Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	21 July 2020
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0029750

About the designated centre

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

Bridhaven Nursing Home is a designated centre and is located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 184 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in five suites named after local rivers:

1) Clyda is a dementia-specific unit with 18 bedrooms (all single rooms with full en suite facilities of shower, toilet and wash-hand basin) and is located on the lower ground floor
2) Lee (41 beds – two twin and 33 single with en suite facilities) located on the ground floor
3) Blackwater (44 beds – six twin and 32 single full en suite facilities) located on the ground floor
4) Bandon (45 beds – four twin and 37 single with en suite facilities) located on the first floor upstairs
5) Awbeg (36 beds – seven twin and 22 single with en suite facilities) located on the first floor upstairs.

Additional assisted toilet facilities are located throughout the centre adjacent to communal areas. Each suite had a day room and dining room and there are additional seating areas located at reception and throughout the centre. There is a large seating area upstairs for resident to relax with views of the enclosed bonsai garden and also the entrance plaza. Residents in Clyda have access to a well-maintained enclosed garden with walkways, garden furniture and shrubbery; there is a second smaller enclosed garden accessible from the Blackwater day room. Bridhaven Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	150

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 21 July 2020	09:30hrs to 17:30hrs	Breeda Desmond	Lead
Wednesday 22 July 2020	08:00hrs to 14:45hrs	Breeda Desmond	Lead
Tuesday 21 July 2020	09:30hrs to 17:30hrs	Ella Ferriter	Support
Tuesday 21 July 2020	09:30hrs to 17:30hrs	Mary O'Mahony	Support
Wednesday 22 July 2020	08:00hrs to 14:45hrs	Ella Ferriter	Support
Wednesday 22 July 2020	08:00hrs to 14:45hrs	Mary O'Mahony	Support

What residents told us and what inspectors observed

Staff guided the inspectors through the infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing in process, disclosure of medical wellness or otherwise, hand hygiene, face covering, and temperature checks. Inspectors were shown to the side entrance which was clearly identified for visitors to access the centre. Inside this door were facilities to take people's temperatures and questionnaire to be completed to facilitate COVID-19 contact tracing. A marquee was located by the main entrance to facilitate visiting while at the same time ensuring social distancing.

Inspectors spoke with several residents during the inspection and people were complimentary regarding the staff, food and meals, and care received. Residents spoken with understood the necessity for the COVID-19 precautionary restrictions. Residents were well dressed and appeared comfortable and relaxed in their setting. However, inspectors noted that many residents were in bed throughout the day.

Inspectors observed interactions of staff and residents and saw that, in general, residents were treated with kindness and respect. Observations demonstrated that some staff knew residents' preferences and routines and socially interacted with residents, however, other observations were that staff did not interact or socially engage with residents. It was a gorgeous summer's day and there was a live music session in the Blackwater garden with the musician playing songs of their era, however, staff present did not help residents participate in the session. One resident got up to dance but no-one came to him so he sat down again; other residents sat forward in their chairs looking around, possibly for someone to sway to the music with them, but sat back in their chairs again as nobody came to them.

There were dining rooms on each unit and residents were observed there for breakfast, dinner and tea. Activities were facilitated in day rooms. The activities observed were facilitated by the activities co-ordinators; these were interactive and lively and participation was encouraged.

Capacity and capability

The findings from this inspection showed that there was improvement in several areas such as the dining experience and other areas relating to the premises were in the process of being addressed but had to be put on hold due to COVID-19 precaution. Remedial work in Clyda had resumed and these were due to be

completed by end of September 2020; this was Phase 1 of the project plan to upgrade the premises. Work on Blackwater and throughout the centre comprised Phase 2 of the project plan to be completed. The date for completion of Phase 2 was unknown due to the interruptions of COVID-19 and adherence to Health Protection Surveillance Centre (HPSC) precautions.

At the time of the previous inspection in July 2019 the governance structure had just changed with the appointment of a Chief Executive Officer (CEO), reporting to the registered provider. This new governance structure was now embedded and staff reported that this was an invaluable support in the day-to-day running of the centre.

The person in charge had resigned from post in March 2020 and the assistant director of nursing took up the role of person in charge for the interim until a new person in charge was appointed in August. She was full time in post and supported in her role by the assistant director of nursing, five clinical nurse manager (CNMs) two of whom has responsibility for night duty, three senior nurses, senior carers and head chef; the facilities manager was responsible for non-clinical areas; human resources manager supported staff recruitment, training needs and industrial relations. The person in charge demonstrated thorough knowledge of her role and responsibilities including good knowledge of residents and their care needs as well as quality improvement.

COVID-19 preparedness plan was robust and comprehensively addressed issues relating to the pandemic including policies updates, emergency contacts, contingency planning for kitchen, laundry, medical services, admissions and criteria for residents' transferring back to the centre. A containment plan was actioned, for example, residents were accommodated in single rooms; staff movement was restricted between units; staff start and finish times were reviewed and changed to stagger entry and exit from the centre. All staff were issued with scrubs, and these scrubs could be laundered on site. A cohort/isolation wing was established which facilitated suspected cases as well as residents returning from acute care requiring 14 days isolation.

All residents had COVID-19 swab tests and these were negative. Four weeks of COVID-19 swab testing on staff was completed and all test results were negative. A staff wellness board was established to support the well-being of staff through the COVID-19 pandemic. The person in charge communicated fortnightly via e mails with staff with Health Protection Surveillance Centre (HPSC) updates and the impact on service provision. Each unit communicated with relatives regarding COVID-19 status and updates with changing visiting arrangements. Information was also posted on their website to keep relatives and friends informed.

Clinical and non-clinical audits were undertaken with corrective actions and review dates. Quality of Interaction Schedule (QUIS) observations had commenced to enhance the quality improvement strategy and this had identified areas for improvement such as the activities programme.There was an annual programme of audit which provided clinical and non-clinical oversight. In addition, a daily infection control audit was completed including audit of practice to ensure staff adherence to HPSC guidance regarding hand hygiene and PPE usage. The annual review for 2019

was set out in the format of national standard statements and criteria. It demonstrated a good review of the service with improvements detailed, progress of each area highlighted and responsibilities assigned. This was updated by the outgoing person in charge with status and progress to date so that the incoming person in charge had current information available to them on the service.

The statement of purpose was updated to ensure compliance with the regulations. A current insurance certificate was evidenced. The directory of residents was maintained in accordance with the regulations. A synopsis of the complaints procedure was displayed in the centre and records demonstrated thorough investigations of complaints, and discussions with the person in charge demonstrated good oversight of residents' and relatives' feedback. Residents had contracts of care in accordance with the regulation.

The incidents and accidents log was reviewed. While most of the issues were notified to the office of the chief inspector, one incident requiring notification, was not submitted in line with the requirements of the regulations.

The person in charge had reviewed the notifications relating to pressure ulcers in conjunction with care plans and wound management documentation, and this provided much better oversight of wound care. A journal club on wounds was held in 2019 where wound care associated with pressure ulcer care was examined; they were in the process of undertaking another journal club presentation regarding restrictive practice as part of staff ongoing education. They had set up a restrictive practice committee and following from this they reviewed the principles under-pinning their training and education and changed the approach to look at their service delivery from the 'five fundamental human rights' perspective. At the time of inspection, staff had three weeks to read this document and following that, a journal club meeting would be scheduled to discuss restrictive practice and how this will be implemented into practice as a way of promoting a restraint-free environment. The premise under-pinning this was to promote better understanding and reflective practice to facilitate change in approach to bed rail usage and acknowledge other restrictive practices in place.

A sample of staff documents reviewed demonstrated comprehensive records as specified in Schedule 2. In order to continue staff training, a large external venue was rented to enable staff training to continue while complying with social distancing. The person in charge had completed several training sessions there with a maximum of nine staff per session to ensure staff training remained up-to-date. The recently appointed HR manager had introduced several quality measures to enable and ensure records including staff records, induction and appraisal programme were comprehensively maintained and up-to-date.

Overall, the number and skill mix of staff required review cognisant of the size and lay out of the centre, the individual sizes of each unit (ranging from 37 - 45 bedded units) and the dependency levels of residents at the time of inspection were as follows:

Night duty staff levels -

1) Awbeg - (eight maximum and five high dependency resident) - one nurse and one healthcare assistant (HCA)

2) Leeside - (18 maximum and high dependency residents) - one nurse and one healthcare assistant (HCA)

3) Blackwater - (16 maximum and 15 high dependency residents) - one nurse and one healthcare assistant (HCA)

There was an additional HCA on night duty to help out in different units throughout the night. Cognisant that the nurse on night duty would be undertaking medication rounds, this would leave the HCA undertake comfort rounds on their own with many high to maximum dependency residents.

The activities programme in Clyda was the responsibility of all staff in Clyda and the person in charge reported that this worked well, and was particularly effective during the COVID-19 visiting lock-down. There were two activities co-ordinators each day for the remainder of the centre, approximately 130 residents at the time of inspection. This was identified as inadequate for the size, layout and dependency of residents. As described earlier, observations showed that many residents remained in bed throughout the day with little or no stimulation. Outdoor space continued to be inadequate for the size and layout of the centre: residents from Blackwater had an enclosed garden available to them; the remainder 140 residents (Awbeg 36, Bandon 45, Leeside 41 and Clyda 18 residents) had access to the Clyda garden. Even though they were gorgeous summer days, apart from the music session one afternoon, there was little activity observed in the gardens.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider submitted the appropriate documentation to support this application to re-register Bridhaven Nursing Home in a timely manner. Fees were paid in accordance with the requirements of the application.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was full time in post. She had the necessary experience and qualifications as required in the regulations. She demonstrated good knowledge regarding her role and responsibility and was articulate regarding governance and management of the service. She demonstrated good knowledge of residents, their

care needs and preferences and the importance of delivering individualised care.

Judgment: Compliant

Regulation 15: Staffing

Overall, the number and skill mix of care staff was not appropriate having regard for the needs of residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre as follows:

1) There were three activities personnel working in the centre with two staff on each day. On a given day there were two activities co-ordinators for approximately 130 - 140 residents.

2) Night duty staff levels were inadequate on some units to ensure individualised safe care.

Judgment: Not compliant

Regulation 16: Training and staff development

The induction process was discussed and a robust system was described to ensure that staff had appropriate knowledge regarding care delivery. The training matrix demonstrated mandatory training as well as other relevant training completed. The system in place enabled oversight of training needs with alerts when training was due. The person in charge and assistant director of nursing were qualified to undertake in-house training for example, protection, manual handling and lifting and fire safety, and external facilitators further enhanced training such as palliative care. They had developed a training video to demonstrate to staff the proper donning and doffing practice for PPE and used this as part of their on-going education programme to ensure practice was in accordance with current HPSC guidance.

Better staff supervision was necessary to ensure delivery of care was in line with the ethos described in the statement of purpose.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was maintained in line with the requirements set out in

the regulations.

Judgment: Compliant

Regulation 21: Records

Staff files reviewed were comprehensively maintained in line with regulatory requirements.

Judgment: Compliant

Regulation 22: Insurance

Current insurance cert was available, which complied with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined roles and responsibilities defined and staff were aware of reporting protocols. A new person in charge was due to be appointed at the end of August 202, at which point the interim person in charge would resume her role as assistant director of nursing (ADON); this would bring the number of ADONs currently to two.

The annual review demonstrated an in-depth and honest review of the service with actions and updates as well as responsibilities for actions.This was updated by the outgoing person in charge so the incoming person in charge would have current information available to them regarding the service.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Residents had contracts of care which identified fees including possible additional fees to be charged as well as the room occupied by the resident. They were signed and dated appropriately.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was updated to reflect the current governance and management arrangements as well as the other regulatory requirements listed in Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

Most incidents requiring notification were timely submitted in accordance with regulations, however, following examination of the incident and accident log, one incident requiring notification, was not submitted as stipulated in the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Residents and relatives spoken with relayed that they could raise issues with staff and that issues would be dealt with in a timely manner. The complaints log was reviewed and showed that complaints were recorded in line with the regulations and investigated thoroughly and appropriately. These were discussed with the person in charge who outlined that feedback was used as a quality improvement measure to review practices and change processes to ensure residents and their families were satisfied with the service provided.

Judgment: Compliant

Regulation 4: Written policies and procedures

The Schedule 5 policies and procedures were available to staff. Many of these were updated in line with the changing requirements as detailed in HPSC guidance to support staff, for example, medication management, admissions and transfer policy, visiting policy, staff uniform policy.

Judgment: Compliant

Quality and safety

Improvements were observed in the dining experience for residents as breakfast now began after 08:00hrs and some residents were observed having their breakfast in the dining rooms while others had it in their bedrooms.

A sample of care plans reviewed showed detailed personal information to inform individualised care. Care plans and assessments were in place to support challenging behaviours including triggers staff should be aware of to provide suitable distraction techniques. End-of-life care plans were updated following discussions with residents or their next-of-kin when appropriate. Referrals and reviews by psychiatry and other community clinics such as Parkinsons' clinic provided ongoing support for residents. Tissue viability nurse specialist support was sought to provide specialist care in wound management. Pressure relieving equipment was available as part of residents care support. Good GP access was maintained in that an electronic tablet devise was installed where the GP consulted with residents and discussed their status, and when necessary, the GP attended the centre to review residents.

Good infection prevention and control measures were in place in line with HPSC guidance. Practices observed showed good adherence to best practice and practices were changed to reflect the changing guidance issued by HPSC. Visiting arrangements were facilitated in line with HPSC guidance. A marquee was set up on the grounds of the centre to enable visiting while at the same time maintain social distancing. Relatives whose family member was receiving end of life care were facilitated to come and sit with their relative.

The activities programme in Clyda was the responsibility of all staff in Clyda and the person in charge reported that this worked well, and was particularly effective during the COVID-19 visiting lock-down. There were three activities co-ordinators employed for the remainder of the centre, two staff on each day for approximately 130 residents at the time of inspection. This was identified as inadequate for the size, layout and dependency of residents. As described earlier, observations showed that many residents remained in bed throughout the day with little or no stimulation. There was inadequate outdoor space for the size and layout of the centre: residents from Blackwater had an enclosed garden available to them; otherwise, the remainder 140 residents (Awbeg 36, Bandon 45, Leeside 41 residents and Clyda 18) had access just to the Clyda garden. Even though they were gorgeous summer days, apart from the music session one afternoon, there was little activity in the gardens. While there was some evidence to demonstrate that staff actively and socially engaged with residents, and provided effective strategies with residents including residents with complex communication needs, some observations showed little or no engagement of staff with residents as was described earlier in the report.

The laundry was upgraded since the last inspection. This was set out in line with

infection control protocols in that there was a one-way system for entry and exit to mitigate the risk of cross infection. Work-flows described by staff demonstrated excellent knowledge of infection control best practice. These work-flows had been updated with the advent of COVID-19 precautions and inspectors observed a clearly labelled large red trolley to hold laundry of suspected cases or residents in isolation following transfer back to the centre.

The project plan for upgrading the premises was put on hold due to COVID-19 precautionary measures and only emergency external contractors such as electricians or plumbers were allowed into the centre since March 2020. At the time of inspection, remedial work had resumed in Clyda unit and completion date for Phase 1 was September 2020. Works in Clyda to date were a significant improvement on the previous inspections and provided a much more homely, warm and bright décor and atmosphere. Phase 2 of the project plan included the dining room in Blackwater, general decor and flooring, and orientation signage. Signage had been designed in line with dementia-specific care. The new signage had arrived just before the inspection and the provider erected a sample of them to display, however, the corners of the new signage were sharp and had to be removed as they would possibly hurt residents.

As identified on previous inspection reports, outdoor space was inadequate for the residents accommodated in the centre. The hairdressers' room was a small room located in the lower ground floor, some distance away from all other resident accommodation. During the walk-about of the centre, inspectors noted some poorly maintained furniture such as bedside lockers and bed-ends.

Regulation 11: Visits

Visiting arrangements were facilitated in line with HPSC guidance. Relatives whose family member was receiving end of life care were facilitated to come and sit with their relative. A marquee was set up on the grounds of the centre to enable visiting while at the same time maintain social distancing.

Judgment: Compliant

Regulation 12: Personal possessions

Records of residents' personal property were maintained. Residents' bedrooms had adequate space to maintain their clothes and personal possessions. Personal storage space comprised double wardrobes and bedside locker with lockable storage.

Residents had access to on-site laundry facilities. There was a staff member appointed for night duty with responsibility for laundry. The laundry was being

upgraded in line with infection control best practice since the last inspection and comprehensive work-flows were described regarding non-infected and infected clothing. Clothing was labelled for ease of identification.

Judgment: Compliant

Regulation 13: End of life

A sample of care plans reviewed showed that there was ongoing evaluation and updating of residents' end of life care wishes to ensure that care and support was in accordance with their personal wishes and preferences including their resuscitation wishes. Documentary evidence showed that consultation with residents' families formed part of the care approach.

Judgment: Compliant

Regulation 17: Premises

Servicing records were maintained and these were current for all equipment, for example, lifts, beds and hoists.

Orientation signage was sourced and designed in line with dementia care. This was shown to inspectors during the inspection. A sample was erected to show their impact on the environment regarding orientating people, however, when they erected the signage they identified that the corners were sharp and would potentially cause hurt or damage, so they removed them and returned them to the manufacturer.

There was a large well maintained secure garden for residents' in the Clyda dementia suite with walkways and shrubberies; the second smaller secure garden was located off the dining room in the Blackwater suite; cognisant of the size of the centre with accommodation for 184 residents, access to outdoor space was inadequate. This was a repeat finding.

Phase 2 of the building project plan included the dining room in Blackwater, decor and flooring throughout the centre.

Other issues highlighted on inspection relating to the premises were:

1) Oversight of maintenance; some furniture seen was in poor condition

2) Some residents preferred to have their bedroom door slightly ajar, however, suitable closures were not in place on bedrooms doors to enable residents to this, in

accordance with their preference

3) There was inappropriate storage in one bathroom with trolleys.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was improvement noted in the dining experience for residents as breakfasts were now scheduled from 08:00hrs and not before hand. The head chef attended the individual suites to gain resident's feedback and suggestions, for example, other menu choices. Meals were pleasantly presented and residents gave positive feedback regarding their food.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Residents' records demonstrated that all relevant information about the resident was provided to the receiving designated centre, hospital or place. Upon return to the designated centre, the senior nurse ensured that all relevant information was uploaded to the resident's documents and care plans updated.

Judgment: Compliant

Regulation 26: Risk management

A COVID-19 risk register was maintained along with individual clinical and non-clinical risk registers,however, free-standing hand gels seen throughout the centre had not been risk assessed cognisant of the level of residents with cognitive impairment; in one en suite, the alarm bell chord which hung from the ceiling was trailing on the ground.

Judgment: Substantially compliant

Regulation 27: Infection control

Issues previously identified regarding sluicing facilities in Awbeg and Bandon suites were remedied as new bed-ban washers were in place.

There was good surveillance maintained of infections such as respiratory, urinary and wound infection. Residents were isolated in accordance with HPSC guidance. Staff were observed using PPE appropriately and disposing of them in compliance with HPSC guidance. Residents and staff temperatures were taken twice daily; where necessary, residents oxygen levels were recorded on a daily basis in line with their clinical needs.

Judgment: Compliant

Regulation 28: Fire precautions

Prior to the COVID-19 pandemic, fire drills and evacuations were completed and learnings from drills informed better practice. However, records reviewed showed that these drills were not undertaken cognisant of night duty staff levels. This would ensure that staff could safely evacuate a compartment and wing in a safe and timely manner. In order to ensure adherence to COVID-19 infection control precautions, these drills had temporarily ceased, nonetheless, regular interactive sessions were held with staff discussing fire safety procedures. Residents were invited to these sessions and records showed that some attended.

Emergency floor plans were displayed throughout the centre with points of reference to orientate people. Appropriate records were maintained for daily, weekly and monthly fire safety checks. Personal emergency evacuation plans (PEEPS) were in place for all residents and residents were involved in the fire evacuations.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Medication administration charts and controlled drugs records were maintained in line with professional guidelines. Medication reconciliation was in place as a safeguard measure. Where PRN (when required) medications were used, a record was maintained which detailed the rationale for the administration of the PRN in line with safe practice. Covert administration of medicines was an option on their administration form, however, this was not in keeping with current professional guidelines and the person in charge was asked to

review this.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Pre-admission assessments were completed to ensure the service could provide appropriate care and facilities. Residents had evidence-based risk assessments to guide care and documentation showed that residents and their next-of-kin were consulted with regarding care. The sample of care plans and assessments reviewed demonstrated that they were timely updated and had person centred information to direct and inform care. The COVID-19 risk assessment and care plan was in place to direct care to help the resident maintain a safe environment and where the resident required, care to be given regarding suspected or isolation needs. Other care documentation to inform individualised care included diabetic foot screening tool, behavioural day chart, daily record of intake and output of the resident.

Post fall de-briefing discussions were facilitated to mitigate recurrence and records seen showed a thorough review of incidents. Clinical risk register had risks identified associated with individual residents with controls and additional controls put in place to help safeguard residents. There was good oversight of pain assessment and management for residents in the sample documents reviewed.

Judgment: Compliant

Regulation 6: Health care

Residents had access to tissue viability nurse specialist to inform wound care; wound care records showed wound care management was well documented and supported best practice regimes. Records demonstrated that residents had timely access to medical care, specialist care and allied health care professionals. For example, inspectors noted that physiotherapy, general practitioners (GPs), psychiatry of old age and community based psychiatric services, the dietician, dentist, chiropody, optical and speech and language services (SALT) had been accessed. Fit-for-life assessment and activity was completed by the physiotherapist as part of health promotion. Access to community palliative care was facilitated for management of symptoms to enable best outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The decision-making tool used for bed-rail restraint was supported by a risk-balance tool to ensure appropriate interventions were in place; there was a separate form for reclining-chair usage. Records showed that alternatives were trialled such as low-low bed and crash mattresses, as observed on inspection. Residents had care plans in place supported by behavioural support information such as symptoms and interventions which may alleviate or reduce episodes of challenging behaviours.

Judgment: Compliant

Regulation 8: Protection

Staff had up-to-date training and those spoken with had good knowledge and expressed no hesitation in reporting anything untoward. The service was pension agent for many residents and records examined demonstrated appropriate safeguards to protect residents.

Judgment: Compliant

Regulation 9: Residents' rights

Some bedroom televisions were upgraded since the last inspection and the remainder were being done as soon as COVID-19 precautions were lifted to enable off-site contractors access to the centre.

Some activities were observed during the inspection, however, these were inadequate for the size, layout and assessed needs of residents to facilitate occupation, recreation and opportunities to participate in activities in accordance with their interests and capabilities.

Some practices observed showed that some staff did not actively or socially engage with residents as described earlier in the report.

Residents' surveys were undertaken, however, the surveys seen comprised 10 residents surveyed in 2020, and 20 in 2019, this was not reflective of residents feedback as the centre has capacity for 184 residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0029750

Date of inspection: 22/07/2020

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: The Registered Provider will 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 centre, and to this end we will: Conduct a full review of the activities department, to include: job descriptions, rosters, allocations and service offerings. Further, we will reinforce education for all healthcare assistants to engage in activities as a part of their regular daily duties to ensure that the care provided is person centered and directed by residents' choice. Undertake a review of night time staffing levels.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We will also review the role of staff nurse, senior nurse, CNM and senior managers in the supervision of care and what supervision means, as they act as role models, mentors and trainers to others, in ensuring that the care provided is in line with the culture and ethos espoused in our Statement of Purpose. In order to ensure better supervision of staff we will conduct an audit of training to assess the effectiveness of training, and develop a follow up action plan.	

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Brídhaven has an open and transparent philosophy around submitting notifications, and this is inherent our culture. This particular pattern refers to one resident. There were 6 incidents in the pattern identified. 5 of these incidents were verbal abuses by the resident targeted at staff members and therefore was not notifiable as NF06s notify allegations of abuse of a resident only. The one other incident was a shouting incident by the resident in a communal room occupied by other residents. We did not notify this as an NF06 as it was not directed at any one resident, however, we accept that should any resident feel that it was directed at them that this would be notifiable. In this regard, we will ensure, going forward, that all incidents that could possibly be considered as being directed towards residents are notified.

Clinical Nurse Managers will review HIQA's notification guidance document again.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider will ensure that the premises are appropriate to the number and needs of the residents in accordance with the Statement of Purpose and will conform to the matters set out in Schedule 6.

Brídhaven continuously undertakes a programme of building/premises refurbishment in order to keep the physical environment safe, fresh, inviting and pleasing for residents. It also maintains a building that meets its legislative obligations. In line with Schedule 6 changes to come into effect on 1 January 2022, Brídhaven is now engaging with its Engineer and building contractor in order to revisit a 2022 Programme of building works, which will address all legislative and regulatory obligations. Findings in this inspection regarding storage for trolleys, location of the hair salon will be reviewed in this programme.

The centre has, since the inspection, engaged a landscape architect to design more usable outdoor space for residents' enjoyment.

In compliance with Standards 2.7.5, 2.7.6 and 2.7.7, toilet and washing facilities are available in every bedroom to meet the needs of residents in a dignified and appropriate manner. The majority of bedrooms also have shower facilities. For the bedrooms in

Bandon without a shower, two assisted shower rooms are provided, within easy access and in close proximity to these bedrooms. This will be reviewed further in the 2022 Programme.

More regular health and safety walkabouts will be conducted. These walkabouts will now include staff of each unit to ensure a more involved and robust oversight of each unit.

The damaged locker-tops will be replaced immediately.

Brídhaven has two forms of "door closures" – swing frees and doorgards, both of which meet the required BS Standard. There is a door closure on every bedroom door which allows a door to be kept ajar. All doors are synchronized with the fire alarm. From time to time residents may use items to hold the door ajar. We will encourage all residents to use the swing free/doorgard and not to use bags/chairs.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Brídhaven has effective arrangements in place to manage risk and protect residents from the risk of harm. We also have a risk management policy which includes hazard identification and assessment of risk, measures and actions in place to control risks, arrangements for identification, recording, investigation and learning from incidents and adverse events. Also, the policy addresses how to respond to major incidents likely to cause injury or death. We will review this policy in light of the inspectors' findings and amend/update where necessary.

Free standing hand gel/sanitiser will be removed from resident areas in the centre.

An audit of all alarm bell chords will be undertaken to ensure that they do not trail the ground.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Adequate precautions against the risk of fire are taken. Suitable firefighting equipment, suitable building services, and suitable bedding and furnishing have been provided for. Also, adequate means of escape, including emergency lighting, maintaining fire equipment, building fabric and building service are provided for.

Staff of the centre receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call-points, first aid, firefighting equipment, fire-control techniques and the procedure to be followed should the clothes of a resident catch fire. Fire drills are carried out at suitable intervals, and staff and residents are aware of the procedure to be followed.

Fire drills are conducted at night time. Going forward, we will ensure that all fire drills are carried out cognisant of night duty staff levels.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
It is imperative that all medicinal products are administered in accordance with the directions of the prescriber and in accordance with any advice provided regarding appropriate use.

The PIC is currently undertaking a programme of re/further education with nursing staff around medication management. We will ensure that covert administration is covered in this programme. In turn, the medication management policy will be reviewed and updated as necessary.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
It is imperative that residents are offered a choice of appropriate recreational and stimulating activities to meet their needs and preferences. In order to address the Inspectors' findings we will conduct a full review of the activities department, to include: job descriptions, rosters, allocations and service offerings. Further, we will reinforce education for all healthcare assistants to engage in activities as a part of their regular daily duties.

A new training session on residents' rights will be developed and will be rolled out for all staff.

From September 2020 we will undertake one resident survey per unit per week, throughout the year. This will ensure that we get a greater cross section of residents'

comments, thoughts, feedback etc. We will collate the data from these surveys quarterly in order to assist us to trend common themes and to action recommendations promptly.

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	31/10/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2020
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2020
Regulation 26(1)(a)	The registered provider shall	Substantially Compliant	Yellow	31/10/2020

	ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	31/10/2020
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in	Substantially Compliant	Yellow	30/11/2020

	accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
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	30/09/2020
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	21/08/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30/10/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Not Compliant	Orange	30/10/2020

	capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/10/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	01/09/2020