspection also found that the specific roles, responsibilities, and accountability of the management team in relation to the supervision and oversight of the service were not clearly defined. This posed a risk to the effective implementation of management systems to ensure a safe, consistent and quality service was provided to residents living in the centre.

Within the centre, there was a management structure consisting of a person in charge, a director of nursing, and a clinical nurse manager. Although the person in charge held overall accountability and responsibility for the service, the inspector found that a significant number of their responsibilities were delegate to and carried out by the director of nursing. This arrangement did not ensure that the person in charge maintained effective oversight and assurance of the functions delegated to others as some of the systems in place to manage risk, incidents and records were not effectively implemented. For example, there was no evidence of any action taken in response to an incident involving a resident that had occurred three weeks prior to this inspection.

A review of the risk register evidenced that some clinical and environmental risks were assessed and had been categorised according to their level of risk to residents. However, the risk register did not contain some of the known risks in the centre, such as risks identified with the detection and containment of fire. This impacted on the provider's ability to identify, monitor, and manage risks to resident's safety and welfare.

Record keeping and file management systems consisted of electronic and paper-based systems. A review of staffing records found that all staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. For example, some staff files did not contain a full employment history. In addition, records of staffing rosters were not maintained in line with the requirements of Schedule 4 of the regulations.

The centre had sufficient staffing resources to ensure effective delivery of care and support to residents. The team providing direct care to residents consisted of registered nurses and a team of health care assistants. There were sufficient numbers of housekeeping, activities, catering and maintenance staff in place.

There was a training and development programme in place for all grades of staff. Staff demonstrated an appropriate awareness of their training with regard to fire safety procedures, and their role and responsibility in recognising and responding to allegations of abuse. There were systems in place to support and supervise staff through nurse management presence.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix on duty to meet the needs of residents and having regard to the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated and supported to attend training relevant to their role.

Staff were appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. Arrangements were in place to induct and orientate staff, and to support staff to provided safe and effective care to residents.

Judgment: Compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, two staff files did not contain a full employment history, together with a satisfactory history of any gaps in employment.
- The hours worked by the person in charge of the centre were not recorded on the staff roster as required by Schedule 4 of the regulations. There meant that there was no record of the attendance of the person in charge in the centre with overall responsibility for the day-to-day management and operation of the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The roles and responsibilities of the nurse management team were poorly defined. The person in charge had delegated responsibility for key aspects of the service, including the oversight of risk management, incidents and record management to the director of nursing. This arrangement did not ensure that management systems were being effectively implemented and monitored to ensure effective oversight of the service.

The overall governance and management of the centre was not fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example,

- Risk management systems were not effectively implemented. The centre's risk register did not contain known risks in the centre such as the risks associated with the containment of fire in the centre. Some risks such as those associated with the maintenance of the fire detection system had not been reviewed to reflect that the risk was unresolved. Consequently, there was a lack of mitigating measures in place to manage and reduce the risk of fire in the centre.
- The systems in place to manage resident's finances was not robust. For example, where resident had handed in monies for safekeeping in the safe, and the records of transactions were appropriately maintained, a monthly audit process outlined by the nurse management was not being implemented in practice. The most recent audit had been completed 11 months prior to this inspection.

- Incident management systems were not effectively monitored. For example, there was no evidence of an incident of unexplained bruising being reviewed or investigated.

Judgment: Substantially compliant

Quality and safety

On the day of inspection, resident's health and social care needs were maintained by a satisfactory standard of evidenced-based care and support from a team of staff who demonstrated a clear understanding of each resident's individual needs and preferences. However, some residents individual care plans did not reflected their assessed and known care needs. Additionally, this inspection identified risk in relation to fire safety in the centre. This meant that residents were not adequately protected from the risk of fire.

The inspector found that the needs of residents were known to the nursing and care staff. A sample of residents' individual assessment and care plans were reviewed. While there was evidence that residents needs had been assessed using validated assessment tools, and all residents had a care plan, assessment findings were not always reflective of the residents actual care needs. While this did not appear to have a direct impact on the quality of care provided to residents, the care plans did not always identify the current care needs of the residents or reflect person-centred guidance on the current care needs of the residents.

Residents were supported to retain their own general practitioner (GP) if they wished. Residents were reviewed by their GP as required or requested. Systems were in place to refer residents to allied health and social care professionals for additional assessment and expert advice.

The inspector reviewed the arrangements in place relating to fire safety and found that regular fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included visual assessment of the fire equipment, fire alarm panel, emergency lighting, means of escape and fire exit doors. However, maintenance of the fire panel and emergency lighting had not been kept up-to-date. Other outstanding issues relating to fire safety including the requirements for adequate means of escape and ensuring appropriate compartmentation of the centre were known to the HSE and mitigating controls were in place. However, until such time as all fire safety work has been completed, the finding of this inspection was that Regulation 28: Fire precautions remained not complaint.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of their

safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse.

Residents told the inspector that they felt at home in the centre and that their privacy and dignity was protected. Inspectors observed several positive interactions between staff and residents throughout the inspection. Interactions were polite, supportive and respectful.

Residents' rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Arrangements were in place for residents to meet with the management to provide feedback on the quality of the service they received. There were opportunities for residents to participate in meaningful social engagement and activities through one-to-one and small group activities in each of the three communal rooms. Residents could choose what activity they wanted to attend or could choose to remain in their bedroom and watch television or chat with staff.

Regulation 28: Fire precautions

The inspector identified issues in relation to fire safety arrangements within the designated centre that posed a risk to residents and staff.

The arrangements for maintaining the fire equipment, means of escape, building fabric and building services were not adequate. For example;

- The periodic inspection of the emergency lighting, fire detection and alarm system were not available for review, nor was there an annual certificate of inspection and testing.
- There was no periodic inspection report of the electrical installation available to ensure the electrical installation was free of fault or risk.

While controls were in place to mitigate some of the fire risks, requisite fire safety works had not progressed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not fully in line with the requirements of the regulations.

- Some care plans were not guided by a comprehensive assessment of the residents care needs. Some residents who had chronic pain did not have the interventions in place to support their needs accurately reflected in their care

plans. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, a resident who had experienced weight loss did not have an appropriate assessment of their weight completed or their care plan updated to reflect their current care needs, risk of malnutrition, or weight management plan.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre. Residents could retire to bed and get up when they choose.

There were opportunities for residents to participate in a variety of activities such as exercise classes, and live music events. Residents complimented the provision of activities in the centre and the social aspect of the activities on offer.

Residents attended meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received.

Residents were provided with information about the services they could access, if needed. This included independent advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bushfield Care Centre OSV-0005242

Inspection ID: MON-0047222

Date of inspection: 26/05/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Action: All staff files are currently being reviewed to ensure full employment histories and explanations for any employment gaps are documented in accordance with Schedule 2 of the regulations. The staff roster has been updated to accurately reflect the hours worked by the Person in Charge. The Person in Charge is on-site on alternate days; there is a robust handover process in place—both verbal and written—to ensure continuity of management and governance in their absence.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Actions: A revised and clearly defined governance structure is being implemented, clarifying the roles and responsibilities of the Person in Charge and Director of Nursing. This includes delineation of delegated tasks and accountability tracking mechanisms. The Person in Charge is on-site on alternate days and has now been formally added to the staff roster in compliance with Schedule 4. To ensure continuity of governance and oversight, a robust handover	

process is in place—both verbal and written—between the Person in Charge and Director of Nursing.

Weekly clinical governance meetings have commenced and will be formally minuted.

A system of monthly audits for incidents, care documentation, risk registers, and resident finances is now in place. Audit findings will be reported to the Provider.

Date for compliance: 22 July 2025

Regulation 28: Fire precautions	Not Compliant

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

A full fire safety audit was completed on Friday, 13th June 2025 by a certified contractor. An action plan is currently being finalised based on the audit findings.

Fire safety works, including compartmentation and system upgrades, are scheduled to commence in August 2025.

Interim safety measures remain in place to mitigate known risks and ensure resident safety in the meantime.

Updated certification for fire detection, alarm systems, and electrical installation will be completed and submitted upon conclusion of the required works.

Date for compliance: 30 September 2025

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:
Action:
Caseload allocation has been reviewed, and all residents have been allocated a key nurse.
The importance of resident/ family involvement as appropriate in developing care plans has been highlighted to all staff with a focus on meaningful goals that the resident

contributes to setting.
Changes will be made to the care plan when a need to do so is identified outside of the regular review. Factors influencing review are:
• Change in a person's condition, needs, or preferences.
• Clinical assessment or MDT reviews.
• Incidents or accidents.
• Feedback from the residents, family or staff.
Audit of care plans will be completed quarterly to ensure that they are person centered and reflect the resident's needs and ensure that they receive care and support that maintains and improves their wellbeing. Adjustments to care plans will be timely, appropriate and communicated to all relevant staff.

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 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	15/07/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	22/07/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	22/07/2025

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/09/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2025
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	15/07/2025
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	Substantially Compliant	Yellow	15/07/2025

	consultation with the resident concerned and where appropriate that resident's family.			