

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Bramleigh Lodge Nursing Home
Centre ID:	OSV-0000204
Centre address:	Cashel Road, Cahir, Tipperary.
Telephone number:	052 744 2129
Email address:	selma.kelly@sacrecoeur.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bramleigh Lodge Nursing Home Limited
Provider Nominee:	Selma Kelly
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	3

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 05 October 2017 07:30 To: 05 October 2017 17:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This was a one day unannounced inspection by the Health Information and Quality Authority (HIQA). This unannounced inspection was conducted to follow up on non-compliances identified at a previous registration renewal inspection on the 6 September 2016 and to monitor ongoing compliance with the regulations and standards.

Bramleigh Lodge Nursing Home is a single-storey premises located on the Cashel Road on the outskirts of Cahir town. The center can accommodate 26 residents and on the day of this inspection there were 23 residents living in the center. There is a small enclosed secure garden area available to residents and the center is within walking distance of the local shops, churches and amenities.

As part of the inspection process, the inspector met with residents, their representatives, staff members, the person in charge and the provider representative. The inspector observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. A number of residents stated that they were well cared for by staff, that staff couldn't do enough for them and that they felt safe living in the center. Visitors also outlined that their loved one was well cared for and that staff

were very attentive to residents' needs. A number of visitors were observed attending the center at various times during the day and the inspector observed that some visitors were on first name terms with some staff. Visitors to whom the inspector spoke stated that they were always made to feel welcome when visiting. Staff knew residents well and were able to demonstrate a good knowledge of the residents' healthcare and support needs.

There were eight outcomes reviewed and three were compliant, four outcomes substantially compliant and one outcome health and safety and risk management was moderately non-compliant with the regulations. The action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and 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.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was an effective management team in place as evidenced by the level of compliance identified on previous inspections, the findings from this inspection and the on-going improvements within the centre. The inspector was informed that the operations manager (OM) was normally based on site and he was a qualified solicitor that had worked in the center since 2010. The provider representative, who was on site on the day of inspection, was also a qualified solicitor and was also a director of another center since 2009. She attended the center every couple days and made herself available to the inspector during this inspection. The person in charge was recently appointed in March this year. However, he was suitably experienced and qualified nurse and had made a number of improvements since his relatively recent appointment. For example, there had been improvements in care planning, medication management and residents care outcomes. The person in charge was supported by the OM who was based on site. There was also a senior nurse available to support the person in charge in his role. The person in charge and the OM reported to the provider representative through regular management meetings and the provider representative was always available when required. Staff to whom the inspector spoke were familiar with the organisational structure of the centre. The provider representative and person in charge had excellent oversight of the service. The person in charge informed the inspector that he had adequate autonomy and support to meet his responsibilities under regulation. For example, the person in charge had been supported by the provider representative to implement a number of quality improvement initiatives including the establishment of a new computerized care planning system, improved auditing and additional staff training. Details of these initiatives are further outlined under various outcomes of this report.

The inspector spoke to both the provider representative and the person in charge. They explained their areas of responsibility and were found to be suitably knowledgeable and

resident oriented, in their approach. They were aware of the regulations governing the sector and the national standards. Evidence of consultation with residents was clearly available in a sample of residents care plans and minutes of residents' meetings. There was also evidence of good consultation with residents and relatives via resident/relative satisfaction surveys and the most recent survey had been completed in October 2017. The response rate was very good at 46% response rate and the overwhelming results were very positive. From a review of the results of this survey 60% of respondents reported their overall satisfaction level as "very satisfied" and a further 30% recorded their satisfaction level at "satisfied". Relatives and residents spoken with by the inspector were very complementary of their experience of care in the center. The inspector was informed that resources were available to ensure on going premises upkeep and for the continuous professional development of staff. Supervision and appraisal of staff was on-going. The annual review of the safety and quality of care had been completed for 2016 with the action plan for 2017. The person in charge had made this report available to residents and the inspector.

There was evidence of meetings with staff and regular meetings were held with residents and the person in charge was known to residents and relatives to whom the inspector spoke with. From a review of the minutes of residents meetings it was clear that issues identified were addressed in a timely manner and that the person in charge was proactive in addressing any concerns or issues raised. For example, residents had raised queries in relation to changes to the breakfast menu options and choice of available activities. However, the inspector noted that these issues had been remedied by the provider/person in charge immediately. Where areas for improvement were identified in the course of the inspection both the person in charge and the provider representative demonstrated a conscientious approach to addressing these issues and a commitment to compliance with the regulations.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The person in charge had been appointed to this post in March 2017. The person in charge was a registered nurse with management experienced and was suitably qualified with evidence of his current registration in place. The person in charge had clinical and managerial experience as a unit manager and as an assistant director and acting

director of nursing. The inspector noted that the person in charge managed the center with suitable authority and accountability. For example, the inspector saw that he was present in the center at different times of the day and at weekends and that he had suitably managed a number of challenges since his appointment as person in charge. From speaking to residents and staff it was evident that the person in charge was familiar with the residents and their health and social care needs. The person in charge worked Monday to Friday however, the inspector noted that the person in charge also attended the center in time for morning handover meeting at 8 am. This ensured that he had the opportunity to obtain contemporaneous clinical updates, meet night staff and contribute to clinical support plans for residents each day. The person in charge was fully informed of each resident's holistic requirements and demonstrated sound evidence based nursing knowledge and exercised his role, his professional and his regulatory responsibilities to a good standard. The person in charge also visited the center at weekends and was available outside of core hours as required. Since his appointment in March this year he had focused on a number of initiatives aimed at improving the care, quality and safety in the center. For example, a new computerized care planning system had been successfully implemented into the center. There had been enhanced structured communications with residents and their representatives, there had been improvements in wound care and the level of resident falls with a reduction in the incidence of both. The inspector was informed that these improvements had been achieved through enhanced monitoring of the residents nutritional status. In addition, these improvements were due to on-going staff education on identifying residents at risk and using validated nursing assessments tools and implementing the correct preventative measures such as pressure relieving equipment. The inspector noted that there had been some improvements in medication management with a marked reduction in the use of poly-pharmacy / psychotropic medication use. However, there was one issue identified in relation to one stock control record of medication requiring additional controls under the Misuse of Drugs Regulations. The inspector noted that one of the required two signatures was absent from one record. This matter was addressed under outcome 9 of this report.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

On the previous inspection there had been improvements required in relation to providing Garda vetting, recording gaps in observation charts and not all staff had adequate knowledge in relation safeguarding and safety. However, on this inspection the inspector noted that each of these improvements had been sufficiently progressed.

There was a culture of promoting a restraint free environment. This was evidenced by the reducing level of restraint and the on-going efforts that had been made to achieve and maintain this reduction. This included for example, the use of alternative measures such as low-low beds, mat and bed alarms which had increased. There were clear rationale in residents care plans in relation to the use of bed rails and lap belts. The inspector looked at a sample of the decision making tools used when considering the use of restraints. The documentation of alternatives considered or trialled in risk assessments was clear. Balancing risk with residents choice was evidenced for example, following suitable risk assessments; residents and when appropriate their representatives were proactively consulted/involved in relation to such residents continuing to mobilise with the least restrictive supports possible. From speaking with residents the inspector was told that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

There was a policy on responsive behaviours (a term used to describe how persons with dementia represent how their actions, words and gestures are a response to something important to them). There was evidence that residents who presented with responsive behaviour were reviewed by their General Practitioner (GP) and referred to other professionals such as Psychiatric services for review and follow up as required. Inspectors saw evidence of positive behavioural strategies and staff spoken to outlined suitable practices to prevent responsive behaviours. Care plans reviewed by the inspector for residents exhibiting responsive behaviours were seen to reflect the positive behavioural strategies proposed including staff using person-centred de-escalation methods. Staff spoken to were sufficiently knowledgeable in suitable de-escalating techniques in the management of responsive behaviors. The inspector noted that further responsive behavior training dates had been scheduled for staff however, most but not all staff had been provided with training in responsive behaviors.

The inspector saw that there were positive and respectful interactions between staff and residents and that residents were comfortable in asserting themselves and bringing any issues of concern to staff or to the person in charge. Residents and relatives spoken to articulated clearly that they had full confidence in the staff and expressed their satisfaction in the care being provided. The inspector was informed that staff did not manage any residents money and that the provider representative was not a pension agent for any resident.

The inspector was satisfied that there were policies and procedures in place for the protection of residents for example, there was a suitable policy dated as reviewed in June 2016 in place for the prevention, detection and management of any protection issues. The person in charge was actively engaged in the operation of the centre on a daily basis. There was evidence of adequate recruitment practices including verification of references and a good level of visitor activity. Staff had received training on the prevention of elder abuse and all staff spoken to were clear on their role and

responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. Procedures to protect residents, such as a structured staff induction process and a continuous comprehensive staff development and training were also in place.

Judgment:

Substantially Compliant

***Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.***

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Most of the actions in from the previous inspection had been satisfactorily progressed. Documentation seen indicated that hoists required for moving techniques in resident care were serviced regularly. Care plans contained a current manual handling assessment and referenced the specific equipment required for resident and staff safety. Manual handling practices observed were seen to be in line with current best practice and the training matrix recorded that all staff were trained in manual handling. Fire drills were held regularly however, one action from the previous inspection in relation to fire drills had not been satisfactorily progressed. This issue was in relation to recording in the fire drill records and the inspector noted that the fire scenario had not been recorded in the records of fire drills reviewed.

The circulation areas, toilets and bathrooms were adequately equipped with handrails and grab-rails. Staff confirmed that personal protective equipment such as latex gloves and plastic aprons were available and the inspector noted that specially designed cupboards had been installed as a control measure to safely store the latex gloves in each bathroom. Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place including regular training and reminder notices strategically placed in certain areas of the center. Overall the centre including the communal areas and bedrooms were found to be clean and there was a good standard of general hygiene evident. However, there were a number of infection control issues including:

- not all staff spoken to displayed adequate knowledge of suitable cleaning procedures to ensure infection prevention and control
- the water taps of the wash hand sinks in the center's sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices
- the cleaners room was not adequate as it did not contain any sink for staff to promote

good hand hygiene and infection control practices

- there was two urinals unsuitably stored one the floor of a toilet and another stored on the top of a toilet cistern
- there was commode unsuitably stored (for periods) in one communal shower room.

The fire policies and procedures were center-specific. There was a no smoking policy in place and the person in charge confirmed that no residents smoked in the center. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was provided to staff in a number of dates in 2017 and all staff had up to date fire training as required by legislation. The person in charge told the inspector and records confirmed that fire drills were undertaken regularly in the center. The inspector examined the fire safety register with detailed services and fire safety tests carried out. However, as mentioned above, one action from the previous inspection in relation to fire drills had not been satisfactorily progressed. This issue was in relation to recording in the fire drill records and the inspector noted that the fire scenario had not been recorded in the records of practiced fire drills reviewed. All fire door exits were generally unobstructed and fire fighting and safety equipment had been tested in March 2017. The inspector noted that there were up to seven wheelchairs stored against the wall on one corridor that lead to a fire exit door. However, the provider representative agreed to immediately review this arrangement to ensure that such storage did not potentially compromise any evacuation from the center in the event of a fire.

Records viewed recorded that the fire alarm was last tested in February 2017. Each resident had a personal emergency evacuation plan (PEEP's) in place. However, there were a number of improvements required in relation to PEEP's records including:

- the PEEP records viewed were not adequate as they did not contain adequate details regarding the understanding of the resident in relation to fire safety awareness
- these records did not contain adequate details regarding the residents level of supervision when brought to a place of safety following evacuation
- there was no recent photograph of the resident in these records.

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the centre. These lights had been reviewed by a competent person with the most recent review dated in October 2017. However, the inspector noted that frequency of the servicing of the emergency lighting was not adequate as such servicing had not been completed each quarter. The internal and external premise and grounds of the centre appeared safe and secure, with appropriate locks installed on all interior and exterior doors. However, some residents bedroom doors did not have any locking facility and this issue was actioned under outcome 16 of this report.

There were appropriate arrangements for investigating and learning from serious incidents/adverse events which for example included identifying residents who were at risk of falls and putting in place appropriate measures to minimise and manage such risks. For all residents who had fallen, falls risk assessments had been amended after the falls, and care plans were updated accordingly. Suitable governance and supervision

systems were in place to monitor residents at risk of falls, wandering or negative interactions including the maintenance of a residents' monitoring record. Such arrangements were reviewed on an on-going basis by the person in charge. There was an up-to-date risk management policy that addressed the identification and assessment of risks and the controls that were in place and addressed the requirements of the regulations.

The centre had other policies relating to health and safety including a center specific safety statement. There was a plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The action from the previous inspection in relation to the transcribing of medication had been completed satisfactorily. There were some improvements in the management of medication noted on this inspection. For example, there had been a significant reduction in the use of poly-pharmacy / psychotropic medication use. The person in charge outlined how there had been enhanced training of staff in managing behaviors that challenge and non-pharmacological interventions. There had been education of staff about altered communication. There had been meetings with families to establish patterns and discuss the residents past to identify triggers for behaviors. The person in charge outlined how this combined approach had facilitated the reduction in the use psychotropic medication.

The centre-specific and up to date policies on medication management were made available to the inspector. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were made available to nursing staff who demonstrated adequate knowledge of these documents. There was evidence of improvements in the management of medication since the last inspection. For example, there was an enhanced medication reconciliation process with formal accuracy checks each week on receipt of medication from the pharmacy and the maintenance of a complete and accurate list of residents current medications. There had been ongoing medication management training and assessment of nurses competency in relation to medication management practices. Nursing staff with whom the inspector met outlined a robust procedure for the ordering and receipt of medicines in a timely fashion. Medicines

were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of this fridge was monitored and recorded daily. The temperature of the medication refrigerator and storage areas was noted to be within an acceptable range.

Nursing staff with whom inspectors spoke demonstrated adequate knowledge of the general principles and responsibilities of medication management. Medication administration practice was observed by the inspector. Nurses wore red "do not disturb bibs" while administering medications and the inspector noted that the nursing staff adopted a person-centred approach by for example, interacting and speaking to each resident while administering medications. A sample of medication prescription records was reviewed and were in accordance of regulatory requirements. Staff informed the inspector that currently no residents were responsible for their own medication.

Regarding medications requiring additional controls under the Misuse of Drugs Regulations, the inspector noted that these medications were seen to be suitably stored with robust measures in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation. On arrival to the center the inspector observed that the night staff and a staff nurse from day duty checked the stock balance of medications requiring additional controls. Both nursing staff were required to sign this stock balance record to confirm that the total number of such medications was correct. However, from a review of the stock balance record the inspector noted that there was one occasion where only one signature was recorded in the record and there was a blank where the second nurses' signature should have been. Therefore it could not be established if a second nurse had checked the stock balance of medications requiring additional controls on this one date. The inspector with the assistance of nursing staff, checked the stock balance that this particular medication and noted that it was accurate and correct when compared to medication records. However, the person in charge immediately logged this issue as a medication related incident and informed the inspector that he would investigate this matter further.

The practice in relation to the transcription of medications was in line with the center-specific policy or guidance issued by An Bord Altranais agus Cnáimhseachais for all prescriptions seen. All prescribed prescriptions were signed by the prescriber within 72 hours. Medications were reviewed by GP's every three months. Medicines were recorded and administered in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais (Irish Nursing and Midwifery Board of Ireland). The maximum daily dosage for PRN (as required) medicines was consistently indicated on the medication prescription records.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an

individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Care planning had been identified as requiring improvement on the previous inspection and the in inspector noted that these improvements had been made. For example, since the previous inspection there had been a completely new computerized care planning system put in place. All residents were assigned to a named nurse who had responsibility to ensure that each residents' care plan addressed their needs on an ongoing basis. The person in charge outlined how they had focused on wound care with a marked reduction in the incidence of any wounds. There had been no occurrences of pressure ulcers occurring on-site within the center for the past number of months. The person in charge stated that this had been achieved through close monitoring of residents nutritional status, staff education on identifying residents at risk and using validated nursing assessments tools. In addition, from also implementing preventative measures such as pressure relieving equipment. The inspector noted that preventative strategies including pressure relieving equipment were implemented in practice. A validated assessment tool was used to establish each resident's risk of falling and there was evidence of the routine implementation of falls and injury prevention strategies including close monitoring or residents and low beds.

The person in charge informed the inspector that prospective residents were assessed prior to admission. This pre admission assessment was carried out to ensure that each new residents' health and social care needs could be effectively met in the center. The inspector was satisfied that residents' healthcare requirements were met to a good standard. There was a morning and evening handover each day and all staff including the person in charge discussed residents clinical, health and social care needs. The inspector joined the morning handover meeting and noted that this meeting also highlighted to all staff any changes or issues of concern. Residents to whom the inspector spoke to confirmed that they were well cared for and were complementary about the kindness and standard of care and support provided to them by all staff.

There was evidence to support that residents' healthcare requirements were adequately and regularly assessed by competent nursing staff and that arrangements were in place to meet their assessed clinical needs. On admission residents were facilitated to retain access to their GP of preference. There was documentary evidence that residents, as appropriate to their needs, had access to other healthcare professionals and services including dietetics, speech and language therapy, occupational therapy, psychiatry, chiropody and physiotherapy. There was also records of arrangements in place to facilitate optical and dental review. There was evidence of seasonal influenza vaccination. Nursing and care staff informed the inspector that there had been

significant changes made to the care planning documentation/record system since the previous inspection. They outlined how the care planning system had been changed from a paper based recording system to a computerized system. There was a number of touch screens located in a number of locations for all care staff to facilitate the recording of resident care. The person in charge monitored closely the implementation of this new system and provided ongoing guidance and support to call care staff in this transition.

The inspector reviewed a random sample of care plans and were satisfied that the new system was clearly understood by staff and the general standard of care planning was good. There was evidence that each care plan was informed by assessment and reassessment as required and at a minimum four monthly intervals. Care plans were completed in consultation with the resident and/or their representative and were supported by a number of validated assessment tools. Care plans seen were person centered, clearly set out the arrangements to meet identified needs as specific to each resident. They also incorporated interventions prescribed by other healthcare professionals for example speech and language therapist or dietetics. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. The resident's right to refuse treatment was respected and recorded and brought to the attention of the relevant GP. There were procedures in place and records seen supported that relevant information about the resident was provided and received when they were absent or returned to the center from another care setting.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Residents and/or their representatives were consulted with and participated in the organisation of the center. For example, there were records of on-going meetings with residents and their families. These meetings/consultations were confirmed by residents and relatives to whom the inspector spoke with. Regular residents committee meetings were held with the most recent meeting recoded as having occurred in 22 August 2017.

The person in charge outlined that the role of these meetings was to ensure residents' actively participated in decision making regarding all aspects of living in the center. The activities coordinator also attended residents' committee meetings and the inspector noted that this committee met regularly to also discuss issues such as future activities or outings. Feedback and suggestions were recorded and an action plan with timeframes was in place. There was evidence that the person in charge had reviewed any issues raised at these meetings and there had been changes made as a result of these meetings. For example, there had been issues highlighted in relation to suggested changes to the breakfast menu choices and options for outings from the center. The inspector noted that both issues had been actioned. In addition, the inspector noted that the person in charge had also sought feedback from residents by conducting a residents/representatives survey which had just been completed in October 2017. The overall findings from this survey were very positive and included feedback from both residents and their representatives. The inspector noted that an action plan had been developed in response to any issues raised. For example, some residents felt that the sitting room became very full at times, that the color scheme of this room needed review as some felt it was "a little dreary" and others mentioned that sometimes laundry went missing. The inspector noted that each of these issues were contained in an action plan with specific interventions and timescales for review recorded.

There were no restrictions to visiting in the center and the inspector observed several visitors at different times throughout the inspection. Residents right to choice, and control over their daily life, was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

A programme of varied internal activities was in place for residents and there was some outside activities for example regular visiting musicians. Information on the day's events and activities was prominently displayed in the centre. The activities coordinator was very visible each afternoon and actively involved with supporting residents. Residents to whom the inspector spoke with confirmed that the activities coordinator was well known to residents, provided on-going support to them and was very approachable. The inspector spoke to the activities coordinator who had been in post since April 2017 and she outlined how she delivered the programme which included both group and one to one activities. The inspector was told that residents spiritual needs were met through regular prayers sessions and Mass was celebrated in the center every fortnight with a visiting Roman Catholic Priest. The inspector was informed that any other religious denominations were also catered for as necessary.

Residents to whom the inspector spoke stated that they knew how to make a complaint to and would not have any hesitation in doing so, if required. Overall, residents' rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. A number of residents spoken with confirmed that they were afforded choice in relation their daily lives and for example were facilitated to receive visitors in private. One visitor stated that she visited the center at different times both early morning and evenings. This visitor said that she was always assured by what she saw and heard from staff in the respectful way that they provided care and support to her relative and other residents. However, the inspector noted that not all residents had the facility to lock their bedroom door and that a small number of bedroom doors

contained a small window that did not have any window blind or curtain. The inspector formed the view that this arrangement was not adequate as it may have potentially compromised some residents privacy.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

On the previous inspection not all staff had suitable Garda vetting records in place. However, on this inspection improvements were noted in the staff records and the provider representative confirmed that all staff had been suitably Garda vetted.

An actual and planned roster was maintained in the center. The inspector noted that the person in charge worked full time and was available on site Monday to Friday. He was also available if required on call to staff outside of the normal working hours. This arrangement was confirmed by staffing records viewed and from speaking to staff. The inspector observed practices and spoke with HCA's, household staff, the person in charge, staff nurses and the provider representative. The provider representative stated that there currently was no issue with staffing in the center. The person in charge and staff to whom the inspector spoke confirmed that staffing in the center was adequate. This was confirmed by a review of the staffing roster, reviewing residents' dependency profile, speaking to residents and their visitors, reviewing care planning documentation, speaking to staff, a review of residents returned questionnaires and review of minutes of residents, staff and management meetings.

Residents spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their

likes and dislikes.

From speaking to the person in charge, staff and a review of documentation; staff appeared to be supervised appropriate to their role and responsibilities. Staff appraisals were in place and included recently recruited staff who confirmed that they had received induction and on going performance reviews. The person in charge discussed staff issues with the inspector and suitable protocols and records were seen to be in place where any concerns had been identified. There was an education and training programme available to staff. The training matrix indicated that most mandatory training was provided and many staff had attended training in areas such as manual handling, cardio pulmonary resuscitation (CPR) and elder abuse. However, most but not all staff had received training in dysphagia, (difficulty in swallowing) and falls management. The person in charge outlined that further dates were scheduled for any staff that had yet received this training.

The inspector reviewed a sample of staff files which included all the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were also seen by the inspector.

Judgment:

Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Bramleigh Lodge Nursing Home
Centre ID:	OSV-0000204
Date of inspection:	05/10/2017
Date of response:	31/10/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

To ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

1. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

that is challenging.

Please state the actions you have taken or are planning to take:

All newly appointed staff receive training in responding to behaviours that challenge & altered communication as part of their induction. Two new courses, Dementia Awareness & Responding to Behaviours that Challenge, were added to the training schedule in 2017. Half of the staff attended this training and the remaining staff are scheduled to complete this training by the 30/11/2017.

Proposed Timescale: 30/11/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff including the following:

- not all staff spoken to displayed adequate knowledge of suitable cleaning procedures to ensure infection prevention and control practices
- the water taps of the wash hand sinks in the center's sluice facilities were not adequate as they were domestic in design and did not promote good hygiene and infection control practices
- the cleaners room was not adequate as it did not contain any sink for staff to promote good hand hygiene and infection control practices
- there was two urinals unsuitably stored one the floor of a toilet and another stored on the top of a toilet cistern
- there was commode unsuitably stored (for periods) in one communal shower room.

2. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:

At all times, Infection Control remains a priority in the nursing home and staff are educated in up-to-date best practice to ensure compliance with the standards for the prevention and control of healthcare associated infections published by the Authority. All staff receive Infection Control training as part of their induction and updated training, annually, with a qualified Infection Control Officer. Staff whom require additional education with Infection Control practices will complete a refresher course to ensure knowledge is up to date with current best practice guidelines & procedures. The Registered Provider will ensure that the following are carried out within the given timeframe:

The water taps in the wash hand sink in the sluice room will be replaced with elbow

lever tap.

A handwashing sink will be installed in the cleaning room.

Additional racking will be installed in the sluice room to ensure adequate storage for urinals.

All commodes are taken immediately to the sluice room for decontamination and stored appropriately in a designated area.

Proposed Timescale: 30/11/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire including recording the fire scenario in the records of practiced fire drills.

3. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

All staff receive 'Fire Safety Awareness Induction', an educational & training session which includes awareness of fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques. A record of this induction is kept in the individual staff file.

Each member of staff receives fire safety training by a fire safety officer and an evacuation drill is carried out by the instructor on the day, including instruction in the use of fire fighting equipment. Certified fire training is conducted as part of induction and updated on an annual basis.

All residents' have a personal emergency egress plans (PEEP) developed at the time of admission and fire safety awareness, including the procedure to follow in the case of fire, forms part of the admission process. Each residents' PEEP is updated weekly and quarterly to reflect any changes that may affect the residents ability to respond to an emergency event.

Fire drills are conducted quarterly and will record the fire scenarior being tested. The fire drill is discussed at staff meetings and includes a discussion of the outcomes, lessons learned and improvements required.

Proposed Timescale: 06/10/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To make adequate arrangements for reviewing fire precautions including:

- the PEEP records viewed were not adequate as they did not contain adequate details regarding the understanding of the resident in relation to fire safety awareness
- these records did not contain adequate details regarding the residents level of supervision when brought to a place of safety following evacuation
- there was no recent photograph of the resident in these records
- fire safety drills records did not record the fire scenario being tested

4. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:

The emergency evacuation plan is updated weekly to include all residents' personal emergency egress plans (PEEP) in the event of a fire or emergency that may require evacuation of the home. Each residents PEEP has been updated to include a current photograph of the resident, the understanding of each resident in relation to fire safety awareness and the appropriate supervision required for each resident in the event of a fire and evacuation, to ensure residents' safety.

Following inspection, the quarterly unannounced fire drill was conducted on 26/10/2017, consisting of a horizontal evacuation procedure. The drill documented the attendees, date, time and duration of the drill and included the fire scenario being tested. Learning outcomes and recommended actions were identified & documented following the drill and discussed at the staff meeting and management meeting and this is the procedure which will be followed going forward.

Proposed Timescale: 26/10/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To provide adequate means of escape, including emergency lighting is serviced each quarter by a competent person.

5. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:

The emergency lighting system was most recently inspected and certified on 03/10/2017. The Registered Provider will ensure that future inspections of the emergency lighting system are carried out on a quarterly basis.

Proposed Timescale: 06/10/2017

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

To store all medicinal products dispensed or supplied to a resident securely at the center including accurate records of the stock balance of medications requiring additional controls under the Misuse of Drugs Regulations.

6. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:

The signature omission in the Stock Balance Book was logged as a medication error and corrective actions taken following investigation. All nursing staff were informed of the incident and reminded of the requirements under the Misuse of Drugs Acts and subsequent regulations for the ordering, storage and administration by registered nurses and midwives of MDA Scheduled controlled drugs to patients across care settings.

The staff nurse(s) completed a medication management education programme, medication competency assessment by the PIC, and completed a medication incident form which includes reflective practice to encourage the nurse to analyse the incident and develop an action plan to prevent reoccurrence. The PIC will continue to spot check both the Controlled Drug Register and Stock Balance Book weekly for compliance.

Proposed Timescale: 09/10/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Ensure that each resident may undertake personal activities in private by ensuring that all residents' bedroom doors are suitable and did not potentially compromise residents privacy.

7. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:

The Registered Provider will review all resident's bedroom doors (blinds and locks) to ensure that they are suitable and do not potentially compromise resident's privacy.

Proposed Timescale: 15/12/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

To ensure that staff have access to appropriate training including dysphagia and falls management

8. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:

As part of the on-going improvements in the home, all staff have up to date mandatory training and a selection of educational courses have been added to the homes training schedule to enhance staff learning and professional development to provide safe & effective care to residents in the home. Falls prevention and dysphagia training is provided to all new staff at the time of induction and updated regularly by a qualified person. Most staff have completed this training and the remaining staff are scheduled to complete the training by the 30/11/2017.

Proposed Timescale: 30/11/2017