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:	Brampton Care Home
Name of provider:	Brampton Care Ltd
Address of centre:	Main Street, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	21 March 2023
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0039677

About the designated centre

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

Brampton Care Home is located in the heart of Oranmore town, Co. Galway. The designated centre cares for residents with aging related health issues inclusive of physical, psychological and social concerns. The service cares for both male and female residents that are aged 18 years and over. The care extends to those with dementia, cognitive impairment, mental illness, intellectual disabilities, physical disabilities and chronic physical illness. There is 24 hour nursing care available in the centre. The centre is laid out over three floors of a four storey development. Residents have access to outdoor gardens. The centre has 79 beds, 67 single occupancy en-suite rooms and six double occupancy en-suite rooms. All bedroom accommodation is situated on the second floor and third floor which are accessed by two lifts. Each floor also contains a sitting room, dining room and kitchenette.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	72

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 March 2023	09:00hrs to 17:00hrs	Una Fitzgerald	Lead
Wednesday 22 March 2023	09:00hrs to 13:15hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Residents living in Brampton Care Home reported that they were satisfied with the standard of care they received. Residents felt that the team of staff knew their individual needs and preferences. Residents told the inspector that they felt at home living in the centre. Positive resident quotes included "everything is done for you" and "we get spoilt". Residents were aware that there had been an increase in the staff in the centre and this change was welcomed. The majority of residents spoken with were satisfied with the length of time it took to have their call bells answered.

Following an introductory meeting, the inspector walked through the premises with the person in charge. There was a calm and welcoming atmosphere in the centre throughout the inspection. The entrance foyer of the centre has a cafeteria where residents congregate and catch up with each other. This area was a hub of activity throughout the two days of inspection. The inspector sat and conversed with individual residents and with small groups throughout the two days. The provision of the coffee dock service was important to the residents and they felt the space was a great meeting place.

On the upper floors of the centre, residents were observed relaxing and watching television in the communal day rooms. Staff were observed to provide continuous supervision in communal areas and were observed to be attentive to residents needs such as providing snacks and refreshments. Residents were observed walking independently along corridors and staff greeted them by name when passing.

The design and layout of the centre supported the needs of the residents to move freely and safely. The building was warm and well ventilated. There was adequate natural and artificial light throughout the centre. Most residents spent their day in the main communal day rooms and a small number of residents chose to remain in their bedrooms. Residents' bedrooms were personalised with ornaments, family photos and personal items of significance.

Residents told the inspector that they knew the management team well and would not hesitate to bring a concern or complaint to the attention of the management team with confidence that the issue would be resolved. When asked about how they spend their days a small group of residents told the inspector that their was sufficient activities to attend. Residents reported that their choice was respected. One resident stated that there were "no restrictions on us". This comment represented the groups' feelings on choice.

The residents dining experience was observed to be a pleasant, relaxed and sociable occasion for residents. Residents told the inspector that they were satisfied with the quality and quantity of food they received at mealtimes and confirmed the availability of snacks and refreshments at their request. The inspector observed that meals were freshly prepared and were appetising in appearance.

The inspector spent time observing residents with dementia and their engagement with staff. While none of the residents met with were able to tell the inspector their views on the quality and safety of the service, the inspector observed that the residents were relaxed. The communal rooms were supervised by staff.

The following sections of this report details the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

The inspector found that this was a well-managed centre, where residents were supported and facilitated to have a good quality of life. The inspector followed up on the last inspection findings from May 2022 and found that the provider had made good progress with addressing issues of non-compliance found at that time. Notwithstanding the positive findings, the inspector found that the systems in place to monitor the provision of direct care provided to the residents was insufficient. While auditing of the service was in place, the oversight and actions taken following the identification of issues requiring improvement were not always addressed or completed.

This was a risk inspection carried out by an inspector of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This unannounced risk inspection took place over two days. There were 72 residents accommodated in the centre on the day of the inspection and seven vacancies.

Brampton Care Ltd is the provider of this centre. There was a clearly defined management structure in place with identified lines of authority and accountability. The director of nursing and assistant director of nursing facilitated this inspection. They demonstrated an understanding of their role and responsibility and were a visible presence in the centre. They were supported in this role by an operational manager, a clinical nurse manager and a full complement of staff including nursing and care staff, activities, housekeeping, catering, administrative and maintenance staff.

The governance and management of the designated centre was well-organised and the centre was well-resourced. On the day of the inspection, there were sufficient numbers of suitably qualified staff available to support residents' assessed needs.

There was evidence of governance and management meetings. The quality and safety of care delivered to residents was monitored through a range of clinical and operational audits. The audits included reviews of care planning documentation, nutritional audits and wound management. However, the detail contained in the audits did not provide assurances that adequate oversight was in place, with regard to the direct provision of care. There was insufficient oversight of the audit findings

and no evidence of timely follow up to ensure appropriate action was taken to address the audit findings. The provider had failed to identify areas for improvement or develop quality improvement plans. The detail of this finding is outlined under Regulation 23; Governance and Management. In addition, the inspector found an incident that had occurred in the centre that was not notified to the Chief Inspector, as required by the regulations.

Staff files reviewed did not contained all of the information required under Schedule 2 of the regulations. The template document that was in place to support all new staff through the induction and orientation process was comprehensive. However, this document was not available for the inspector to review for any of the 17 new staff that had commenced since January 2023. Therefore, assurances could not be provided that the induction process in place ensured that new staff were appropriately inducted and had sufficient knowledge of the systems in place. For example; the electronic care planning system that requires all health care staff to record the care delivered.

Regulation 15: Staffing

There was sufficient staff on duty with appropriate skill mix to meet the needs of all residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix that captures the training provided was reviewed and evidenced a lack of appropriate staff training. For example, incomplete training records for annual fire training, the management of responsive behaviours, manual handling practices and safeguarding of vulnerable adults were found on this review.

Judgment: Substantially compliant

Regulation 21: Records

Staff personnel files reviewed did not contain all of the information required by Schedule 2 of the regulations. For example, staff files did not consistently contain documentary evidence of relevant qualifications and written references.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that systems that would ensure that the service delivered to residents is safe and effectively monitored were inadequate. This was evidenced by;

- Significant incomplete information in the training and in the induction process for new staff.
- Poor oversight of records management. For example, staff files did not contain the information required under Regulation 21; Records.
- Poor oversight of the quality of nursing documentation. For example, inaccurate completion, and in some cases, no assessments of residents needs.
- The audit system in place that monitored the direct provision of care was inadequate. For example;
    - a completed nutritional audit identified that the policy in the management of unintended weight loss in individual residents was not followed. This audit was completed in February 2023. At the time of inspection, insufficient action to follow up and address the findings had been taken.
    - An audit of wound management failed to identify that a number of wound and pain assessments were incomplete.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the record of incidents that had occurred in the centre found that a resident had an unexplained absence from the centre. This incident had not been notified to the Chief Inspector, as required by the regulations.

Judgment: Substantially compliant

Quality and safety

Residents who spoke with the inspector were very complimentary about staff and the care they received. However, action was required to ensure that all residents received health and social care that was in line with regulatory requirements, in particular with regards to Regulation 5; Individual assessments and care plans and

Regulation 6; Healthcare.

Record-keeping and file-management systems were largely computerised. The inspector reviewed a sample of resident records and found that validated nursing assessments were used to assess residents risk of impaired skin integrity, falls risk and risk of malnutrition. The inspector found incomplete assessments in wound and pain management. Where assessments were completed, care plans were then developed from the assessments to guide staff on how to support residents with their needs. While it was evident that the staff knew the residents individual needs, further oversight was required to ensure that residents assessed needs and risks had an appropriate care plan in place to support them. Further findings are discussed under Regulation 5: Individual assessments and care plans.

There was regular on site medical reviews occurring in the centre. Where residents required further health and social care expertise, they were supported to access these services which included dietitian services, speech and language, physiotherapy, occupational therapy and psychiatry of later life. However, where changes in the residents care and treatment were recommended, these changes were not consistently implemented and updated into the resident's plan of care. For example; wounds were not assessed and treated in line with the recommendations of the tissue viability nurse specialists.

The centre actively promoted a restraint-free environment and there was appropriate oversight and monitoring of restrictive practices in the centre.

The inspector observed that residents' rights and choices were upheld, and their independence was promoted. Residents were provided with opportunities to consult with management and staff on how the centre was run. Resident meetings were held. Resident feedback was observed to be acted upon. Minutes of residents meetings held in February and March 2023 evidenced that residents were consulted about the activities held and the satisfaction with the food served. Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were available. Residents had access to an independent advocacy service.

The centre is furnished to a high standard and residents voiced a high level of satisfaction with their bedrooms. The inspector observed that the centre was visibly clean. There was adequate communal and dining space available to ensure that all residents had the option to spend their day in a large communal space, have their meals in a dining area or, if they preferred in their bedrooms.

There was adequate supplies of personal protective equipment available to staff and wall mounted hand sanatisers were placed throughout the centre and at the point of care. Cleaning schedules were in place and equipment was cleaned after each use.

The inspector reviewed the documentation that supports the monitoring of fire safety in the centre. The fire safety action plan submitted following the previous inspection was progressed. Fire equipment such as fire extinguishers had been inspected by a competent person. Documentation on the completion of fire drills was comprehensive. The records evidenced the scenario created, the size of the

compartment evacuated and staff responses. In addition, lessons learnt and areas that require improvement were recorded. The fire evacuation strategy for the occupants of the first floor had been reviewed. The escape routes of the first floor was no longer shared with the escape routes for the floors that were occupied by the residents. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. The inspector reviewed the fire training records and found that while there were gaps in the fire training delivered, it was confined to the new staff that had commenced since January 2023.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted.

Judgment: Compliant

Regulation 27: Infection control

Infection Prevention and Control (IPC) measures were in place. Staff had access to appropriate IPC training and staff had completed this. Good practices were observed with hand hygiene procedures and appropriate use of personal protective equipment.

The centre was visibly clean and residents spoken with confirmed that their bedrooms are cleaned daily.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had taken appropriate action to address the non-compliance found on the last inspection in May 2022.

Detailed fire drills had been completed. An external fire expert company had attended the centre on a weekly basis to complete testing of the fire alarm. While there were some gaps in staff responses in what action to take in the event of the fire alarm being activated, the inspector acknowledged that all new staff had fire induction orientation completed on day one of working in the centre.

The provider had constructed fire exits from the first floor of the building. This ensured that in the event of the need to evacuate the building the occupants of the

unregistered first floor did not share a fire exit with the residents living in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The assessment of residents health care needs was not fully completed. For example, wound assessments were not completed in line with the recommendations of a tissue viability nurse specialist. Records reviewed evidenced that the resident required assessment of their wound every two days, however, records evidenced no assessment was completed for periods of six days. In addition, a resident with known pain had no pain assessments completed. There was no care plan in place to guide the care of the resident when they had pain.

Care plans were not reviewed or updated when a residents condition changed. For example, the care plan for a resident with a wound had not been updated in line with the progress of the wound.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care in accordance with professional guidance. This is evidenced by;

- A review of resident records found that recommendations received from allied health care professionals was not always implemented. For example; wounds were not assessed and treated in line with the recommendations of the tissue viability nurse specialists.
- A review of resident records found that pain was poorly managed and not in line with professional guidance.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider promoted a restraint-free environment in the centre, in line with local and national policy. The provider had regularly reviewed the use of restrictive practices to ensure appropriate usage.

Judgment: Compliant

Regulation 9: Residents' rights

Staff ensured that residents' rights were upheld in the designated centre. Staff were observed to engage in positive, person-centred interactions with residents. Residents told the inspector that they were well looked after and that they had a choice about how they spent their day.

There was an activity schedule in place. Residents were observed to be socially engaged throughout the day of the inspection.

Independent advocacy services were available for residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brampton Care Home OSV-0005812

Inspection ID: MON-0039677

Date of inspection: 22/03/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There is a training schedule in place that details a plan for staff training for new staff, and refresher training that is required for existing staff. Staff that are scheduled for training are noted on the training matrix and are on the roster two weeks in advance. Monitoring of scheduling and attendance at the training will be undertaken by the PIC and HR/Quality and Compliance Manager on a monthly basis and the results reported at the weekly management meeting. Risk assessment has been completed to ensure that any risks associated with staff being on duty that have not completed all training fully has been completed.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: An audit of records required in Schedule 2 in staff files has been undertaken by the PIC and any gaps identified. Individual staff members have been contacted in writing and requested to furnish the information needed within a designated time period. Qualifications that were not available for review at the time of inspection were available to the inspector on the second day of the inspection. References that were not available in writing have been requested	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All staff were issued with an induction form on commencement of employment; they are being followed up to ensure that the documents have been completed by their supervisor, they have achieved the required standard of practice, and have been signed as complete by the trainee the supervisor and the PIC/ADON . Records required under schedule 2 -Regulation 21 are being followed up with staff and correct documentation is being obtained to complete records. The system of audit for Nursing documentation is being reviewed, and the PIC and ADON are following up the actions identified in audits closely to ensure that all actions have been completed in a timely and complete way. Retraining of Nursing staff on wound and pain assessment will be completed	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC has submitted the required notification to the Chief Inspector immediately following inspection.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: The PIC and ADON are carrying out a full review of all assessments and care plans to ensure that they are fully complete, that advice received from MDT/specialist services is incorporated into the care plans and that they are reviewed within the designated time frame; this will be overseen by the Clinical Nurses Managers and DON/ADON. Re-education on assessments, care planning and pain management is currently being undertaken with nursing staff. This will ensure that when a residents' condition changes, re-assessment and updating of care plans takes place.	

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The PIC and ADON are carrying out a full review of all assessments and care plans to ensure that they are fully complete, that advice received from MDT/specialist services is incorporated into the care plans and that they are reviewed within the designated time frame; this will be overseen by the Clinical Nurses Managers and DON/ADON. Re-education on assessments, care planning and pain management is currently being undertaken with nursing staff. This will ensure that when a residents' condition changes, re-assessment and updating of care plans takes place.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/05/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/05/2023
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	28/05/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1)	Substantially Compliant	Yellow	24/03/2023

	(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.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	28/05/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/05/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under	Substantially Compliant	Yellow	28/05/2023

	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.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	28/05/2023