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:	Brookvale Manor Private Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Hazelhill, Ballyhaunis, Mayo
Type of inspection:	Unannounced
Date of inspection:	11 June 2020
Centre ID:	OSV-0000325
Fieldwork ID:	MON-0029666

About the designated centre

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

Brookvale Manor is a purpose-built single-storey premises located in a residential area a short drive from the town of Ballyhaunis. The centre is registered to provide long and short term care for 57 residents, both male and female over the age of 18 years. Twenty-four-hour nursing care is provided. Residents' accommodation comprises of single rooms and double rooms all of which have full en-suite facilities including a shower, toilet and wash hand basin. Adequate screening to protect residents' privacy is provided in the shared bedrooms. The centre has a variety of communal space and the arrangements provide residents with a choice of quiet areas or spaces where they can socialise. There are two large sitting rooms and a dining room to the front of the building, an additional sitting/activity area that is centrally located and a foyer at the front that some residents use to read or to see their visitors. Other rooms include a laundry, sluice facilities, kitchen and staff areas and offices. There is a safe secure outdoor garden for residents to use and this was accessible from several points of the building. It was well cultivated, provided with appropriate seating and had interesting features such as a summer house where residents could sit in the shade. The centre also has two pet rabbits that lives in the garden and provides additional interest for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 June 2020	08:00hrs to 19:00hrs	Catherine Sweeney	Lead
Thursday 11 June 2020	08:00hrs to 19:00hrs	Brid McGoldrick	Support
Thursday 11 June 2020	08:00hrs to 19:00hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

Throughout the inspection, inspectors spoke with residents and observed how they spent their day. Overall, residents reported that they were happy with the care and the staff who looked after them but they told inspectors how the COVID-19 restrictions had affected them. The COVID-19 restrictions in place limited group activities resulting in residents spending extended periods of time in their bedrooms. Some residents did not have access to a call bell to ring for assistance when in their room. While there were call bells installed in each bedroom, they were not left so that the resident would have access to them. Inspectors observed that some residents came out of their bedrooms on to the corridor to summon staff. Inspectors observed that there were large spacious communal rooms and a safe outdoor space which would have provided residents with a break from their bedrooms, but which were unused on the day of inspection.

Residents spoken with described how staff were good to them and looked after them well. In general, Inspectors observed that staff spoke respectfully to residents and were observed to knock and wait before entering bedrooms.The staff working in the kitchen were also attentive to residents' preferences facilitating their choices and preferences during breakfast service.

Inspectors observed that some residents were despondent as they described long and boring days devoid of activities and visitors. They were anticipating the day when the centre would open to visitors again. Inspectors queried whether their family members could come to their bedroom windows and talk to them but staff and residents advised that this was not allowed even for those residents who were not diagnosed with COVID-19.

Inspectors observed a resident displaying responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) who did not receive an appropriate response from staff. The staff observed did not appropriately assess the situation as an incident of responsive behaviour and failed to provide the resident with reassurance or employ any deescalating measures to help the resident to feel safe. Inspectors observed that the nursing staff did not assist the care staff to respond appropriately to the situation and concluded that training and development is required in dementia care and the care of residents who display responsive behaviours.

Capacity and capability

Inspectors found that the governance arrangements and management oversight of

this centre were not adequate to ensure safe quality care for residents.
Nine regulations were reviewed as part of this inspection and none were found to be compliant. This level of non-compliance has resulted in poor outcomes for residents, as detailed in this report. Significant improvements in the governance and management of the centre is required.

The centre is managed by the Brindley Manor Federation of Nursing Homes Limited. The centre has a person in charge supported by one Person Participating in Management. A second person participating in management had taken up a role in another centre of the group in May 2020, reducing the support in the centre to one person participating in the management. Both the person in charge and the person participating in management reported to the chief operating officer and the chief executive officer. Prior to this inspection, the centre had a history of good compliance with the regulations.

The person in charge of a nursing home is the senior nurse responsible for the care and welfare of residents and the oversight and supervision of clinical care. Inspectors were concerned that frequent changes of person in charge, four changes have been made to this role since October 2018, have contributed to some of the issues identified on the day of the inspection as set out below.

This inspection was carried out following the notification to the Chief Inspector of an outbreak of COVID-19 where a number of residents and staff were affected. The centre had experienced nine COVID-19 related deaths between 18 April 2020 and 13 May 2020. Prior to the inspection, unsolicited information was received by the Chief Inspector relating to poor infection control and prevention practices, poor standards of care, and poor communication with residents and staff, all of which were reviewed by inspectors during the inspection. Inspectors also reviewed recent notifications submitted to the Chief Inspector by the management team.

Inspectors reviewed the staffing rosters and found that staffing levels were not adequate to ensure safe and effective care during the outbreak of COVID-19 infection. The staffing model in place during the outbreak resulted in the centre requiring the support of an emergency response team to supplement the staffing. There were two occasions where, according to the rosters provided to the inspectors, by the person participating in management on the day of inspection, there was no registered nurse rostered on duty to provide clinical care to residents.

Following the inspection, the provider submitted 'clock-in' details for staff which contradicted the information on the rosters supplied to inspectors on the day of inspection.

A full and comprehensive review by the registered provider of the staffing model and requirements of the centre was required.

The training and supervision of staff also required review. Inspectors found that some staff had not received induction and training appropriate to their role. Supervision of nursing documentation also required improvement, the nursing documentation and care plans reviewed by inspectors were not adequate

and the interventions were resulting in poor outcomes for residents as evidenced by the number of non-compliance's found during this inspection.

Inspectors reviewed the records kept at the centre and found that, due to gaps in the information and poor record management, the records did not meet with regulatory requirements. Furthermore, there was a significant delay from the time documentation was requested by inspectors to when this documentation was made available for review. Some information requested by the inspectors relating to the tracking of resident and staff test results and symptoms was never made available. Staff files were not readily accessible.

Inspectors found that overall governance was poor, for example, systems had not been put in place to adequately respond to and manage an outbreak of COVID-19. Resources were poorly managed which resulted in inadequate staffing levels. Staff communication was poorly documented. The systems in place for the on-going management of the outbreak were not documented.

Oversight of incidents which required notification to the Chief inspector, and the oversight and management of complaints require review to ensure regulatory compliance.

Regulation 15: Staffing

The staffing model as set out in reviewed rosters were not appropriate for the needs of the residents in relation to the outbreak of COVID-19, the size and layout of the centre nor in line with the provider's own staffing Statement of Purpose. For example;

- the number of carers in the statement of purpose was 24 but there were only 19 employed on the day of the inspection
- the number of social care facilitators in the statement of purpose was two but was only one employed on the day of the inspection

The staffing model relied on four registered general nurses to cover day duty and night duty. This meant there was only one nurse on duty for up to 37 residents a lot of the time. During the COVID-19 outbreak the centre had an emergency response team in place to support staffing which consisted of support from a nurse on a temporary contract, a registered nurse from another centre in the group, a chef, an administrator, and two persons participating in management (reducing to one in May 2020).

The nursing care record of a residents condition and the care provided was not completed in a timely manner to ensure that changes to a residents condition were documented in line with professional guidelines.

In addition Inspectors were very concerned that on at least two occasions, residents were at risk due to there being no registered nurse rostered on duty. Despite the

emergency response team, a review of the 'worked' roster given to inspectors by the person participating in management on the day of inspection found that there was no nurse rostered on day duty between 2pm and 8pm on the 24 April 2020, which exposed residents to the risk of having no access to clinical care. Following the inspection the provider submitted a clock-in sheet which identified that one nurse (person participating in management) 'clocked in' on 23 April 2020 from 6pm to 24 April 2020 6am. The same nurse clocked in 24 April 20 from 2pm to 8pm. The person in charge was rostered to work 24 April 2020 from 8am to 2pm and was the only nurse on duty. Notwithstanding that a nurse was clocked in for duty, Inspectors were concerned that clinical documentation did not support effective care of residents during this period.

During the outbreak, the registered provider increased night staffing arrangements from one nurse to two nurses to ensure that staff did not move from COVID-19 positive residents to COVID-19 negative residents and potentially spread the infection from one group to another. This arrangement which was to remain in place during the outbreak, was discontinued on the weekend prior to the inspection, before public health declared the outbreak over.

One person was allocated to clean the centre each day. Inspectors were not satisfied that this level of cleaning staff was sufficient in response to an outbreak of COVID-19 infection. Inspectors found that it did not allow for separation of duties between the cohorted COVID-19 positive and negative areas of the centre nor did this level of cleaning staff support the infection prevention and control contingency plan described by staff.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that the training and supervision of staff was not adequate to ensure that residents received safe, quality care.

A schedule and record of staff training was made available for review. A review found that there were some staff, who had been allocated to care for and assist residents with responsive behaviour, did not have the appropriate training to ensure a safe standard of care was delivered. There was no record of induction for new staff or for staff who had changed roles.

Inspectors observed poor supervision of care assistants, and found evidence of inadequate nursing supervision, particularly in relation to nursing and care plan documentation, responding to incidents such as falls, and poor COVID-19 symptom recognition. This was evidenced by:

- resident assessments did not inform the development of care plans. For example, a resident who had lost significant weight did not have a care plan developed to reflect this risk.

- progress reports and care plans were documented with no resident-centred detail and no changes to care as a result of a diagnosis of COVID-19.
- a resident displaying possible signs and symptoms of COVID-19 was not transferred to hospital for treatment in line with their care plan and the record did not include a rationale for the decision not to transfer.
- a resident who had displayed possible signs and symptoms had not been referred for testing in a timely manner; the resident subsequently tested positive on transfer to hospital.
- a review of one resident's daily progress notes found that, between the 13 May 2020 and 9 June 2020, a duplicate copy of a resident's progress report, recording the resident's care for that day was documented 24 times. The progress report was updated in this manner until the residents illness had escalated to the point where medical intervention was required.
- the duplication of daily progress reports was noted on five resident files reviewed.

Judgment: Not compliant

Regulation 21: Records

During the course of the inspection, there were inexplicable delays in obtaining records that should have been readily available in the centre. Inspectors were concerned that if these records were not easily retrievable for inspectors to review, they was also not available for staff working in the centre. For example, the records of worked rosters for the previous few months and three staff files requested at 09:10am were provided intermittently from 10:15am over the space of an hour and a half.

When the staff files were provided they were incomplete. A review found that there were significant gaps in the information required under Schedule 2, and Schedule 4 of the regulations, including:

- details and documentary evidence of any relevant qualifications,
- references for some staff were not on file,
- the dates on which a staff member ceased employment were not recorded
- staff member was hired for a role as a kitchen assistant, however a review of the roster found they were now working as a health care assistant.

The nursing record and care plan of a persons health and condition and treatment given was not completed in a timely manner to ensure that changes to a residents condition were documented in line with professional guidelines ' For example:

- a number of records reviewed had been completed by a person whom the roster did not evidence was present in the centre on the date the record was created. The record did not state that the content was entered retrospectively.

- records were duplicated in residents' progress reports
- care plans were not updated in a timely manner and there was evidence that care plans were being updated from a remote location by a nurse not present in the centre on the date the record was updated and who, according to the roster, had not been in the centre for four weeks. The records did not indicate that the content was entered retrospectively.
- a residents diagnosis was omitted from the nursing records

The accuracy of some records could not be determined, for example, daily records of the safety pause were signed by senior nurses not always present in the centre according to the rosters for the day on which they were signed. The rosters received for relevant dates did not reflect the presence of those who had signed the nursing records. The value of this documentation as evidence of quality of care initiatives was undermined by such contradictions.

Inspectors requested a record of the allocation of staff to the COVID-19 positive and negative areas of the centre during the outbreak. The allocation record provided only documented the names of residents and staff, and did not record their COVID-19 status. Staff spoken with were unclear about the cohorting arrangements within the centre during the outbreak. Some staff described working with both positive and negative residents, at different times of the day. This record keeping was not in line with the Health Protection and Surveillance Centre (HPSC) guidelines and posed an infection control risk to the residents and staff.

The centre's directory of residents was incomplete. Inspectors found gaps in the information documented in the directory of residents, for example, the register did not consistently reflect residents transfers to and from the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not have appropriate management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Inspectors were also concerned that decisions regarding the management in this centre taken by the provider resulted in less support to the person in charge.

The management structure of the centre on the day of inspection was not in line with the centre's statement of purpose. The statement of purpose stated that there were two persons participating in management to support the person in charge but one of the persons participating in management was redeployed to another centre from 15 May 2020 and was therefore not available to support this centre.

As outlined under the Regulation 15: Staffing, the staffing levels in the centre were not sufficient to ensure that safe care could be delivered. Four nurses were employed to work in the nursing home providing a maximum of one nurse on any

shift. A review of the rosters from 30 March 2020 found that both the person in charge and a person participating in the management of the centre were regularly required to cover nursing duties, which resulted in poor oversight and supervision of care and staff. In addition, on the day of the inspection, staffing was not in line with the providers own statement of purpose as outlined previously.

The system in place to communicate with staff required review to ensure that all staff were aware of safe practice guidelines in relation to COVID-19. Meetings held with staff did not include detail relating to the management of a COVID-19 outbreak. A newly introduced system of 'safety pauses' was in place to update staff three times a day. However, the content of these meetings was not documented and the record of the pause was signed by managers who were not rostered on duty at the time and date of the safety pause.

Other aspects of the management of the centre which required review included:

- staff and resident files; those reviewed were disorganised, disjointed and difficult to assess.
- communication with families; there was no system in place to communicate changes in routine and care plans with residents and families.
- oversight of incidents which occurred in the centre; see regulation 31.
- oversight of complaints which occurred in the centre; see regulation 34.
- inadequate staff supervision and oversight, evidenced by poor quality nursing documentation and nursing care.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had failed to notify the Chief Inspector in relation to a number of incidents occurring in the centre, including an unexpected death of a resident and an injury to a resident which required medical attention. Both notifications were submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The mechanism by which the provider and management team received and responded to feedback and complaints required significant review. There was no evidence that complaints were documented and investigated in line with the requirements under Regulation 34. Information received by the Chief Inspector on 9 March 2020 indicted that concerns in relation to infection control

procedures had been communicated to the centres management team. A review of the complaints log found that this complaint had not been documented. No complaints or concerns had been documented in the centre since November 2018. As a result, inspectors were concerned that residents' feedback was not being documented and reviewed in order to improve their lived experiences in the centre. This is a restated non- compliance from the last inspection in January 2020.

Judgment: Not compliant

Quality and safety

Inspectors found that the quality and safety of resident care during the COVID-19 outbreak, up to and including on the day of the inspection, was compromised by inadequate management of infection control, lack of clinical oversight in relation to recognising symptoms of COVID-19 infection and adhering to resident's care plans during the outbreak. Failure to monitor symptoms, track time-lines of testing, infection and recovery led to confusion and inadequate infection prevention and control arrangements.

Due to the inadequate documentation and tracking of residents and staff, which the management team was were unable to provide, Inspectors were unable to assess the total number of residents and staff who had tested positive for COVID-19, and how many residents had recovered. This could not be established on the day of inspection. A total of nine of the centre's residents had died with COVID-19 infection between 18 April 2020 and 13 May 2020.

Inspectors observed that residents spent extended periods of their day in their bedrooms. Due to the COVID-19 restrictions, the day rooms were not available for use by the residents. Activities and recreational time had also been restricted during the management of the outbreak. There was no alternative schedule of activities in place for residents who were required to remain in their bedrooms. Some residents told inspectors that they had not been outside since the the restrictions came into effect in March 2020. Residents told inspectors that they would have liked a plan to facilitate visiting. Window visits were prohibited as part of the centre's COVID-19 contingency plan.

Overall, documentation of resident nursing care required immediate review. Assessment tools were duplicated and ineffective; for example, dependency assessments were made without regard to a resident's cognitive deficits. Care plans were not informed by the assessments completed and were not reviewed and updated in an appropriate and timely manner. For example, residents with a positive diagnosis of COVID-19 did not have their care plans updated to reflect isolation arrangements, PPE requirements, or changes in their physical, psychological and emotional care needs.

Resident progress reports completed by nurses were duplicated and lacked person-

centred detail. The daily report was not always completed by the nurse on the duty roster or in a timely manner. This posed a risk that all relevant information relating to a residents care needs were not documented and delivered safely or effectively. From the sample of files reviewed, clinical supervision was required to ensure that resident needs are responded to in a professional and timely manner.

Residents had appropriate access to GPs during the outbreak; however, the quality of the nursing assessment and the information shared following referral required review.

Regulation 27: Infection control

Overall inspectors found the infection prevention and control measures in the centre to be inadequate to respond to and manage an outbreak such as COVID-19.

Inspectors found that the overall management of the COVID-19 outbreak was inadequately documented. The HPSC COVID-19 guidelines require monitoring and ongoing surveillance to identify new cases and to update the status of ill residents and staff. This information could not be provided when requested during the inspection.

Staff confirmed that this information, vital for anyone working in the centre, was not easily available. Inspectors asked staff on duty how a member of staff returning to work after a period of time off would determine what residents were COVID-19 positive, recovered or negative. Staff advised that the entire electronic record of a resident would have to be checked as there was no uniformity in how information was recorded.

The contingency plan in place for the centre was not in line with the HPSC national guidelines. The plan focused on infection prevention but did not detail how the centre would manage an outbreak of COVID-19. It did not describe how symptoms would be identified and tracked. It did not include the cohorting or isolation arrangements to be put in place.

On arrival to the centre, inspectors were informed that the Greenacre unit was used to isolate residents with a positive COVID-19 diagnosis. The unit accommodates eight residents and has a separate day room. All bedrooms are en-suite. Staff access this unit from the negative area of the centre. From a review of the documents and from speaking with staff, it was unclear how residents were cohorted in line with HPSC guidelines as there was no supporting documentation in relation to cohorting details available for review. There were no residents accommodated in this area on the day of inspection.

A person participating in the management of the centre told inspectors that there were no positive cases of COVID-19 in the centre on the day of inspection. All residents remained in their bedrooms and two residents in the centre remained in isolation in their rooms following hospital transfers. Staff donned PPE when

attending to them. The isolation arrangements for these resident's was not identified in the residents daily notes or care plan. There was one nurse rostered on night duty from the start of the outbreak who was required to work in both positive and negative areas of the centre until the 18 May when, following interaction with Public Health representatives, a second nurse was rostered onto night duty.

On arrival to the centre on the day of inspection, there was one night nurse on duty. Night time nurse numbers had been reduced on 7 June 2020 although the outbreak had not been declared over by Public Health.

On the day of inspection, inspectors requested the tracking records of all residents and staff who had been tested in the centre, the dates of testing, the results, the symptoms and recovery dates. These records were unavailable for review. Cohorting arrangements in the Greenacre area of the centre were identified by staff but not identified in any documentation reviewed including resident progress notes, resident care plan or the centre's COVID-19 folder. There was no record detailing how staff had been allocated to positive and negative zones as described by staff on the day of inspection. A facility to record this information was available on the electronic nursing record, however, this was not utilised.

On the day of the inspection, there was one member of cleaning staff on duty daily. Cleaning staff confirmed that during the outbreak the cleaning schedule required staff to work in both the positive and negative areas of the centre. Inspectors were informed that positive areas were cleaned at the end of the working day.

The centre was visibly clean on the day of inspection, however, inspectors had a number of concerns in relation to infection control on the day of inspection including

- the availability of hand washing facilities and hand gel dispensers- alcohol gel in bottles in use required staff to touch the bottle before opening and again when putting the cap back on the bottle
- the lack of waste disposal arrangements in location where staff were taking off PPE posed a risk of cross infection
- the service contract for the bedpan washer was not available
- support equipment such as a hoist was not visibly clean, increasing the risk of infection
- individual hoist slings were not in use for all residents, posing a risk of cross infection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Each resident had a care plan, however, from the sample files reviewed, a number of areas were identified for immediate improvement and oversight to ensure that the care and welfare of residents was informed by relevant up-to-date care plans,

and also that care plans were in compliance with regulation 5 and with guidelines set out by the Nursing and Midwifery Board (An Bord Altranais agus Cnáimhseachais).

These included:

- Care plans were not informed by the assessments completed. For example, a resident with an assessment that identified them as being at high risk of malnutrition did not have this risk identified in their care plan. In addition, residents with a positive diagnosis of COVID-19 did not have a care plan developed to reflect the residents needs as a result of this infection.
- Care plans were not updated in a timely manner, in line with professional guidelines. For example, a resident who tested positive for COVID-19 on 26 May 2020 did not have a COVID-19 care plan commenced until 11 June 2020 (the day of inspection). Due to the progression of the disease, the lack of a care plan to inform the care of this resident did not ensure that the care interventions for this resident could be reviewed and monitored.
- Care plans relating to assessments for the risk of testing positive for COVID-19 were not complete. Therefore any interventions that had been put in place to mitigate the risk for any resident becoming infected was not documented could not be reviewed as to their effectiveness.
- Resident who had tested positive for COVID-19 did not have a care plan developed to address the care needs associated with their symptoms by which to inform staff on how best to provide care and support to these residents.
- Residents' mental and social well-being was not recorded in relation to their response to their diagnosis, for example, their wishes in relation to hospital transfer, and their feelings in relation to social isolation. As such, the wishes of residents did not inform care interventions.
- Of five resident files reviewed, end of life care plans had not been updated to reflect any discussion with the residents, their doctors or their families in relation to the residents' wishes, and therefore the wishes of the residents were not incorporated into the care plan by which to inform care interventions.

Judgment: Not compliant

Regulation 6: Health care

Due to the COVID-19 restrictions, residents had restricted access to general practitioners (GPs); however, from a sample of five resident records reviewed, GPs were available by telephone and some residents were reviewed by their GP in the centre. Although records reviewed document contact with GPs, inspectors were concerned that nursing assessments and reports to the GP were not comprehensive and lacked the necessary detail to ensure appropriate treatment plans were

developed.

Inspectors requested that a review of a number of nursing and medical records be conducted to identify learning, and in turn, to improve outcomes for residents accommodated in the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Brookvale Manor Private Nursing Home OSV-0000325

Inspection ID: MON-0029666

Date of inspection: 11/06/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
S - A thorough review of the SOP has been conducted which now reflects a graduated increase in registered nurse staffing levels over the coming three months to fully address the issues highlighted in the report. Based on this review, registered nurse staffing levels will increase as follows: 2 x registered nurses 08:00am to 00:00 midnight and 1 x registered nurse 00:00 midnight to 08:00am.

- By way of contingency planning, our Emergency Response Team is at all times available to support the PIC and other key staff (including the PPIM) in the event of any future COVID-19 outbreak. Our Emergency Response Team includes registered nurses, health care assistants and other support staff and will be used to supplement staffing levels within the centre.

- The SOP has been revised to reflect the fact that one Social Care Facilitator is employed within the centre.

- Additional training has been provided to registered nurses to ensure that all documentation is completed in a timely manner and in accordance with professional guidelines.

- While there was at least one registered nurse on duty in the centre at all times, the documentation, provided to inspectors on the day of inspection was factually incorrect. A thorough review of rostering has subsequently taken place to ensure the records reflect the actual shifts worked. A new rostering template has been introduced that accurately records all shifts worked. This will ensure going forward that there is no ambiguity as to the number of registered nurses on duty in the centre at any one point in time.

- Staffing levels had been increased following discussion with Public Health to fully meet the additional needs of residents who had been placed in the cohorted area. These staffing levels remained in place until residents returned to their rooms and the cohorted area was closed. On the day of inspection, albeit the outbreak had not yet been closed

by Public Health, the cohorted area was not being used and therefore there was no requirement to staff this area. Notwithstanding, in the event of a future outbreak, dedicated staff will be rostered and allocated to the cohort area in accordance with Public Health advice.

- While the cohorted area was not in use at the time of inspection, additional housekeeping staff had been rostered to provide enhanced cleaning when the cohorted area was in use. In the event of a future outbreak requiring residents to be cohorted, additional housekeeping staff will be rostered.
M – Through review and in compliance with our SOP and the needs of the service.
A – By the in house management team.
R – Overview by the regional team in conjunction with the COO.
T – 11th December 2020

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
S - A comprehensive review has been undertaken of all staff training and supervision. Observation sessions have been conducted within the centre and dedicated training in the Positive Approaches to Care using the GEM's model has been provided to those assisting residents with responsive behaviours.

- Any staff who change role within the centre will complete an induction pertinent to their new role.

- Additional training has been provided to registered staff nurses to enhance their supervision of care teams and documentation. This training included record keeping, care planning, falls management and use of the COVID-19 tab on the electronic nurse recording system.
M – Through review and in conjunction with the management team with the HR and training department.
A – By the in house management team.
R – Overview with the regional team in conjunction with the COO.
T – 30th October 2020.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
S - A thorough review of records under Schedule 2 and Schedule 4 have been conducted and measures have been implemented to bolster gaps and enhance retrievability.

- Training has been provided to all registered nurses to ensure timely and accurate recording and record keeping.

- The COVID-19 tab on our electronic nurse recording system has been implemented in order that a timely record of COVID-19 testing and results are available for ease of reference.

- In the event of a future outbreak, it will be reiterated to staff at daily handovers and at safety pause meetings with regard to residents requiring cohorting and advanced levels of infection prevention and control within the centre.

- A full review of the directory of residents has been completed and a bi-weekly audit will be conducted by the PIC.

M – Through compliance visits, observation visits and training where required.
A – By the PIC.
R – Overview by the regional team in conjunction with the COO.
T – 15th October 2020.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
S - A thorough review has been completed by the RPR of governance within the centre and has appointed the COO to conduct bi-weekly on-site visits and weekly meetings to assure compliance and assurance of the support structures in place to the PIC by the regional team, the HR department and other corporate functions.

- As outlined under Regulation 15, a graduated increase in registered nurse staffing levels is taking place over the coming three months to fully address the issues highlighted in the report.

- The SOP has been revised to reflect the Social Care Facilitator role more accurately within the centre and the CCO has been identified as an additional PPIM.

- A thorough review by the HR department has been conducted and any gaps identified have been corrected.

- A full review of resident files has been concluded. All files are clearly structured and the

information contained therein easily accessed.

- Training has been provided to all registered nurses to ensure timely and accurate recording and record keeping.

- All families have been consulted on their preferred methods of communication. Three monthly reviews are conducted with residents and families around care plan changes and systems are in place to ensure that any changes are communicated to families in a timely manner.

- Training will be provided to all registered nurses in regard to the management of incidents and complaints.

M – Bi-weekly visitations, weekly meetings, compliance visits, observational visits and additional supports where required.
A – Through onsite visits and desktop reviews.
R – Overview by the regional team in conjunction with the COO.
T – 30th October 2020.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
S - Education and support has been provided to the PIC to ensure that all notifications to the Authority are submitted in accordance with the requirements of the regulation.

M – Through education, audit and review.
A – By the PIC with additional support.
R – Overview by the regional team in conjunction with the COO.
T – 12th June 2020

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
S - All complaints will be recorded and investigated in accordance with the requirements of Regulation 34
M – All concerns and complaints directed to the centre or through the Authority will be addressed in accordance with the complaints procedure, recorded and maintained

within the centre and learnings will be disseminated to enhance the lived experience of residents.
A – By the PIC.
R – Overview by the regional team in conjunction with the COO.
T – 18th August 2020.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Post inspection, the COVID-19 tab on our electronic nurse recording system has been implemented to ensure all information in relation to live COVID-19 testing and results are readily available.

- A full review by the COO has been concluded to confirm that the contingency plan is in line with HPSC guidelines and includes details of proposed management in the event of an outbreak. In the event of a future outbreak, dedicated staff will be rostered in the cohort area.

- All registered nurses have been reminded of the need for accurate recording of the precautionary isolation of residents and any future outbreaks within the centre

- A full review of hospitality services to residents has been concluded of which a plan of staff allocation has been reviewed in the event of a further COVID-19 outbreak and a cleaning regime for precautionary isolation rooms within the centre. This is included in our COVID-19 preparedness plan within the centre.

- Following the inspection, a comprehensive review of the infection prevention and control measures in place within the centre was commissioned by the RPR and was carried out by an external infection control nurse specialist. The recommendations from the report have been implemented including the provision of additional wall mounted hand gel dispensers, the location of PPE dispensers and hand sanitization stations throughout the centre.

- A service contract is in place for the bed pan washer.

- A revised cleaning regime has been introduced within the centre to ensure the effective cleaning of all equipment.

- A review of hoist slings has been conducted and disposable slings are available in the event of being required.

M – Through enhanced monitoring.
A – Through audit, reflection, and learning.

R – Overview by the regional team in conjunction with the COO.
T – 15th October 2020

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
S- A review of all individual assessments and care plans has commenced to ensure compliance with regulation 5. Through this review, improvements have been incorporated to enhance care interventions.
M – Through comprehensive review.
A – Carried out by the inhouse management team.
R – Overview by the regional team in conjunction with the COO.
T – 15th October 2020

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
S – A comprehensive review of nursing and medical records has been carried out and the learning of this has been used to inform nursing assessments and reports to the G.P.
M – Through full and comprehensive reviews in conjunction with the team to ensure timely referrals in line with best practice and appropriate support.
A – Through the inhouse management team.
R – Overview by the regional team in conjunction with the COO.
T – 30th June 2020

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	11/12/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/10/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/10/2020
Regulation 21(2)	Records kept in accordance with this section and set out in Schedule 2 shall be retained for a period of not less then 7 years	Not Compliant	Orange	15/10/2020

	after the staff member has ceased to be employed in the designated centre concerned.			
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Not Compliant	Orange	15/10/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/10/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/10/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and	Not Compliant	Orange	15/09/2020

	control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	12/06/2020
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death has been established, the Chief Inspector is informed of that cause in writing.	Not Compliant	Orange	12/06/2020
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	18/08/2020
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into	Not Compliant	Orange	18/08/2020

	the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be 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.	Not Compliant	Orange	15/10/2020
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	15/10/2020
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under	Not Compliant	Orange	30/06/2020

	Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			