Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Brampton Care Home
Name of provider:	Brampton Care Ltd
Address of centre:	Main Street, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	03 September 2021
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0034071

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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
Friday 3 September 2021	09:30hrs to 18:30hrs	Una Fitzgerald	Lead
Friday 3 September 2021	09:30hrs to 18:30hrs	Sean Ryan	Support

What residents told us and what inspectors observed

The inspectors spoke with individual residents and spent periods of time observing staff and resident engagement in communal areas. Residents spoken with were aware that there had been a number of changes to the governance and management structure within the centre and told inspectors that this caused them great concern; they told inspectors that there was insufficient numbers of staff available to attend to their needs, and that when staff phoned in as unavailable they were not replaced. Overall, the feedback given was that residents were not happy with the service provided in the centre.

On arrival to the centre, the inspectors walked the premises with the person in charge. The communal spaces are bright and airy. Walking along corridors is a pleasant experience as the centre is decorated to a high standard. The main reception area has a coffee dock station. There are multiple communal dining and sitting rooms an each floor for resident use. There is open access to gardens that have seating and tables for residents to sit and get some fresh air.

Residents told inspectors that the standard of care was not optimal, and clearly stated that this was not as a result of any individual staff, but rather as a result of the workload placed on staff when there were insufficient numbers of staff on duty. Residents were quick to state that individual staff members were kind and supported them. Inspectors observed staff interactions with residents to be kind, respectful and engaging. Residents spoke of the close connections they had built with staff, but equally expressed sadness and concern at the numbers of staff that had left, and the loss of some of these relationships. Residents told inspectors that the 'banter' has stopped between residents and staff due to workload and a change in the overall culture in the centre.

Through conversations with the residents, inspectors found common themes emerging. Residents were not satisfied with:

- the staffing numbers on duty to deliver direct care
- the multiple changes in the management team that was a source of worry and uncertainty
- the frequency and provision of showers
- the provision of towels and the laundry services.
- their concerns were not being heard

The findings from this inspection support the residents views.

Healthcare assistants were required to perform catering duties in the morning to assist with breakfast and also evening teas. Residents told inspectors they felt that it was inappropriate to be tasked with handling food and also then be responsible to provide residents with personal care. Residents had brought this concerns to the attention of the management team and to date, no action had been taken. When

inspectors discussed this with the management team, it was acknowledged that the reason no change had occurred was due to the current staffing shortages.

Residents expressed concern regarding their safety in the event of a fire, and how they would be safely evacuated when staffing levels were not maintained. Some residents wished for more inclusion in the development of their personal evacuation plan and inspectors brought this to the attention of the management team in the context of supporting residents to be active participants in their care and welfare.

Residents confirmed to inspectors that improvements had been made to the tea time menu and four choices were offered. Inspectors observed the residents dining experience and there was a relaxed and calm atmosphere. Dinner orders were taken directly from residents at their table and food served fresh from the kitchen. Staff were on hand to provide support and assistance to residents with their meals and the engagement was observed to be respectful and person-centred. The inspectors spoke with catering staff who displayed good knowledge of each residents individual preferences and nutritional requirements.

Inspector observed residents to be engaged in activities in the afternoon on the ground floor. There was singing, music and movies on offer for residents. Inspectors observed some residents sitting for long period in the dayroom on the first floor, particularly in the morning, where there was little stimulation or engagement occuring. Some residents required support and assistance to manage their psychological symptoms of dementia but there were periods where staff were not available to provide this support. Staff were observed to be very busy throughout the morning and residents said they did not like to delay staff talking as she were aware that others requires assistance elsewhere in the centre.

The following sections of the report outline the inspection findings in relation to the governance and management in the centre and how this supports the quality and safety of the service been delivered.

Capacity and capability

Brampton Care Ltd is the registered provider of Brampton care home. Inspectors found that the provider needed to strengthen and stabilise the governance and management structure in the centre. The staffing numbers available in all departments was not in line with the numbers outlined in the statement of purpose. Staff turnover was high. Inspectors acknowledge that the centre had had a number of changes to the person in charge over a short period of time and that this change has had a significant impact on the day to day running of the service. However, inspectors found that the current person in charge did not have sufficient numbers of staff available to deliver the care as per the assessed needs of the current number of residents.

Inspectors found repeated non-compliance's with the regulations reviewed and that

the compliance plan response to the previous inspection findings had not been implemented. Inspectors found that Regulations 23 Governance and Management, Regulation 34 Complaints procedure, Regulation 5 Individual assessment and care plan, and Regulation 9 Residents Right remain not complaint.

This was an unannounced risk-based inspection undertaken to follow up on

- the previous inspection findings in May 2021
- To follow up on unsolicited information received by the office of the Chief Inspector specific to the quality of the care
- An application to renew the registration of the centre.

As a result of the last inspection and follow up meetings with the office of the Chief Inspector the provider had voluntarily ceased all admissions to the centre until 31 July 2021 or until the Chief inspector was satisfied that the centre had returned to regulatory compliance. The purpose of this decision had been to allow for the governance and management structure to strengthen and to demonstrate sustainable governance. The provider had submitted a governance and management structure that consisted of the person in charge and operations manager. While minor improvements were noted on this inspection, management changes and availability of staff continued to be not compliant.

Inspectors found that the centre was moving away from regulatory compliance and that there was insufficient resources and inadequate managerial oversight. The systems in place are not sufficiently robust enough. This was evidenced by:

- Staffing - there were insufficient staff numbers on duty. For example, the clinical nursing management team are delivering direct care due to staffing shortages. This was impacting on their ability to ensure oversight and monitoring of the service delivered.
- The audit folder was examined. While inspectors found that in house audits had been completed, the actions required to bridge gaps were not followed up and appropriate action taken.
- Inspectors were informed that an external company had completed care audits of the service. The nursing management team were not aware of the audit findings and had therefore not implemented actions to address the findings of these audits.
- Care plans were not completed in accordance with Regulation 5 requirements. Inspectors found significant gaps in the management of wounds. This was discussed with the person in charge on the day of inspection who committed to address the findings as a priority.
- Complaints made were not always recorded and not always addressed as per the centres own policy.

A sample of staff files were reviewed. All nurse registration documentation was available. Vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021 were in place. The training matrix was reviewed. There were significant gaps identified in mandatory training required by the regulations. This training was discussed with the management team. Inspectors

found that many training sessions were completed on-line, and not followed up on site to establish that staff knew and understood the course content. This meant that the management could not be assured if staff were implementing the learning and that practice was delivered in line with the centres specific policies and procedures. Inspectors found that some staff responses to questions and familiarity in areas such as fire safety, drills and evacuation were poor.

Staff recruitment was actively ongoing. On the day of inspection the Inspectors found that the current high numbers of staffing changes was directly impacting the day-to-day running of the service. The Person in charge was being supported by an Assistant Director of Nursing, registered nurses, health care assistants, activities staff and a team of non clinical staff. Inspectors were informed that the management team meet frequently and discuss all clinical and operational matters. However, on the day of inspection the records of these meetings were not available for review. The centre had had multiple changes in the governance structure and as a result inspectors found that the new management structure required time to become familiar with the service, familiar with the systems and embed the changes required to ensure the service provided was safe, appropriate, consistent and effectively monitored.

The person in charge had recently reviewed and updated the risk register that formed part of the risk management strategy in the centre. Some risks required review such as the risk associated with the recruitment and retention of staff in the context of the ongoing challenges with staffing in the centre. Further risks were identified specific to staff training and development that required review and updating to the risk register. A review of the incident log found that while incidents were documented, there was little evidence of investigation, analysis of the incident or learning opportunities from incidence that could be shared with staff to provide opportunities for quality improvement. Three incidents documented in June 2021 remained open and had not been acted upon.

Following this inspection, the office of the Chief Inspector had engagement with the registered provider in relation to the instability of the governance and management structure and the finding from this inspection. A warning meeting was held on 08 September 2021. The registered provider gave a commitment to address the non-compliance and to voluntarily cease admission to the centre until such time as the Chief Inspector is satisfied that the centre has returned to regulatory compliance.

Registration Regulation 4: Application for registration or renewal of registration

The application form was submitted and the required registration fee had been paid.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge is a registered nurse with experience in caring for the older adult. The person in charge holds a post registration management qualification and meets the requirements of the regulation.

Judgment: Compliant

Regulation 15: Staffing

The management team on the day of inspection confirmed that a significant number of staff had recently left the centre for varied reasons. Inspectors were told that the recruitment of staff was on-going.

The inspectors reviewed the staffing rosters, and found that the number of staff available cross referenced with the staffing requirement as detailed in the centres Statement of Purpose submitted to the office of the Chief Inspector for the purpose of registration renewal evidenced significant shortfalls. For example there was:

- a clinical nurse management vacancy
- the operations manager was redeployed to the role of person in charge
- 10 Whole Time Equivalent (WTE) nurses instead of 11.5
- 2 WTE activities co-ordinators instead of 3
- 19 WTE healthcare assistants and 13 part time were available. However, the total hours did not accumulate to the 28.5 WTE as stated in the amended Statement of purpose.
- 4 housekeeping instead of the 6 WTE required.

As a result of the ongoing staffing shortages, the negative impact was

- the nursing management team were redirected to deliver the care and so were unable to supervise and monitor the service
- there were extended periods of time when communal areas occupied by residents were unsupervised.
- Residents choice was impacted upon in terms of being able to choose when they would like to have a shower and also in regards to the level of support they received in simple tasks such as changing their bed linen.
- The bedrooms were to be cleaned on alternative days due to staffing shortages.

Inspectors found that the appropriate staffing levels were not maintained on a daily basis to meet the needs of the current residents and that the Whole Time Equivalent(WTE) in the Statement of Purpose had been reduced from what was previously submitted with the application to renew registration.

Judgment: Not compliant

Regulation 16: Training and staff development

The training matrix provided to inspectors on the day of inspection identified significant gaps in mandatory training required by the regulations. For example:

- 56% of staff had completed elder abuse training. This meant that there were 36 staff member who did not have in date training.
- 67% of staff had completed their manual handling training. This meant that there were a total of eleven staff directly involved in manual handling practices that did not have appropriate in date training.

While staff had received training in fire safety, the training was not effective in ensuring staff were knowledgeable and confident the the centres fire safety procedures. Some staff were unclear regarding the procedure to take in the event of fire alarm activation and progressive horizontal evacuation.

The compliance plan response submitted to the Chief Inspector following the May 2021 inspection had outlined that a structured induction was implemented for all new members of staff. This was to consist of a mix of education, training, and staff supervision. However, inspectors observed that this action had not been implemented.

The management team had been required to provide direct care to residents and this impacted on the arrangements for the supervision of staff.

Judgment: Not compliant

Regulation 19: Directory of residents

A review of the residents directory found that information required by schedule 3 of the regulations was not recorded. For example:

- a number of records did not record the residents nominated general practitioner
- there was no record of a residents transfer to the acute hospital

This is a repeated non- compliance.

Judgment: Substantially compliant

Regulation 23: Governance and management

The totality of the findings over the day of this inspection evidenced that Brampton Care Ltd. did not have robust systems of governance and management in place. This was further compounded by the governance and management structure undergoing significant changes.

There was insufficient resources available to:

- maintain consistent healthcare staffing levels on a daily basis.
- ensure that all areas of the centre were cleaned daily.

The management systems for monitoring and oversight of the service were not in place to ensure that the service was safe, appropriate, consistently and effectively monitored. This was evidenced by:

- The auditing system was not effective in promoting quality improvements.
- There was poor supervision and awareness of the impact staffing levels had on the day to day operations of the centre. For example; staff were cleaning the second and third floor on alternate days due to staffing availability.
- The nursing management team, on occasions, were required to provide the direct care.
- The supervision and monitoring of staff training needs and the effectiveness of training required improvement.
- The management and oversight of complaints.

Effective systems were not in place to oversee and manage risk. Inspectors reviewed the risk register, incident and accident log and found that significant improvement was required in the management of incidents in the centre. A further review of risk management was required regarding the assessment of risk, implementing risk reducing measures and analysing risk and learning opportunities from adverse events. This was evidence by:

- The high level of falls in the centre and repeated incidents that did not evidence a root cause analysis, investigation of the incident or identify learning or quality improvement opportunities as per the centres policy and procedure.
- The risk register required further review and analysis to ensure risks identified specific to the the centre were recorded. For example, the risk associated with the challenges of staff recruitment and retention, the risk associated with gaps in staff training and development and its impact of service provision.

The unsolicited information received by the office of the Chief inspector specific to the staffing concerns and the delivery of care was substantiated.

Judgment: Not compliant

Regulation 34: Complaints procedure

As per the previous inspection compliance plan response the Complaints policy and procedure was reviewed. However, actions taken have not resulted in the centre coming into compliance with the regulation. This was evidenced by:

- The complaints procedure was not displayed on the ground or third floor for residents.
- The complaint policy on the second floor was not updated and guided the complainant to personnel that no longer worked in the centre.
- A written complaint received on the 03/08/2021 had not been acknowledged or progressed through the centres own complaints procedure. There was no evidence of follow up or actions taken to address the complaint.
- Residents told inspectors that they had brought their concerns on staffing to the management team. This was confirmed by the management team on the day of inspection. However, on the day of inspection here was no evidence of the complaints been documented or any actions taken to address the complaints.
- A complaint logged on the electronic system was closed with no evidence of acknowledgement of action taken.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the provision of good quality care was significantly impacted upon and inconsistent due to the significant number of ongoing staff absenteeism in the centre and the deficits in the governance and management of the centre. This was also impacting on the supervision and oversight of care delivered and this was evidenced in the nursing documentation and through the voice of the residents. The systems in place to monitor and improve the quality and safety of the service provided to residents had not been implemented following the previous inspection in May 2021. Under the quality and safety section of this report, these systems include the monitoring and oversight of:

- Assessments and care plans
- Wound care
- Risk identification and management
- Management of incidents
- Premises
- Fire precautions
- Resident rights

All residents had a comprehensive nursing assessment completed on admission and a care plan developed. Improvements has been made in developing person-centred social care plans for residents that took account of their individual likes and dislikes and incorporated their social care assessment into the care plan. However, inspectors were concerned that the findings arising from nursing risk assessment were not being utilised to inform reviews and updates to the residents care plans. Inspectors reviewed a sample of resident records and observed where assessments identified clinical risks associated with malnutrition, falls and dysphagia, this risk was not consistently updated in the residents care plan. Evidence of consultation with the resident or their relative following care plan reviews was not documented and some residents confirmed to inspectors that they were not routinely consulted about changes to their care plan. Significant improvement was required in the identification and documentation of pressure wounds in the centre. Inspectors found numerous instances where pressure wounds were incorrectly documented as moisture lesions or unexplained injuries. Wound assessment and the care plan did not accurately detail the presentation of the wound or demonstrate progression, deterioration or healing as the documentation appears to be duplications of the previous entries. Inspectors found that residents returning from hospital did not have their care plan reviewed in full or updated to reflect their complex and changing care needs following review in hospital.

Inspectors reviewed the records of residents that had been transferred to the acute hospital for further investigation and treatment. Nursing transfer letters were not available for review and therefore it could not be determined if all relevant information about the resident had been communicated to the receiving hospital. In some cases, there was no record of the residents transfer out of the centre.

Residents had unrestricted access to allied healthcare professionals and general practitioners (GP) attended the centre weekly to review residents. Residents were provided with timely referral and review by physiotherapy, occupational therapy, dietician and palliative care services.

Inspectors reviewed the documentation that supports the monitoring of fire safety in the centre. Daily checks of the fire panel and means of escape and weekly checks of fire doors were completed. Fire equipment such as fire extinguishers and fire blankets had recently been inspected by a competent person. However, inspectors observed that some of the fire safety documentation did not align with the findings on the day of inspection. There was uncertainty among staff and management as to the location and size of the centres largest compartment and some staff were unclear regarding the procedure for evacuation in the event of a fire. Further assurances were requested in this regards. This is discussed further under Regulation 28: Fire Precautions.

Inspectors reviewed the risk management policy that now contained the specific risks as required by the regulation. The person in charge had recently reviewed and updated the risk register that formed part of the risk management strategy in the centre. Some risks required review such as the risk associated with the recruitment and retention of staff in the context of the ongoing challenges with staffing in the centre. Further risks were identified specific to staff training and development that

required review and updating to the risk register. A review of the incident log found that while incidents were documented, there was little evidence of investigation, analysis of the incident or learning opportunities from incidence that could be shared with staff to provide opportunities for quality improvement. Three incidents documented in June 2021 remained open and had not been acted upon.

Inspectors found that the premises and its facilities were designed and laid out to meet the needs of the residents. Inspectors observed that the centre was clean in parts but the cleaning procedure had been amended in recent days to manage the reduction in housekeeping staff. For example, each floor of the building was being cleaned on alternate days and this was evidenced in the cleaning documentation and discussions with staff and residents. The storage of equipment required review as some items were observed to be inappropriately stored in sluice rooms. There was some ongoing disruption in the centre due to the nature of the building works but residents reported that there had been a marked improvement in the management of noise.

Residents confirmed that staff were very kind, caring and respectful towards them. Residents had access to adequate indoor communal space and external garden space but this was observed to be reduced in size due to ongoing building works. Residents reported improvements in the service but were acutely aware of the challenges the centre was experiencing and detailed how this impacted on their daily lives. Residents complemented the availability of activities in the centre and their choice to participate in activities. Many residents were observed attending the ground floor day room to take part in activities but residents who chose to remain in their bedroom expressed that some days they were not engaged in meaningful activities. Residents specifically detailed that this was not as a result of being 'forgotten' but rather a result of staff being very busy.

Residents overheard inspectors discussing fire safety with staff and asked inspectors if they could or should be involved in fire safety management in the centre. They expressed concerns that they did not know how staff would assist them in an evacuation and this was a concern for residents in light of the ongoing building works in the centre. Overall, residents felt that they were not being fully informed on matters that affect them in the centre.

Regulation 17: Premises

Inspectors found that the cleanliness of the centre was being impacted upon by staffing shortages in the area of housekeeping. In response to this shortage, not all areas were cleaned on a daily basis but rather different floor were cleaned on alternate days.

The storage of equipment in the centre required review. Equipment such as mobility aids and personal protective equipment (PPE) were stored in sluice rooms. Inspectors observed that one sluice room did not have storage racking or drip trays and as a result used commode buckets and lids were stored alongside clean

equipment.

The person in charge confirmed to inspectors that this equipment had been ordered and was due for delivery in the weeks following the inspection.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspector tracked the file of two residents that had been admitted to the acute hospital for further investigation and treatment.

A nursing transfer letter was not available for review for both residents or a medical letter outlining the reason for the residents transfer to the hospital and therefore it could not be determined if all relevant information about the resident had been communicated to the receiving hospital

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors observed the following discrepancies in the documentation that supports fire safety:

- Inspectors observed a fault on the fire alarm panel on arrival to the centre and again in the afternoon. The documentation of the daily fire alarm check did not capture this fault and while action had been taken, this was also not documented in the record.
- The weekly fire door checks had been completed but had not identified that a cross corridor fire door was not closing correctly and therefore the fire door was compromised in its function of containing smoke.

Inspectors identified the following fire risks:

- The management team and staff could not provide assurance regarding the location and size of the centres largest compartment.
- A simulated fire evacuation drill of three residents was completed in April 2021. A number of staff confirmed that they had not taken part in a a simulated night time evacuation drill when staffing levels were reduced. Inspectors found that some staff were unclear on the horizontal evacuation procedure.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The assessments reviewed by inspectors, and recommendations made by allied healthcare professionals, were not consistently updated or incorporated in the residents individual care plan.

- A resident with significant weight loss over a 3 month period and identified as nutritionally at risk did not have these assessment findings updated into their care plan.
- A residents care plan detailed that the resident was provided with a normal texture diet despite the speech and language therapist prescribing a modified textured diet in June 2021.

The process for wound care management involved a specific care plan and a separate wound progress chart that incorporated assessment of the wound, the dressing regime and photographs to monitor progression. The correct identification and documentation of wounds was of a poor standard.

- Inspectors found a number of examples where pressure wounds were recorded as moisture lesion, unexplained injuries or a skin tear.
- Inspectors identified a wound documented as an unexplained injury that was a reoccurring pressure wound. The documentation to assess and monitor the wounds progression was inconsistent and did not evidence if the wound was deteriorating or healing.
- A pressure wound was being documented as a moisture lesion despite correspondence from a tissue viability nurse in August 2021 diagnosing a persistent pressure related wound.

The wound care plans did not accurately detail the management of residents pressure wounds and the documentation was disjointed which further complicated efforts to provide effective wound care management.

This was brought to the attention of the person in charge who committed to reviewing all wounds in the centre immediately.

Judgment: Not compliant

Regulation 6: Health care

Residents were provided with unrestricted access to a general practitioner of their choice. Residents had access to allied healthcare professionals such as

physiotherapy, occupation therapy, dietician services and tissue viability expertise.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were aware of the challenges the service was experiencing in terms of staffing and this awareness came from their own observations. Residents told inspectors that they felt some issue were being 'concealed' from them such as the aforementioned. This was a cause of much anxiety, uncertainty and worry for residents in the centre.

Resident expressed that daily staff shortages were having a direct impact on their ability to exercise choice and dignity. For example, showers were not always offered to residents, some residents required attention to their nail care and bed linen was not changed unless requested by the residents.

Residents felt that they were not always informed or included in matters that directly impacted them in the service such as being included in discussions around fire safety or in being provided with basic information such as their personal evacuation plan.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Brampton Care Home OSV-0005812

Inspection ID: MON-0034071

Date of inspection: 03/09/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There have been ongoing and sustained efforts to recruit the required staff for the centre. For the number of residents now residing in the centre (66% occupancy) we have adequate numbers of Registered Nurses, Care Assistants, Housekeeping staff and activity staff. It is our intention to incrementally recruit the staff numbers required for the centre being occupied at 85% and again at 100%. We will voluntarily submit to not taking further admissions until the staffing numbers are at a level where the staff are able to meet the needs of the residents. We also intend to recruit over and above the required levels calculated to ensure that there is adequate cover for unexpected absence and illness, and also to allow staff to avail of annual leave when requested. Staff that are recruited will be subject to an induction period and will be supernumerary for the duration of the induction. A record of the induction will be completed and signed off by the mentor/supervisor and the PIC.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff training has been reviewed and all gaps identified in mandatory training. External training providers have been booked where appropriate and in-house and E-Learning is taking place to ensure that there is full compliance with requirements. Training records will be held on one consolidated training matrix which will be overseen by the Person in Charge.	

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The Directory of Residents has been updated to include the residents' General Practitioner and all absences from the centre to acute hospitals. This is now being maintained by the Director of Nursing to ensure that ongoing compliance is maintained.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The staffing required to ensure that the residents needs are met on a day-to-day basis have been recruited and are being inducted into their role. This includes Nursing, Healthcare Assistants and Housekeeping staff. The centre is actively recruiting additional staff over and above the required whole-time equivalents to ensure that there are sufficient numbers of staff in all departments to cover unexpected absence and illness, and annual leave requirements.
A robust system of audits is being implemented that includes input from the Clinical Nurse Managers, ADON, Staff Nurses and the head of each department. The audits will include an action plan that is specific, measurable, achievable, realistic and timed to ensure that continuous quality improvement takes place. Feedback from the audits will be shared with each area to ensure continuous quality improvement and learning.
A clinical Governance Committee has been established to review falls, accidents, incidents, complaints, restrictive practice, wounds, and pressure sores and the centre's risk register. The clinical governance committee will, as a team, analyse the above and put in place appropriate actions which will be reviewed again the following month. Incidents and accidents will be tracked and trends identified and analysed. Actions will then be taken to reduce the incidence of accidents and incidents. The risk register will be updated on an ongoing basis as and when additional risks are identified. The Clinical Governance Committee will consist of a Director of the company, DON/ADON/CNM/Physiotherapist, and Occupational Therapist.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The centre has retrospectively reviewed all complaints that have been recorded and the outcome of each complaint has been recorded. Complaints are reviewed as part of clinical governance meetings. A new document is in place to enable residents to report their complaints to the Director of Nursing, and these forms are available at reception and in resident areas. The centre has reviewed the complaints policy and timelines to resolve complaints are now in place. The centre will ensure that any complaints have been resolved insofar as is possible to the complainants' satisfaction. There are now forms available in each resident area and in the foyer for residents or their visitors to record complaints, concerns or compliments and these can be completed anonymously if wished and forwarded to the Director of Nursing. There is a copy of the complaint procedure in prominent areas on each floor and in the reception area. This includes the appeals procedure both internally and externally to the ombudsman. The centre will follow up each complaint and will investigate, report back to the complainant, and ensure, insofar as is possible that the complainant is satisfied with the outcome of the investigation into their complaint.
The centre is committed to improving the service and to following up on any complaints, comments or concerns received from the residents or their visitors. Easy read information has now been put in place to ensure that all residents have information relating to the complaints procedure. Complaints will be reviewed by the Clinical Governance Committee and any actions required as part of the continuous quality improvement plan will be implemented

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Additional housekeeping staff have been recruited and all areas of the centre are being cleaned to a high standard on a daily basis.
Additional stainless-steel racking has been received and is installed. A review of storage has taken place and clean items are now segregated from used items.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

A copy of Nursing transfer letter/GP letter is now being taken and retained on the residents' file for each transfer to hospital to ensure that all relevant information is retained by the Centre
The centre makes every effort to ensure that information is received in advance from the discharging hospital when a resident is returning to the centre. The centre provides a secure email address to facilitate rapid transfer of information from the acute hospital setting. It is acknowledged that there are occasions when transfer information has not been sent with the resident being discharged from acute hospitals and Nursing staff follow this up with telephone calls to the hospital to get information whilst awaiting receipt of written information.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A full review of all fire doors has taken place with a registered fire consultant and an action plan for remedial work has been put in place. Works have commenced and will be completed no later than the 25th October 2021.
There is now a qualified in-house fire trainer who is in the process of completing fire training for all existing staff and will complete fire training for new staff as part of the induction process. This will include simulated fire drills on all shifts including night duty staff. There are fire maps throughout the centre which highlight the fire compartments and the means of progressive horizontal evacuation.
Residents are also being invited to attend a bespoke version of the fire training so that they are aware of the procedures that they, and staff would take in the event of a fire or a fire evacuation. A document outlining these procedures is being developed and will be available to residents in their room for reference.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The centre is undertaking a complete review of each residents' care plans and all associated assessments. Nursing staff will under the guidance of the person in charge, develop a person centred and rights-based care plan in conjunction with the resident, and where the resident is unable to participate in the care planning process, their nominated care representative. Nursing staff are currently undertaking training in the assessments used to identify risk and the development of person centred and rights-based care plans. Nursing staff will also attend training relating to wound care, pressure

sore prevention and management, and dysphagia as a matter of urgency. All wounds and pressure sores that were incorrectly classified have been reviewed and are now correctly classified with the appropriate care plan in place. Residents that are prescribed a modified texture diet have had updated information detailed in their care plans and catering staff and Healthcare assistant staff have been informed of the changes. Assessments and care plans will be reviewed at an interval no greater than every 4 months and sooner if required based on the residents' individual needs.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The centre recognises that the service has not enabled residents to fully exercise their rights and choice due to the impact of staffing deficiencies. The recruitment of staff in all departments and effective induction procedures will enable residents to fully exercise their rights and choice.
Residents have invited the management team to attend resident forum meetings so that information can be shared directly with them and questions can be asked and answered in a timely way. The management of the centre welcome this opportunity. Residents are now individually being provided with a bulletin containing information relating to issues affecting the centre such as staffing, recruitment and ongoing building works. Residents are being invited to attend bespoke fire training sessions and information is being provided to them in relation to their personal emergency evacuation plan and the means of progressive horizontal evacuation. Residents will be invited to participate in the organisation of the centre and provide feedback to management on issues that affect their day to day lives.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/10/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/10/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/10/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	31/10/2021

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	01/10/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2021
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	31/10/2021
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant	Substantially Compliant	Yellow	31/10/2021

	information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 25(2)	When a resident returns from another designated centre, hospital or place, the person in charge of the designated centre from which the resident was temporarily absent shall take all reasonable steps to ensure that all relevant information about the resident is obtained from the other designated centre, hospital or place.	Substantially Compliant	Yellow	31/10/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	25/10/2021
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	Not Compliant	Orange	31/10/2021

	case of fire.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	01/10/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	01/10/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and	Not Compliant	Orange	01/10/2021

	whether or not the resident was satisfied.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	01/10/2021
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	01/10/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Not Compliant	Orange	31/10/2021

	the resident concerned and where appropriate that resident's family.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/10/2021
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.	Not Compliant	Orange	31/10/2021