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:	Brabazon House
Name of provider:	The Brabazon Trust
Address of centre:	2 Gilford Road, Sandymount, Dublin 4
Type of inspection:	Unannounced
Date of inspection:	22 February 2023
Centre ID:	OSV-0000017
Fieldwork ID:	MON-0038988

About the designated centre

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

Brabazon House Nursing Home is a 51-bed centre providing residential and convalescent care services to males and females over the age of 18 years. The service is nurse-led by the person in charge and delivers 24-hour care to residents with a range of low to maximum dependency needs. Admissions are primarily accepted from people living in the sheltered accommodation apartments in Brabazon Court and Strand Road, although direct admissions to the centre are accepted, in exceptional circumstances, subject to bed availability. The building is an original Edwardian House (circa 1902) that has been extended and refurbished while retaining some of its older features. It is located in a quiet road just off the Strand Road close to the strand and Dublin Bay. Local amenities include nearby shopping centres, restaurants, libraries and parks and also the strand. Accommodation for residents is across two floors. The centre contains 40 single bedrooms of which 34 have en-suite facilities. There are also three twin and two three bedded rooms. Communal facilities include assisted shower bathroom and toilets, dining room, two sitting rooms, an activity room, sensory room and a library. There are small rest areas situated on the ground floor at reception and on the first floor outside the hairdressing room which residents and visitors can enjoy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

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
Wednesday 22 February 2023	09:20hrs to 17:45hrs	Bairbre Moynihan	Lead
Thursday 23 February 2023	09:00hrs to 16:30hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

Overall, on the day of inspection, the inspector observed residents being supported to enjoy a good quality of life by staff who were kind and caring. Residents expressed that they were happy in the centre and were particularly complimentary about the care they received and the staff. However, a number of residents expressed their dissatisfaction with the food to the inspector.

The inspector arrived to the centre in the morning to conduct a two day unannounced inspection to monitor ongoing regulatory compliance with the regulations and standards. The inspector was greeted by the person in charge and following an introductory meeting completed a walkaround of the centre.

The centre is registered to accommodate 51 residents with 48 residents on the days of inspection. The centre is laid out over two floors divided into seven different areas - Pax, Lower Brabazon and Lower Kerr on the ground floor and Upper Pax, Upper Brabazon, Upper Albert and Upper Kerr on the first floor. The centre had 39 single rooms with 34 en-suite rooms, three twin rooms and two triple rooms. Not all rooms were en-suite and not all en-suites contained a shower. Three rooms included a separate sitting room in their layout. Residents' rooms were personalised with their furniture and belongings from home creating a homely feel. Communal showering and bathing facilities were available for residents. The ground floor contained a dining room, day room, sitting room, library and snoezelen. The snoezelen was not designed for use as a snoezelen but was used by activities staff for providing one to one activities with residents and this was observed by the inspector on both days of inspection. Upstairs there was a small open plan seating area. In addition, the centre had a dedicated hairdressing salon. The hairdresser attended on Tuesdays and Wednesdays but had not attended the week of inspection due to an ongoing outbreak. Residents expressed to the inspector that they could not wait for the hairdresser to return to the centre.

The registered provider had employed three activities co-ordinators. Activities were provided seven days a week. Activities observed included a sensory activity with multiple residents and one to one activities. Residents described poetry that they had done the previous evening and knitting that had taken place on the previous Thursday and a movie night was planned for that evening. A resident informed the inspector that hats knitted by the residents were provided to a local organisation and sold to raise funds. The activities timetable was on display on notice boards in the centre. However, the inspector was informed that activities were mainly focused on residents with dementia. A number of residents were observed during the two days sitting in the sitting room for long periods watching the tv or reading newspapers. WIFI was available for residents if they required it. The inspector was informed that a bus was provided to bring residents to church on Sundays.

The registered provider had established a "Brabazon Trust Advisory Committee" which included a small representation from Brabazon House and residents from the

sheltered housing. This committee met monthly and was attended by the chairperson of the board and the chief executive officer. However, only one resident and one resident representative represented the residents of Brabazon House. The inspector was informed that the representatives seek feedback from residents prior to the meeting. Issues raised included residents' privacy in the centre and that communication to residents could be improved and made more effective. Outside of this meeting no other meeting was held where all residents' voices could be heard. The inspector was informed that a resident satisfaction survey was completed early in 2023. Management stated that the feedback was not onsite at the time of the inspection as the feedback was given to an external provider to collate it. Outside of this a catering survey was completed in 2022.

The dining experience was observed. The majority of the residents attended the dining room or residents requiring assistance attended the day room. Residents were observed to be chatting amongst each other, with staff or quietly enjoying their meal. Residents who required assistance were provided with it in a discreet manner and there were a number of staff available in both areas to provide assistance. Residents were provided with a choice at mealtimes but residents were not complimentary about the food. Residents expressed to the inspector that the food was not hot enough and the choice at tea time needed improvement as alot of the food was fried. On Thursday mornings male residents had an option of having a "men's breakfast." This was observed and attended by a small number of men who were enjoying a traditional Irish breakfast.

Visiting was restricted at the time of inspection due to an ongoing outbreak. Visitors were observed in the centre. They were required to make a booking with a 20 minute restriction. This will be discussed under Regulation 11: Visits.

The next two sections of the report present the findings of this inspection in relation to governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This unannounced inspection was carried out to assess the overall governance of Brabazon House and to identify if actions outlined in the compliance plan from the infection control focused inspection from May 2022 had been completed and improvements sustained. Overall, the inspector found that the a number of areas were actioned for example; the number of housekeeping staff in the centre had increased and two handwash sinks were installed on the first floor. However, some areas still required action. For example; the compliance plan indicated that staff were rostered for infection prevention and control training which was scheduled to be completed by 30 September 2022, however significant gaps in this training were identified on inspection. Areas of non-compliance were identified on inspection under Regulations 23: Governance and Management, 16: Training and staff

development, 27: Infection Control and 28: Fire Precautions. Following the inspection an urgent action plan was issued requesting assurances around fire safety. A satisfactory response was received.

The registered provider had a condition on the registration of the centre that "the three bedrooms (Rooms 114, 119 & 120) that are only accessible by either steps or a chair lift may only be occupied by residents who undergo professional assessment in relation to their safe use of the steps and chair lift. This condition is subject to ongoing professional assessment as part of the care planning process as required by the residents changing needs or circumstance and no less frequently than four monthly intervals". The inspector identified that the assessments on residents occupying these rooms were not completed. This will be discussed under the domain of Quality and Safety.

The Brabazon Trust was the registered provider for Brabazon House. Oversight of the centre was provided by a committee. The committee met monthly and the person in charge provided a monthly report to the committee. Meeting minutes reviewed identified that the person in charge provided an update on the residents, staff, training, COVID-19 and activities in November 2022. The inspector was informed that incidents, complaints, metrics and key performance indicators were also discussed, however, this report was not available with the minutes. The inspector was shown a copy from a previous meeting in April 2022 which provided for example; a breakdown of the falls in the centre for that month and previous months.

The person in charge had commenced in the role in November 2022. She had the required management experience and experience of nursing older persons, however, a gap was identified in the post registration management qualification. At the time of inspection the person in charge was completing the required course. The person in charge reported to the chief executive officer. Brabazon House had a general manager onsite who worked alongside the person in charge. These roles also included the oversight of residents in sheltered housing onsite which had a further 55 residents. The person in charge was supported in the role by two clinical nurse managers, staff nurses, healthcare assistants, activities co-ordinators and maintenance staff. The registered provider had outsourced housekeeping and the catering to external providers. One staff nurse was rostered daily to the sheltered housing units and a member of the housekeeping staff attended to the sheltered housing following completion of cleaning in the nursing home.The inspector was informed that the assistant director of nursing post was replaced by a clinical nurse manager role so both clinical nurse managers could provide oversight and management on alternate weekends. It was identified on inspection that the staffing was not in line with the most recent statement of purpose that was submitted to the Office of the Chief Inspector. Management stated that they were at full complement and that staffing numbers provided in the statement of purpose was the overall headcount as opposed to the wholetime equivalents. An updated statement of purpose is required which provides clarity on the staffing in the centre.

Staff had access to mandatory training including manual handling, safeguarding and medication management, however, gaps were identified in the training which will be

discussed under Regulation 16: Training and staff development

The inspector reviewed a sample of staff files. Of the files reviewed all staff had up-to-date Garda (police) vetting in place and the professional registration for nursing staff where required was available. Gaps in the employment history in three out of the five staff files reviewed was identified.

The registered provider had a suite of audits in place. These were completed generally monthly until approximately September 2022 except for a restraint audit completed in December 2022. Audits included falls audit, restraint audits and wound audits. Audits had not been completed for 2023 to date. Audit results did not in all cases contain recommendations and in some cases the audit results were the same each month indicating that the issues identified remained. Furthermore, the last environmental audit/infection control audit completed was in November 2022. The inspector was informed that issues identified were discussed with staff however, no timebound action plan accompanied it and no re-audit was completed to ensure the areas were addressed.

The registered provider had completed an annual review of the quality and safety of care aligned to the National Standards for Residential Care Settings for Older People in Ireland. The annual review indicated that training needed to be scheduled when Covid lockdown restrictions permitted it. However, there were no lockdown restrictions in 2023 and for much of 2022. Systems of communication were in place between the committee and the person in charge, however, only one staff meeting was held in 2022 and one to date in 2023. Similar to findings on inspection, meeting minutes identified the need for residents to have a recreation plan if not attending activities in the day room. However, no timebound action plan accompanied the meeting minutes. The registered provider had completed a number of risk assessments. Risks assessed included safeguarding, smoking and infection prevention and control risk assessment. However, the oversight of risk required review as risks identified on inspection had not been identified and risk assessed. Tracking and trending of some incidents was taking place for example; falls though audit, however no trending of other incidents such as medication incidents was completed and learning shared. Not withstanding this all incidents that met the criteria for reporting to the Office of the Chief Inspector were notified within the required timelines.

Complaints were managed in line with the regulation and centre's own policy. The complaints procedure and policy required updating with the name of the current person in charge.

Regulation 14: Persons in charge

The person in charge did not meet all the requirements under the regulation. Specifically, the person in charge did not have a post registration management qualification in health or a related field. At the time of inspection the person in

charge had commenced a Quality and Qualifications Ireland (QQI) level 6 course.

Judgment: Substantially compliant

Regulation 15: Staffing

The centre had sufficient staffing on the day of inspection taking into account the assessed needs of the residents and the size and layout of the designated centre. For example; on day one of inspection the centre had the person in charge who was supernumery, four staff nurses were rostered with three on duty and fourteen healthcare assistants. Two staff nurses and four healthcare assistants were rostered at night. In addition, there were five housekeeping staff on duty who worked from 7am - 3pm.

Judgment: Compliant

Regulation 16: Training and staff development

Significant gaps in training and staff development were identified:

- 38 staff had not completed fire training within the last year. The inspector was informed that fire training was planned for March 2023.
- 14 staff had not completed safeguarding training.
- 10 staff had not completed training in managing behaviours that challenge.

Judgment: Not compliant

Regulation 21: Records

Three out of five staff files reviewed had gaps in their employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

The assurance systems in place were not robust enough to be assured of the quality and safety of care. For example:

- A fire safety risk assessment completed and received by the provider in November contained a number of orange and red rated risks. No time bound action plan was completed and it was unclear what risks had been addressed.
- The centre had experienced a number of outbreaks over the last year. No outbreak reports were completed following the outbreaks and therefore no learning was derived and shared with staff.
- Issues identified through complaints from residents about the food were ongoing. Management stated that they had engaged with the external company to try and improve the food.
- No audits had been completed to date in 2023. Furthermore, recommendations from audits were similar to previous months indicating that the issues had not been addressed or in some cases audits did not contain recommendations or actions plans.
- Tracking and trending of all incidents was not taking place. For example; staff had identified in July 2022 that there was an increase number of falls and skin tears but there was no evidence to suggest that this was reviewed and actions identified to address these observations.
- One staff meeting had taken place in 2022.
- Risks identified on inspection such as the infrastructure, outbreak management and the risk of unauthorised entry of residents from the sheltered housing had not been risk assessed.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents set out in schedule 4 of the regulations were notified to the Office of the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display at the entrance to the centre. This identified the person in charge as the nominated person to investigate complaints. The complaints log was reviewed. The provider had received a small number of complaints since the last inspection. A review of these showed that complaints were recorded, investigated and the satisfaction or otherwise of the complainant was recorded. In addition, the provider had an up-to-date complaints policy in place.

Judgment: Compliant

Quality and safety

Overall, while the centre was working to sustain a good level of person-centred care provision, deficits in the governance and management of the centre were impacting on key areas such as infection control, fire precautions, care planning, management of behaviours that challenge and residents' rights. Improved oversight of these areas is required to ensure a consistent safe service which supports best outcomes for residents.

Inspectors found that the healthcare needs of residents were met through good access to access to medical and other healthcare services if required. There was evidence from the review of resident's files of reviews by for example; physiotherapists, dietitian and general practitioner.

Visiting was restricted at the time of inspection on public health advice. Visitors were observed in the centre and visitors were complimentary about the care their relative/friend was receiving. The centre had identified the library as a designated visiting room. In addition, as discussed above a small number of residents in the centre had adjoining sitting rooms with their bedrooms.

The centre was generally well maintained with few exceptions. Corridors were narrow but clutter free with assistive handrails throughout. The centre had carpets in all communal areas and in some bedrooms The registered provider was in the process of gradually replacing carpets in resident bedrooms. Steam cleaning of these were taking place six monthly. On the days of inspection, the centre was generally clean. The infrastructure of the onsite laundry supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and tidy. However, the centre had five outbreaks of infection since the last inspection in May 2022. Three of the outbreaks were large outbreaks and included acute respiratory infection, COVID-19 and a gastroenteritis outbreak. While it may be impossible to prevent all outbreaks, a review of the notifications submitted to HIQA indicated that management had not successfully contained all the outbreaks in a timely manner to limit the spread of infection within the centre. No outbreak reports were completed following any of the outbreaks and while a sheet with learning was provided to the inspector this was overall learning around COVID-19. These were lost opportunities for learning. The centre had appointed a nurse as an infection prevention and control liaison. The inspector was informed that the role included surveillance, education and liaising with cleaners. This role had only commenced in November and no protected time for this role was provided. Further areas for action are discussed under Regulation 27: Infection control.

As discussed under capacity and capability significant gaps were identified in fire precautions. An urgent action plan was issued following the inspection. Quarterly servicing of emergency lighting and yearly servicing of fire extinguishers were completed. However, gaps were identified in the servicing of the fire alarm system. Management stated that this was due to outbreaks in the centre. In addition, documentation reviewed indicated that the fire alarm system was an L2/L3 system

but additional documentation reviewed stated it was an L1 system. Further clarification on this is required.

A variety of validated assessment tools were used to assess the residents' individual needs. These assessments informed the residents' care plans and were easy to understand. Care plans were person centred and updated four monthly in line with regulations or more frequently where required.

The use of bedrails in the centre was low. On the day of inspection four residents had bedrails. Safety checks were in place and risk assessments were completed. However, while a consent was completed for the bedrails it was documented that three out of the four residents had requested the bedrails but the resident was not included in the consent form. Furthermore other practices in the centre for example; the door to the external garden was always locked had not been identified as a restrictive practice. This will be discussed under Regulation 7.

Residents were observed to be freely mobilising around the centre, interacting with staff and residents. Residents were provided with a choice at mealtimes, however, complaints reviewed and discussions with residents indicated that residents were not satisfied with the food offered. A catering survey was undertaken in October 2022. 12 out of the 51 residents responded to the survey. Eight out of the 12 residents rated the food as good, however, 3 residents rated the food as average, poor or unhappy. Four residents were unhappy with the temperature of the food which was a similar finding on the day of inspection. One comment suggested that a meeting take place to provide suggestions, however, no meeting had taken place at the time of inspection. Furthermore, no time bound action plan accompanied the survey. Management stated at the feedback meeting that they were aware of the issues and that they had emailed the external company.

Regulation 11: Visits

The inspector was informed that visiting had been restricted to a nominated visitor by public health due to an ongoing outbreak in the centre. The visitors were required to make an appointment and it was restricted to 20 minutes per visitor. Management stated that they had implemented a 20 minute visiting restriction and it was not on the advice of public health. This decision was based on evidence from the early stages of the COVID-19 pandemic and a risk assessment was not completed in the context of the ongoing outbreak balanced with the rights of residents. Furthermore, while the visiting policy was dated as being up to date, it referenced visiting guidance from 2020.

Judgment: Substantially compliant

Regulation 17: Premises

While the centre was generally well maintained improvements were required in order to ensure compliance with schedule 6 of the regulations. For example:

- The nurses' station was both a clinical and administrative room. Residents' wound dressings were attended to in the room where residents' files, folders and nurses updated their clinical notes.
- The assisted bathroom (room 021) had exposed wiring exiting a wall above a mirror. This was brought to managements' attention on the day.
- The flooring in the dining room was uneven and damaged in places. This posed a falls risk to residents. This was highlighted on the inspection in May 2022 and meeting minutes reviewed indicated that costings had been completed with a view to replacement but the current flooring remained.
- The storage room in Upper Pax required review as it was overstocked, with stock stored on the floor and untidy.

Judgment: Substantially compliant

Regulation 27: Infection control

While the inspector observed that the centre was generally clean on the day of inspection, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example:

- In the context of an ongoing outbreak, a chlorine based solution was not being used on all surfaces.
- Oversight of staff practices with standard and transmission based precautions were required as breaches in these were identified on the days of inspection.
- Signage indicating that a resident was isolating required updating in line with current infection prevention and control guidelines.
- 39 Staff had not completed infection control training within the last year. This is concern in the context of a centre that had multiple outbreaks over the course of 2022 and early 2023.
- The inspector was informed that no outbreak reports had been completed following previous outbreaks. As a result staff were vague on the specific learning from outbreaks.
- The registered provider had identified a nurse who would lead out on infection control, however, no protected hours were provided for this role. This role was evolving at the time of inspection and further training was required to fulfil this role.
- The sluice room on the first floor required review as for example multiple bed pans were not inverted and the sluice room contained no clinical waste bin.
- Wound dressings including open, but unused portions of wound dressings were stored together on a dressing trolley. This posed a risk of cross contamination.

- Similar to findings from the last inspection hoist slings were stored together in a hoist store room. Furthermore, the hoist was cleaned once weekly and not after each resident use. This is not in line with the centre's own infection control policy.
- Hand hygiene sinks were installed since the last inspection, however, none of the hand hygiene sinks were in line with the required specifications.

Judgment: Not compliant

Regulation 28: Fire precautions

Significant action was required to ensure residents were adequately protected from the risk of fire. For example:

- A time bound action plan was not devised following the receipt of fire safety risk assessment (FSRA) report received in November 2022. This FSRA contained a number of red and orange rated risks.
- Documentation reviewed had conflicting information regarding the type of fire alarm system in place.
- A number of fire doors did not fully close or were identified as being slow to close on inspection. These were highlighted to the person in charge at the walk around on the first day of inspection. Furthermore, one of these was identified in the FSRA and had not been addressed. In addition, records identified that fire doors were checked weekly however, issues around the fire doors were not identified in the weekly checks.
- Daily checks of for example; means of escape were not consistently completed daily. In January eight days were identified by the inspector where the daily checks were not completed.
- While the inspector was informed that fire drills were taking place weekly there was inadequate detail in the fire drills to provide assurances that staff could evacuate residents in a timely manner in the event of a fire, both during the day and at night. In addition, management stated that no fire drill had taken place of the largest compartment with night-time staffing levels.
- The fire alarm required quarterly servicing. The alarm was serviced twice in 2022 and twice in 2021. The inspector was informed that the maintenance was unable to be conducted as required due to infection outbreaks in the centre.
- Fire training was discussed under Regulation 16: Training and staff development.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While care planning was generally person centred and assessments completed, areas for action were identified:

- As discussed under capacity and capability, the registered provider had a condition on their registration. Residents' care plans and health and social care provider records of residents who occupied the three rooms were viewed by the inspector and there was no evidence that ongoing professional assessment as part of the care planning process at a minimum of four monthly intervals was completed or more frequently if the residents needs changed.
- Wound assessment charts were not completed in two out of four wounds observed in resident files.
- A resident's occupational and recreational therapy care plan was dated Decemeber 2022, however, it referenced visiting arrangements were window visits and communication with family through a video call. This is not in line with what was observed on the day of inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to general practitioners. One attended onsite on a Wednesday and one on a Thursday. The general practitioners were available by phone and attended onsite if required outside of the weekly visit. Out of hours an on call service was used. A physiotherapist attended weekly and a dietitian twice monthly which had been recently increased from once monthly. An occupational therapist attended on request. Residents incurred no costs for these services. Speech and language therapy was by referral and a member of staff from the HSE attended onsite. Residents had access to the frailty team from a local acute hospital and reviewed residents onsite if requested to by the general practitioner.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While the registered provider had some good practices in place around managing behaviours that challenge, the inspector observed that further actions were required:

- Three residents were administered a PRN (as required) psychotropic medication. The resident's daily nursing narrative indicated that the residents were displaying behaviours that challenge but the narrative did not always

indicate what alternative de-escalating techniques were used. In addition, ABC (Antecedents, Behaviour and Consequence) charts were not completed on two out of the three episodes reviewed. This is not in line with the centre's own policy.

- While the general practitioner, person in charge and a staff nurse signed a consent form for residents' bed rails, the resident did not sign the consent and there was no evidence that the resident consented to it other than it was documented in three cases on the consent form that the resident requested the bed rails.
- Residents were unable to freely move between the centre and the enclosed garden. This door was always locked and staff had to unlock it if a resident wished to mobilise in the garden. Furthermore, this form of restraint was not notified to HIQA as required by regulation 31.
- The centre's policies on challenging behaviours and restrictive practices was out of date since August 2022.
- Gaps in staff training in managing behaviours that challenge are discussed under Regulation 16: Training and staff development.

Judgment: Not compliant

Regulation 9: Residents' rights

Actions were required by the registered provider to ensure residents' rights were respected:

- No residents' meetings had been held in the centre where all residents were included and consulted about the organisation of the centre.
- One catering survey was completed in 2022 however, no time bound action plan accompanied the survey. Furthermore, no overall satisfaction survey was available for review on the day of inspection. Management stated that a satisfaction survey was just completed and was being collated externally.
- While activities were taking place on both days of inspection, activities were targeted towards a specific co-hort of residents and activities were not available for the remaining residents so they could have the opportunity to participate in activities in accordance with their interests and capabilities.

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 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brabazon House OSV-0000017

Inspection ID: MON-0038988

Date of inspection: 23/02/2023

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The PIC has commenced a Quality and Qualifications Ireland (QQI) level 6 course Leadership Training. Completed on 23rd March 2023. Provisional results will be available in April 2023 on request from Skillnets. QQI Certificate will be awarded in June 2023	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · Fire training in progress – 6 sessions completed (24/2,28/2, 7/3,8/3,16/3,21/3) – total 52 staff. Remaining staff due will also complete the Fire training on site by the 1st week of May 2023, which includes, Maintenance, Kitchen and the Cleaning staff). · Safe Guarding Residents – valid for 2 years – last done in Nov 2021 – online trainings will be done by all staff by the end of May 2023. · Managing Challenging Behaviour training – Dates scheduled in May/June 2023 (to be confirmed). Infection Control training scheduled for 26/4 (on site); online HSE Land trainings will be completed by all staff by the mid of May 2023 (ARMIC Basics of IPC; ARMIC Standard and transmission-based precautions)	

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: · Staff records are being reviewed and all gaps in CVS will be filled in the employment history, which is ongoing and will be completed by end of April 2023.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: ·· Fire Risk Assessment Report Action Plan (time bound) completed with expected completion dates and status · Outbreak reports prepared and circulated to all staff – agenda item at staff meeting on 31/3 · Copies of outbreak reports kept in the carers folder for them to read – discussed in staff meetings and daily reports. · Reporting and documenting will be continued in monthly staff meetings – scheduled for last Friday of each month – next 31/03 and will be continued on the last week of the month. · Chairman and RPR met with Catering Providers on 21/3 – Brabazon Catering Action plan (time bound) in place, including food quality, portion size, IDDSI evening, meal times, menu cycle, feedback, EHO constraints. · Monthly and quarterly review meetings with Catering Provider confirmed. · All audits will be completed by the end of every month and issues identified will be discussed in the staff meetings, recommendations for improvement will be discussed and recorded in the minutes of the staff meetings and reported in the committee meetings. Same will be recorded in the audit reports with an action plan and compared to the previous report as a follow up to see if there is a need for further improvement. · Staff meetings are held monthly during the last week of each month. Minutes of the meeting are recorded and filed. · Risks assessments have been made in relation to infection prevention and control and there is a contingency plan in place to manage an outbreak situation. A copy is available in the Nurses station for guidance and instruction. · Residents from the Sheltered Housing are authorized to come to the Marquee for their meals in the afternoon. They do not come in close contact with residents in the Nursing Home during an outbreak situation. They are kept informed when necessary and advised to comply to the regulations as per guidelines of The Department of Health.	

Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: · Visiting Policy (including Covid-19) reviewed 16/03/23 – 'in such times as Covid-19 Pandemic, Outbreak of Infection, the clinical needs of all our residents must take priority over any individual personal requests.' · Visitors are allowed freely to visit residents in their rooms or in library as per policy Regular visitors are allowed visiting residents and all HSE guidelines will be followed as per the advice of Department of public health in an outbreak situation.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: · Daily inspection of floors – repairs completed in dining room to prevent risk of falls. · Dressings will be done in resident's rooms and not in nurses' station. · The wiring in the assisted bathroom (Room 021) was tidied up on 23/02/2023. Storage room in the upper pax tidied up with limited stocks and an on going checking for stock is put in place every month.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: · · Cleaning staff/supervisor trained re using chlorine-based solutions on all surfaces during the time of outbreak · Clinical floor supervision by managers is ongoing on daily basis to oversee staff practices are in line with standard precautions and transmission-based precautions · Signage/posters in accordance with IPC guidelines · IPC training will be done online via HSE Land and completed by end of April 2023 by all staff and produce certificates for filing · Outbreak reports prepared and circulated to all staff – agenda item at staff meeting on 31/3 · Copies of outbreak reports kept in the carers folder for them to read – discussed in staff meetings and daily reports · Learnings discussed in daily reports and staff meetings · IPC training completed – policy to be completed by end of April 2023. Protected 12 hours will be provided every week on the rostered hours for this role. · Hoist slings are stored on separate hooks to prevent cross contamination and hoist and	

the slings are disinfected after every use. The slings used are labelled for each resident.
· The issues with the sluice room have been addressed by putting in a checklist and being checked twice a day and being signed off by cleaning Staff.
· CH06 Covid Response Team & ex DON, visited Brabazon on Thursday 9th March 2023 and completed a walk through with PIC. All areas were reviewed and actions taken immediately where required for infection control purposes.
· PIC from a sister concern Nursing Home had a made a sweep of the floor to audit the place and recommendations for improvement in areas of IPC were addressed and acted upon immediately.
· An IPC specialist has been contacted to carry out an inspection and audit – and to provide a report
-date and time will be scheduled in the month of May 2023
· Hand hygiene sinks are now in line with the required specification and the stoppers have been removed

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
· Fire Risk Assessment Report Action Plan (time bound) completed with expected completion dates and status
· All fire doors surveyed and report completed. Action plan being developed
· Identified fire doors closure attended to
· Daily checks on Fire registry completed and recorded- on going daily basis
· Fire evacuation drills in progress- 6 sessions completed on different compartments based on night time and day time scenarios, training staff to use the evacuation aids effectively- still ongoing as a part of evacuation drills
· The fire alarm required quarterly servicing. The alarm was serviced twice in 2022 and twice in 2021. The inspector was informed that the maintenance was unable to be conducted as scheduled and required due to infection outbreaks in the centre and also in the provider organisations.
· The Alarm System Provider has confirmed that the Brabazon House fire alarm system is an L1 compliant system, with the exception of some bathrooms.

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:
· Residents in three rooms where there is a chair lift have been assessed by

physiotherapist and 4 monthly reviews scheduled. Residents will be assessed if there is a decline in their general health condition or with low mobility levels
· Wound assessment updated for those identified. Wound assessments are carried out as required and will be documented when a dressing is done.
· All care plans pertaining to recreational and occupational therapy were reviewed and is online with the current status of the resident. All assessments and care plans are reviewed every 4 months and when necessary

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
· Antecedent Behaviour & Consequences (ABC) chart completed for residents who have challenging behaviours and when PRN medication is required
· Restraint consent form reviewed and updated to include resident signature - by those who request bed side rails for safety
· Policies on Challenging behaviours and restrictive practices were reviewed- 16/03/2023
· The residents have free movement between the centre and the garden through the Dining room door, access through the day room is supervised by staff
Staff training is for 2 years – last session in March 2022 – 27 staff are scheduled for training in May 2023

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
· Nursing Home Residents meeting held on 06/3 – all outcomes recorded
· The Brabazon Trust 2023 Service Satisfaction Survey completed and results collated. Time bound action plan to be finalised by 30/4
· Catering survey report – time bound action plan being included in the catering action Plan
Activities schedule and plan for 2023 being reviewed – to be confirmed 30/04

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	16/03/2023
Regulation 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	30/06/2023
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	31/05/2023

	ensure that staff have access to appropriate training.			
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.	Substantially Compliant	Yellow	01/04/2023
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	30/04/2023
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	31/05/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Not Compliant	Orange	31/05/2023

	published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	31/10/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/10/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	01/04/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire	Not Compliant	Orange	31/05/2023

	alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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.	Not Compliant	Orange	31/05/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	31/05/2023
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	Substantially Compliant	Yellow	01/04/2023

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	31/05/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/04/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/05/2023
Regulation 9(2)(b)	The registered provider shall provide for	Substantially Compliant	Yellow	01/04/2023

	residents opportunities to participate in activities in accordance with their interests and capacities.			
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	01/04/2023