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:	Brookhaven Nursing Home
Name of provider:	Brookhaven Nursing Home Limited
Address of centre:	Donoughmore, Ballyraggett, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	13 February 2024
Centre ID:	OSV-0000207
Fieldwork ID:	MON-0042620

About the designated centre

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

Brookhaven Nursing Home is situated in the village of Ballyragget, seven kilometres from the town of Durrow, Co. Kilkenny. The centre is registered to accommodate 71 residents, both male and female. It is a two-storey building but resident's accommodation and facilities are located on the ground floor; the staff learning hub is located upstairs. Residents' accommodation comprises single and twin bedrooms with en-suite shower and toilet facilities, two dining rooms, an activities room, sitting rooms and a sun room. There are comfortable seating alcoves throughout the centre and toilet facilities are strategically located for residents' convenience. Residents have access to five enclosed garden areas with seating and walkways. Other facilities include the main kitchen and a laundry. Brookhaven provides full-time nursing care for people with low to maximum dependency assessed needs requiring long-term residential, palliative, convalescence and respite care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

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 13 February 2024	09:00hrs to 17:15hrs	Mary Veale	Lead
Wednesday 14 February 2024	08:50hrs to 17:00hrs	Mary Veale	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. Based on the observations of the inspector, and discussions with residents, staff and visitors, Brookhaven Nursing Home was a nice place to live. There was a welcoming and homely atmosphere in the centre. Residents' rights and dignity was supported and promoted by kind and competent staff. The inspector spoke with ten residents in detail, two visitors and groups of residents on the two days of inspection. All residents were very complimentary in their feedback and expressed satisfaction about the standard of care provided. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities and they were supported by a kind and dedicated team of staff. Residents' stated that they were well looked after and that the staff were always available to assist with their personal care.

On arrival the inspector signed the centres visitors' book and was greeted by a member of the centres administration team. The inspector met the person in charge and the assistant director of nursing. Following an introductory meeting with the person in charge and the assistant director of nursing to outline the format of the inspection, the inspector walked the premises with the assistant director of nursing. The centres clinical operations manager attended the centre on the afternoon of the first day of the inspection and remained for the duration of the inspection to support the staff in the centre. The registered provider representative attended the centre on the morning of the second day of the inspection.

Brookhaven Nursing Home is a two story designated centre registered to provided care for 71 residents on the outskirts of the village of Ballyragget, in County Kilkenny. There were 63 residents living in the centre at the time of inspection. Bedroom accommodation consisted of 61 single and five twin bedrooms, all with en-suite wash hand basin, toilet and shower facilities. The privacy and dignity of the residents in the multi-occupancy rooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings. The centre was divided into four wings which were called after local areas, the Attanagh wing, Donoughmore wing, Kilminan wing and Rosconnell wing. The inspector observed that bedrooms had ample storage space, some bedrooms had flat screen televisions and all had lockable locker storage. Many of the residents' bedrooms had fresh jugs of water. Some bedrooms were personal to the resident's containing family photographs and personal belongings. Pressure reliving specialist mattresses, falls injury prevention mats and other supportive equipment was seen in residents' bedrooms. Assistive call bells were available in both the bedroom and en-suite for residents' safety. The first floor of the building was not part of the designated centre. The first floor contained the centres administration office and staff accommodation.

Overall, the inspector observed that the premises was laid out to meet the needs of the residents. There were appropriate handrails and grab rails available in the

bathrooms areas, and along the corridors, to maintain residents' safety. The corridors were sufficiently wide to accommodate walking aids and wheelchairs. The building was well lit, warm and adequately ventilated throughout. Residents on each unit had access to communal space which included day rooms, lounge and sitting rooms. Armchairs were available in all communal areas and corridor alcove areas. Residents had access to a large reception area, two large dining rooms, an oratory, visitor's rooms, an aromatherapy room and a hair salon. The centres production kitchen, laundry, staff changing facilities and maintenance rooms were situated to the rear of the centre. There was an indoor smoking room for residents who chose to smoke. There was an on-going schedule of works taking place to upgrade the premises. Alcohol hand gels were available throughout the centre to promote good hand hygiene practices.

Residents had access to enclosed courtyard garden areas from all units and an outdoor space to the front of the building. The courtyards had level paving, comfortable seating, tables, and flower beds. The inspector was informed that residents were encouraged to use the garden spaces.

The inspector observed the residents spending their day moving freely through the centre from their bedrooms to the communal spaces. Residents were observed engaging in a positive manner with staff and fellow residents throughout the days and it was evident that residents had good relationships with staff and residents had build up friendships with each other. There were many occasions throughout the days of inspection in which the inspector observed laughter and banter between staff and residents.

The inspector observed many examples of kind, discreet, and person- centred interventions throughout the days of inspection. The inspector observed that staff knocked on resident's' bedroom doors before entering. Residents very complementary of the person in charge, staff and services they received. Residents' said they felt safe and trusted staff.

All residents whom the inspector spoke with were very complimentary of the food and the dining experience in the centre. Residents' enjoyed homemade meals and stated that there was always a choice of meals, and the quality of food was excellent. The daily menu was displayed on a large easy to read board in both dining rooms along with a detailed four week menu. There was a choice of two options available for the main meal. The inspector observed the dining experience for residents in the oak dining room on the first day of inspection and ash dining room on the second day. Improvements were observed in the dining experience, both dining rooms were decorated in the style of fine dining which included white linen table cloths on all tables. The meal time experience was quiet and was not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times. The inspector observed home made soup and home baked snacks been offered to residents outside of meal times.

Residents' spoken with said they were very happy with the activities programme in the centre and some preferred their own company but were not bored as they had access to newspapers, books, radios and televisions. The weekly activities

programme was displayed on notice boards on all units. Some residents told the inspector that could leave the centre to go into the local town with their families if they wished. The inspector observed residents reading newspapers, watching television, listening to the radio, knitting and engaging in conversation. Residents, were observed to enjoy friendships with peers throughout the days of inspection. On the first day of inspection, residents were observed attending live streamed mass, playing board games and enjoying pancakes on pancake Tuesday. On the second day residents were observed attending the hair salon and a small group visited Kilkenny castle. On both days of inspection, the inspector observed a visiting dog accompanied by a staff member. Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved.

The centre provided a laundry service for residents. All residents' who the inspector spoke with on the days of inspection were happy with the laundry service and there were no reports of items of clothing missing.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the regulations and standards. The inspector found that this was a well-managed centre where the residents were supported and facilitated to have a good quality of life. The provider had progressed the compliance plan following the previous inspection in June 2023, and some improvements were found in Regulation 27: infection prevention and control. Repeat substantially compliant findings were found with regard to;

- Regulation 27: Infection prevention and control
- Regulation 28: Fire procedures.

On this inspection, the inspector found that actions were required by the registered provider to address areas of Regulation 5: individual assessment and care planning, Regulation 17: premises, Regulation 23: governance and management, Regulation 27: infection prevention and control, Regulation 28: fire precautions and Regulation 34: complaints procedure. The inspector also followed up notifications submitted to the office of the Chief Inspector of Social Services since the previous inspection.

Brookhaven Nursing Home Limited was the registered provider for this centre. At the time of inspection there were four directors in the company. The office of the Chief Inspector had been notified of changes to the company directors in December 2023. At that time a new chief executive officer has been appointed who was the registered provider representative. The centre was part of a group of five nursing

homes and had access to group resources, for example; finance, human resources and facilities management. The person in charge was supported by a team of consisting of an assistant director of nursing, a clinical nurse manager, registered nurses, health care assistants, kitchen staff, housekeepers, activities staff, administration and maintenance staff. Since the previous inspection, changes had been made to the management structure and the person in charge had support from a clinical operations director who attended the centre one day a week. On the first day of inspection the inspector was informed that the post of regional manager was vacant but a person had been appointed and was expected to commence in the role in the weeks following inspection. There were good management systems in place to monitor the centre's quality and safety. There were clear reporting structures and staff were aware of their roles and responsibilities. There was a stable management team in the centre.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a staff team who were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences. The inspector was informed on the first day of inspection that nursing staff were covering health care assistant hours as the centre was not fully occupied. However, improvements were required in staff resources in the centre as staffing levels were not in accordance with the centre's statement of purpose. This is discussed further under Regulation 23: governance and management.

There was an ongoing schedule of training in the centre. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, management of challenging behaviour, and infection prevention and control. Staff whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. Staff had access to an online training platform to support them with their training and development, this included modules such as infection prevention and control, health and safety and palliative care training. Staff were supervised by the person in charge, the assistant director of nursing and the clinical nurse manager. The inspector noted that restrictive practice training took place in the centre on the first day of inspection. There was a schedule for staff annual appraisals and 41 staff had undertaken an annual appraisal since the beginning of 2023. New staff were supported with a comprehensive induction programme and agency staff were supported with an induction form which included fire safety and emergency procedures.

Records and documentation, both manual and electronic were well presented, organised and supported effective care and management systems in the centre. All requested documents were readily available to the inspector throughout the days of inspection. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff.

Improvements were required in staffing resources to ensure a safe, appropriate, consistent and effective service was provided in the centre. The centre had an extensive suite of meetings such as local management meetings, head of department meetings and staff debriefing meetings. There were high staff attendance at meetings in the centre. Meetings took place monthly in the centre. Meeting records were detailed containing agenda items, discussion that took place, actions required, the person responsible and the time frame to complete the outcome of the item. The person in charge completed a weekly report which included items such as key performance indicators (KPI's), training, fire safety, actions required from audits, complaints feedback and clinical risks. There was evidence that this report was discussed at weekly governance meetings and communicated at staff handover. It was evident that the centre was striving to identify improvements and learning identified on feedback from resident's satisfaction surveys, post falls analysis, complaints and audits. Following a review of incidents of falls and complaints in 2023 an additional health care assistant was rostered on night duty. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example; care plans, restrictive practice, medication management, wound care, call bell response time, infection prevention control, and incidents of falls were completed monthly. Audits were objective and identified improvements. There was evident of trending of audit results for example; monthly audit of resident incidents of falls identified contributing factors such as the location of falls and times when resident falls occurred the most. There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2022 with an associated quality improvement plan for 2023. The annual review of the quality and safety of care to residents in 2023 was under review at the time of inspection.

The inspector followed up on incidents that were notified since the previous inspection and found these were managed in accordance with the centre's policies. Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames.

There was a complaints management policy within the centre and a complaints procedure displayed in the reception area. The complaints log for 2023 was reviewed. The inspector observed complaints had been assessed and managed promptly. Residents said they were aware they could raise a complaint with any member of staff or the person in charge. Actions were required to align the complaints procedure with SI 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations, and this will be addressed under Regulation 34 of this report.

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the days of the inspection.

The registered provider ensured that the number and skill-mix of staff was appropriate, to meet the needs of the residents. There were two registered nurses in the centre at night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. Staff were appropriately supervised and supported to perform their respective roles.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure the centre had sufficient resources to ensure effective delivery of care as the governance structure as outlined in the statement of purpose was not implemented in practice and as required under Regulation 23(a).

The statement of purpose which Brookhaven Nursing Home Limited was registered against states that there should be 30 whole time equivalent (WTE) health care attendants, 4 WTE kitchen assistants, 6 WTE household staff and 2 WTE laundry staff. On review of the duty rosters provided to the inspector on the days of inspection and calculation of WTE hours worked by all staff. The following WTE staff vacancies were identified:

- There were 7 WTE vacant health care attendant posts.
- There was 2 vacant household staff posts.
- There was 0.6 WTE vacant laundry staff post.

- There was 0.5 WTE vacant kitchen assistant post.
- The post of regional manager was vacant.

Judgment: Substantially compliant

Regulation 30: Volunteers

Volunteer's attended the centre to enhance the quality of life of residents. Volunteers were supervised and had Garda vetting disclosures in place. Their roles and responsibilities were set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The centres complaints policy and procedure required revision to meet amendments to the regulations that had come into effect in March 2023 (S.I. 628 of 2022). For example:

- The complaints procedure policy did not clearly outline the nominated complaints officer in the centre.
- The complaints procedure and policy did not include information of an independent advocacy service who could assist the complainant with the making of a complaint.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector was assured that residents living in the centre enjoyed a good quality of life. Residents health, social care and spiritual needs were well catered for. On this inspection improvements were required to comply with areas of individual assessment and care planning, infection prevention and control and fire safety.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. The centre had access to GP's from local practices and the person in charge confirmed that GP's called to the centre every week. Residents had access to a mobile dental service and optician services who attended the centre. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse to guide staff on the management of allegations of abuse. Safeguarding training had been provided to staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff whom the inspector spoke with said that they would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The provider assured the inspector that all staff working in the centre and a volunteer had valid Garda vetting disclosures in place.

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications; this was up to date and based on evidence based practice. Medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were stored securely in the centre and returned to pharmacy when no longer required as per the centres guidelines. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

Improvements were required to the centres premises, this is discussed further in this report under Regulation 17: premises. The centre was clean and tidy. Store rooms and ancillary rooms were observed to be clean and free of clutter on the days of inspection. The overall premises were designed and laid out to meet the needs of the residents. Bedrooms were personalised and residents had sufficient space for their belongings. Overall the premises supported the privacy and comfort of residents. Residents had access to call bells in their bedrooms, en-suite bathrooms and all communal rooms. Grab rails were available in all corridor areas, toilets and en-suite bathrooms.

Alcohol gel was available, and observed in convenient locations throughout the building. Dani- centres were available on all corridors to store personal protective equipment (PPE). Staff were observed to have good hygiene practices. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had

been incorporated into the regular cleaning programme in the centre. There was evidence that infection prevention and control (IPC) was discussed at staff meetings in the centre. IPC agenda items included training, actions required from specific IPC audits, for example; hand hygiene and environmental audits and findings from IPC walkabout checks carried out by the person in charge. There were records of a hand hygiene, equipment, sharps, antimicrobial and environmental audits. The centre had an antimicrobial stewardship register and the person in charge had good over sight of antibiotic usage. There was an up to date IPC policies which included COVID-19 and multi-drug resistant organism (MDRO) infections Improvements were required in infection prevention and control which is discussed further in this report under Regulation 27.

The individual dietary needs of residents was met by a holistic approach to meals. A choice of home cooked meals and snacks were offered to all residents. Daily menus were displayed in the residents' dining rooms. Menus were varied and had been reviewed by a dietician for nutritional content to ensure suitability. Residents on modified diets received the correct consistency meals and drinks, and were supervised and assisted where required to ensure their safety and nutritional needs were met. Meal times varied according to the needs and preferences of the residents. The inspector observed dining experience in the oak dining room on the first day of the inspection and the ash dining room on the second day. The dining experience on both days was relaxed and there were adequate staff to provide assistance to ensure a pleasant experience for resident at meal times. Residents' weights were routinely monitored. There were adequate staff to provide assistance and ensure a pleasant experience for resident at meal times. The catering assistant was knowledgeable about the residents' individual dietary requirements and liaised closely with the nursing team, ensuring any required changes to residents' diets were made.

The centre had a risk management policy that contained actions and measures to control specified risks. The centre had a risk register which had been reviewed and updated in December 2023. The risk registered contained site specific risks such as risks associated with individual residents and centre specific risks, for example; risk of residents falling, infection prevention and control risks and risk associated with fire safety. The risk register met the criteria set out in regulation 26.

Repeated findings were found in fire safety following the previous inspection. The centre had automated door closures to all compartment doors, all bedroom on Rosconnell wing and a small number of bedrooms on Donoughmore wing. The inspector had been informed on the previous inspection in June 2023 that the provider had employed a fire safety engineer to complete a fire door audit and that recommenced works would be undertaken to replace fire doors in the centre. A compliance plan had been submitted to the office of the Chief Inspector and works were due to be completed by the end of May 2024. The inspector was informed that a fire safety engineer was planning to attend the centre the week following the inspection to review all the fire doors. Staff had completed fire training in the centre. There was evidence of an on-going schedule for fire safety training. Effective systems were in place for the maintenance of the fire detection, alarm systems, and emergency lighting. The centres emergency lighting had been serviced since the

previous inspection. Fire doors were checked on the days of inspection and most were in working order. There was evidence that fire drills took place monthly. There was evidence of fire drills taking place in each compartment with night time drills taking place in the centres largest compartment. Fire drills records were detailed containing the number of residents evacuated, how long the evacuation took, and learning identified to inform future drills. There was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors. All fire safety equipment service records were up to date. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and supervision required at the assembly area. There were fire evacuation maps displayed throughout the centre, in each compartment and in the residents bedrooms. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre. On the days of the inspection there were three residents who smoked and detailed smoking risk assessments were available for these residents. A call bell, fire aprons, fire blanket, fire extinguisher and fire retardant ash tray were in place in the centre's smoking area.

At the time of inspection, the centre was moving all resident’s pre- admission assessments, nursing assessments and care plans to one electronic documentation system. Previously the centre had used two documentation systems. Residents’ assessments, validated assessment tools and nursing progress notes were kept on one system and residents care plans were maintained on the other. Residents’ needs were comprehensively assessed prior to and following admission. Resident’s assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspector were comprehensive and person- centred. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to incidents of falls and infections. Consultation had taken place with the resident or where appropriate that resident’s family to review the care plan at intervals not exceeding 4 months. There was evidence of ongoing communication with relatives of residents on each unit, using an invitational letter to meet residents’ relatives to inform them of updates and changes to care plans. Further improvements were required to residents care plans which is discussed further under Regulation 5: individual assessment and care planning.

There was a rights based approach to care in this centre. Residents’ rights, and choices were respected and promoted. Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the organisation of the service. The residents had access to SAGE advocacy services. The advocacy service details were displayed in the reception area and activities planners were displayed in the reception area and outside the day care room. Residents has access to daily national newspapers, weekly local newspapers, Internet services, books, televisions, and radio’s. Religious services took place regularly in the centre and Mass was live streamed from local parishes. Musicians attended the centre regularly.

Regulation 10: Communication difficulties

From a review of residents records it was evident that residents who had specialist communication requirements had these recorded in their care plan.

Judgment: Compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Parts of the centre required repair and painting to ensure it could be effectively cleaned. For example; water proof panels were damaged in the en-suite bathrooms of room 57 and 61. Walls, skirting boards and doors in many areas of the building had visible wear tear.
- Flooring in a number of bedrooms, the smoking room and near a compartment door on Rosconnell unit was damaged.

Judgment: Substantially compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

Action were required to ensure the environment was as safe as possible for residents and staff. For example;

- The house keepers room on kilminan wing did not have a hand wash sink.
- Bed tables in bedrooms 34, 41 & 61 were damaged with exposed medium density fiberboard (MDF). A locker in room 37 and a set of drawers in room 66 was damaged with exposed MDF. This posed a risk of cross contamination

as staff could not effectively clean these pieces of furniture.These were repeated non-compliance.

The inspector was informed by two staff members that the contents of commodes, bedpans or urinals were manually decanted into residents' toilets prior to being placed in the bedpan washer for decontamination. This practice could result in an increase environmental contamination and cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example:

- A review of the centre's bedroom doors was required as not all bedroom doors were closing to form a seal to contain smoke and fire in the event of a fire. For example bedroom door 28 was catching on the floor.
- A review of the compartment doors was required as there were gaps under a number of the doors. For example; Gap under the compartment door adjacent to bedroom 51 and the compartment doors adjacent to bedrooms 7 and 8.
- Assurances are required that the works as identified and recommended in a fire door audit completed by a competent person in May 2023 will be completed.
- The Attanagh unit, Kilminan unit and some of the doors on the Donoghmore unit did not have automated closure devices. Properly working closing automated closing devices would ensure that smoke or fire could be contained in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. Medicines were administered in accordance with the prescriber's instructions in a timely manner.

Medicines were stored securely in the centre. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A sample of care plans reviewed were not all formally reviewed on a four monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff and residents had daily opportunities to participate in group or individual activities. Access to daily newspapers, television

and radio was available. Details of advocacy groups was on display in the centre.
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	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brookhaven Nursing Home OSV-0000207

Inspection ID: MON-0042620

Date of inspection: 14/02/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Since the HIQA inspection 13th of February 2024, we have welcomed three new Health Care Assistants to our team.
We are pleased to inform you that we have a pipeline of HCAs coming internationally which we hope to have on site in the coming weeks, work permit permitting.
Additionally, we have onboarded one household assistants and one laundry assistant.

Ongoing recruitment is in progress for Kitchen assistant.

In relation to the Regional Manager post we have filled this vacancy, and the candidate will commence employment on the 30th of April 2024.

Our goal is to complete panels for vacancies to ensure adequate staffing levels and maintain high standards of care. With the above-mentioned information staffing will be in line with the nursing home's SOP.

As part of a contingency plan, we have 10 Casual Relief HCA to ensure that the quality of care is not affected. Along with the casual relief HCA we have 2 Casual Relief Laundry staff and 1 Casual relief Kitchen assistants. Casual relief staff are available for shifts and are allocated shifts if and when they are available.

We also have SLA with over 13 Agency for short term and long term absences with an agreement of set staff attending when booked.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Complaints Procedure and Policy has been updated and now clearly outlines the nominated Complaints Officer and information on Independent Advocacy Services available.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: There is an ongoing schedule of works taking place to upgrade the premises. Water proof panels in the en-suite bathrooms of two bedrooms has been repaired and flooring has been replaced in identified areas of the home. (Completed) Painting had commenced to rectify some of the scuffed paintwork on skirting and doorframes and plans are in place for a programme of upgrading and redecoration throughout. (Ongoing)	

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A clinical hand wash sink for the house keepers' room will be installed by 30/04/2024. Damaged bed tables in three bedrooms and one locker will be replaced. Communication on best practice issued to all staff in relation to decanting contents of commodes. Instructions on how to use the bed pan washer have been printed and displayed in the sluice room. All staff are trained in IPC and ongoing monitoring by the Management Team has been implemented.	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Works identified and recommended in a Fire Door Audit have commenced in the Centre. Phase 1, Fire doors repairs have been completed and Phase 2 scheduled for Q2 2024. Planned works will include installation of automatic closure devices and review of Compartment Doors ensuring there are no gaps.	
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: An updated comprehensive assessment and individualised care plans have been completed for each resident based on their assessed needs and will be reviewed formally at intervals not exceeding four months. Assessment and Care Planning Champion Training commenced 26th March will further enhance the Care Planning Process.	

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 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	30/05/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/04/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	30/04/2024

	associated infections published by the Authority are implemented by staff.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/07/2024
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Substantially Compliant	Yellow	16/02/2024
Regulation 34(5)(b)	The registered provider may, where appropriate assist a person making or seeking to make a complaint, subject to his or her agreement, to identify another person or independent advocacy service who could assist with the making of the complaint.	Substantially Compliant	Yellow	16/02/2024
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	Substantially Compliant	Yellow	26/03/2024

	it, after consultation with the resident concerned and where appropriate that resident's family.			