



# 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:	08 December 2021
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0035020

## 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:	52
--	----

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

As part of our inspection, where possible, we:

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

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

### **1. Capacity and capability of the service:**

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

### **2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Wednesday 8 December 2021	11:30hrs to 18:00hrs	Una Fitzgerald	Lead
Thursday 9 December 2021	09:30hrs to 16:30hrs	Una Fitzgerald	Lead
Thursday 9 December 2021	09:30hrs to 16:30hrs	Noel Sheehan	Support

## What residents told us and what inspectors observed

Inspectors completed an unannounced risk inspection of the centre. At the time of inspection, Brampton Care Home had 52 residents living in the centre. Inspectors spoke with multiple residents about the care they received and about their level of satisfaction with the service provided. Resident feedback was mostly positive. Residents were aware of the multiple changes in the governance and management structure. The general feeling expressed by residents was that this team now required time to bed down new changes and support new staff to enable them to deliver the care to the desired level. Residents used positive language like "a work in progress" when asked about the changes in place. In addition, residents told inspectors that there is a more positive atmosphere in Brampton lately.

Residents in the centre took an active part in the running of the centre. There is an established resident committee. Resident feedback is welcome. Through conversations with the residents, inspectors found that in contrast to the last inspection findings, residents were now satisfied with:

- the staffing numbers on duty to deliver direct care
- the provision of food and choices available
- the changes in the management team had stabilised and was less of a source of worry and uncertainty. For example; residents told inspectors that the concerns found on previous inspections were being addressed.
- the frequency and provision of showers
- the provision of towels and the laundry services.

The inspectors observed that staff chatted freely with residents on topics of interest to them. Staff turnover had stabilised which meant that the staff were familiar with the likes and dislikes of the residents. The inspectors observed there was a range of stimulating and engaging activities that provided opportunities for socialisation and recreation. The centre had staff appointed for activities. All staff had a good understanding in their role and responsibility regarding normal socialisation and engagement with residents. Staff considered activities an important part of their role to ensure residents were comfortable and at ease in the environment. The activities schedule was displayed and included a variety of activities. Throughout the two days, residents were observed partaking and enjoying a number of group activities. There was a staff member allocated to the supervision of communal rooms. Staff were seen to encourage participation and stimulate conversation. Residents spoke highly of the music sessions held in the centre.

The inspectors arrived unannounced to the centre and were guided through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene, face covering, and temperature check. Residents spoken with were delighted that restrictions on visits had been eased in line with public health guidance. Several visitors were observed coming and going throughout the two days. Residents confirmed that they could receive visitors

in the privacy of their own bedrooms if they wished but many were happy to receive visits in the designated visiting area. Residents said they trusted the staff and the management team to keep them safe through the COVID-19 pandemic.

Overall, the premises was bright, clean and communal areas were pleasantly decorated. The atmosphere was calm and relaxed. Personal care was being delivered in many of the bedrooms and observation showed that this was delivered in a kind and respectful manner. There were jugs of fresh water on the lockers in residents' rooms. The inspectors observed many examples of kind and respectful care and interactions throughout the days of inspection. In the main, residents were complementary of individual staff and the services they received.

The environment was well maintained and exceptionally clean. The corridors were sufficiently wide to accommodate walking aids and handrails were installed in all circulating areas. The layout and the signage in the centre helped to orientate residents and facilitate them to move around the building independently. The bedrooms were homely and very personalised. Some residents had brought in their personal furniture and memorabilia. Many residents had pictures of their families framed in their rooms.

On the morning of day two, some residents were up and about, some were reading the daily newspapers, some were still in bed while others were relaxing in their bedrooms. Some residents spoken with told the inspector that they preferred to remain in their bedrooms. Residents reported that the food had improved and that they were now satisfied with the choice and variety of food offered. Some residents commented that the catering staff were very open to suggestions and feedback. For example; a resident told inspectors that they loved mushrooms on toast and following relaying this preference to the catering staff this option was accommodated.

Residents voiced satisfaction with the laundry service and the provision of sheets and towels. Laundry services were provided by an external provider. The system in place required a review to ensure that all items of clothing were returned to the correct resident. Inspectors found that the laundry labelling system was completed in multiple ways. The risk was that items were not returned in a timely manner as the staff could not identify who owned what item. The current system was over reliant of individual staff knowledge as opposed to a defined labelling system. For example; on the days of inspection there was a rail of clean laundry that was not returned to resident bedrooms as staff could not identify the owner of the items.

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

## Capacity and capability

Inspectors found that significant progress had been made since the previous inspection and that the governance and management structures had been strengthened by the appointment of a person in charge who was supported by an operations manager. There was a new proposed schedule of audits drafted that once in place will provide increased monitoring which will lead to improved oversight of the service provided to the residents. However, the plans for monitoring and oversight require the commencement of the assistant director of nursing role to support the person in charge and also requires time to stabilise and embed new systems so as to ensure high quality person centred care was delivered to the residents. The management team were proactive in response to issues as they arose and improvements required where possible were actioned on the days of inspection. In addition, inspectors acknowledge that findings from the previous inspection had been substantially addressed and rectified. Notwithstanding the positive findings, some improvements were required on this inspection in relation to systems in place as discussed in detail throughout the report.

Brampton Care Limited is the registered provider of Brampton Care Home. This was an unannounced risk-based inspection undertaken to follow up on

- The previous inspections findings in May 2021 and September 2021
- To follow up on unsolicited information received by the office of the Chief Inspector specific to the quality of the care.
- To assess if condition 04 that had been attached to the registration of the centre following the previous inspection in September 2021 had been complied with.

Following the previous two inspections, in May 2021 and September 2021, and engagement with the office of the Chief Inspector the registered provider had voluntarily ceased all admissions to the centre until the office of the chief inspector was satisfied that the centre had returned to regulatory compliance. The registered provider had accepted the findings of non compliance and had cooperated fully with the office of the chief inspector. The purpose of the decision to cease admissions 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 who was supported by an assistant director of nursing to oversee all clinical matters and through whom all clinical and care staff reported and the operations manager who oversees all non clinical matters. While significant improvements were noted on this inspection, management changes had not been fully established and the assistant director of nursing, while appointed, had not commenced in the role. The chief executive officer (CEO) who is also a Person Participating in Management is based in the designated centre and was well known by staff and residents.

Care is directed through the person in charge who reports to the chief executive officer. The person in charge is supported in her role by a team of nursing, care, household and catering staff. On a day to day basis the person in charge gets daily update sheets from each of the handover meetings on the floors held at 8am and 8pm. In addition there is a safety pause at midday. There was a monthly clinical governance meeting attended by the person in charge and a director of Brampton

Care Limited. The topics reviewed include, incidents and accidents, falls, bedrail usage, wounds and pressure sores, infections/antibiotic usage, PRN use of psychotropic medications, complaints and hospitalisations. However, the governance system needed to develop in terms of communication. For example, there were very few meeting records of either the management team or of staff meetings.

Overall inspectors found that:

- there was a clearly defined management structure that identified lines of authority and accountability, specific roles and details and responsibilities for all areas of care provision in line with the statement of purpose and function (SOP). As previously stated, the centre was awaiting the commencement of an assistant director of nursing to support the person in charge.
- the centre is now staffed commensurate with the Statement of purpose
- Resident feedback was being satisfactorily managed
- Clinical supervision and oversight was sufficient to ensure the safety and welfare of residents.

The registration of Brampton care was renewed in November 2021 under the Health Act 2007, as amended. In renewing the registration of the centre the office of the chief inspector attached condition 4: "The provider shall address the regulatory non compliances identified on the inspection of 03 September 2021 to the satisfaction of the Office of the Chief Inspector no later than 31st December 2021". The purpose of this condition is to ensure that the registered provider at all times operates the designated centre in compliance with the regulations which are applicable to them. This condition was attached to ensure the issues of non-compliance affecting the care and welfare of residents as described in the inspection reports of 27 May 2021 and 03 September date are addressed.

The staffing numbers available was in line with the numbers outlined in the statement of purpose. Since the previous inspection staff turnover had stabilised and inspectors noted that induction and supervision of newly recruited staff was ongoing. Inspectors found that the current person in charge had sufficient numbers of staff available to deliver the care as per the assessed needs of the current number of residents. Overall, sufficient resources were in place to ensure that high quality person centred care was delivered to the residents.

At the time of inspection, and in the interim of the assistant director of nursing being appointed, two clinical nurse managers were working in a supernumerary capacity to support the person in charge with staff supervision and clinical supervision. In addition, the clinical nurse managers work alternate weekends as the nurse in charge. Once the assistant director of nursing has commenced the two clinical nurse manager posts will revert to two eight hour shifts dedicated to clinical supervision at weekends as the nurse in charge.

The HR manager was leading the recruitment process, and a considerable level of recruitment of staff had taken place since the previous inspection in September 2021. Human resource policies and procedures were found to be centre-specific and included details for the recruitment, selection and vetting of staff. A review of staff



records showed that staff were suitably recruited and inducted. All new staff were allocated a specific supervisor and the induction programme happened over the course of up to two weeks in a supernumerary capacity. A sample of staff files was reviewed and those examined were compliant with the Regulations and contained all the items listed in Schedule 2. Current registration with regulatory professional bodies was in place for all nurses.

The auditing systems were in the process of being implemented. The person in charge had prioritised areas for auditing to wound care, medication management, use of restraint and falls and is working towards implementation of a full programme of audits. The person in charge informed inspectors that the roll out and implementation of the proposed audit schedule will be a priority once the assistant director of nursing post is filled in early 2022. Some quality improvement strategies and monitoring of the service had commenced resulting in improvements in the quality of life and quality of care for the residents. The CEO, person in charge and staff demonstrated a commitment to on-going improvement and quality assurance. An annual review of the quality of care for 2020 had not been completed, however the person in charge and registered provider representative said that the 2021 review would be available. While inspectors acknowledge that regular feedback and satisfaction surveys specific to the food was undertaken, a resident satisfaction survey for the totality of the services provided had not taken place.

There were systems in place to manage critical incidents and risk in the centre and accidents and incidents in the centre were recorded, appropriate action was taken and they were followed up on and reviewed.

### Regulation 15: Staffing

The registered provider ensured that there was an adequate number and skill mix of staff to meet assessed needs of residents. There was a full time person in charge supported by two clinical nurse managers on a supernumerary basis. On the day of inspection there were 2 nurses and 6 healthcare attendants to provide direct care to the 31 residents living on the second floor. On the third floor, there was one staff nurse and five healthcare attendants to provide care to the 21 residents. In addition, there were three staff with responsibility for residents' activities. At night these numbers reduced to a total of two staff nurses and four healthcare attendants. This was further supported by three catering and five house keeping staff.

Judgment: Compliant

### Regulation 16: Training and staff development

The management team were committed to providing ongoing training to staff and

significant progress was noted since the previous inspection in September 2021. There was a training schedule in place and training was scheduled on an on-going basis. Training in infection prevention and control, including hand hygiene and the donning and doffing of PPE was provided through online training. A record was maintained of staff attendance at these mandatory training sessions. The person in charge explained that all on line training was followed up with in house information sessions. A training matrix was in place showing all the mandatory and relevant courses completed by the majority of staff. The training matrix reviewed identified that staff had received mandatory training in safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control, hand hygiene and the management of responsive behaviours.

Inspectors observed that staff adhered to guidance in relation to hand hygiene, maintaining social distance and in wearing PPE in line with the national guidelines. Staff reported that the training they had received had been of a good standard and they were able to implement it in practice.

Judgment: Compliant

### Regulation 19: Directory of residents

The inspector reviewed the Directory of residents. The person in charge had completed a review in November 2021. The inspector found that all detail required as per Schedule 3 requirements had been entered.

Judgment: Compliant

### Regulation 21: Records

A review of the storage and availability of records was required. This was evidenced by;

- Resident photographs were taken on staff mobile phones and not from a Brampton Care Ltd electronic device. Inspectors acknowledge that once this risk was identified immediate action was taken.
- The documentation system in place that monitors and records resident temperature checks.
- The documentation system in place for the recording of resident whereabouts when identified as high risk of absconsion.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Inspectors acknowledge that significant progress had been made in bringing the centre into compliance with regulation requirements following the September 2021 inspection. Inspectors did find that direct care was delivered to a high standard. Notwithstanding the positive findings, inspectors found that further development of management systems in place to monitor the overall quality and safety of the service continued to require further strengthening. For example:

- The system in place for the delivery of resident personal items of clothing requires review
- the annual review of the service had not been completed
- While inspectors were shown a newly developed auditing system that will monitor the care - the commencement of an assistant director of nursing to support the person in charge is crucial to implement the new schedule.
- The system of communication through management team and staff meetings needed to be developed.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The statement of purpose contained all of the required information as per the schedule 1 of Health act 2007, Regulations 2013. The registered provider had ensured that the statement of purpose was reviewed and revised at intervals not less than one year.

Judgment: Compliant

## Regulation 31: Notification of incidents

The person in charge was aware of the requirement to notify the Chief Inspector of all incidents as required by the regulations. All notifications as required had been submitted.

Judgment: Compliant

## Regulation 34: Complaints procedure

There was a policy in place to manage complaints, and residents reported that they knew who to complain to if they needed to and were empowered to do so. A copy of the complaints procedure was displayed prominently at the centre's reception area. Following the last inspection, the management team had developed a new complaints leaflet. Copies of the new leaflet were strategically placed throughout the centre. In addition, there was a secured complaints letter box welcoming feedback on the notice board situated beside the residents' lift. The person in charge was the designated person to deal with complaints. On review of the complaints log there was evidence that complaints were documented and investigated. Complainants were notified of the outcome of their complaint, and records evidenced whether or not they were satisfied with the outcome. Inspectors were informed that on the day of inspection there were no open complaints.

Judgment: Compliant

## Quality and safety

Inspectors were informed that staff and residents were monitored for signs and symptoms of infection twice a day to facilitate prevention, early detection and control the spread of infection. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns regarding a resident. The records in place that record the resident temperatures had multiple gaps and so the system required review. The vaccination uptake in the centre was excellent. The associated benefits of the vaccine uptake among residents had allowed changes in public health measures such as visiting.

Inspectors acknowledge that the needs of residents were known to the staff. Following the last inspection findings, the clinical nursing management team had reviewed the care plan in place for all residents. Education on care planning and record keeping had been rolled out to all appropriate staff to ensure that going forward care plans will be person centered and guide care. Comprehensive clinical assessments of need were completed, individual risks assessments were completed and this information was then used to inform the development of the care plan. Daily monitoring such as frequency of showers, food and nutritional intake were recorded. The inspectors reviewed wound management and documentation and found evidence of good practice that ensured healing of wounds had occurred. Gaps found on the day were discussed with the person in charge and a commitment was given to address the gaps. For example; in one file a resident with significant pain management intervention needs did not have an appropriate pain assessment completed and there was no evidence of monitoring of the effectiveness of medications given to manage the pain.

The person in charge was actively promoting a restraint free environment. There was a small number of bed rails in use in the centre. Individual risk assessment were completed and sign off by the multidisciplinary team. Residents had access to

multiple enclosed garden courtyard areas. The doors were open and access was unrestricted. The garden areas were attractive with bedding and outdoor furniture provided for residents use.

The provider had made good progress on fire safety precautions and procedures within the centre. Fire drills were completed that included night time simulated drills to reflect night time conditions. Records documented the scenarios created and how staff responded. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan in place to guide staff. Appropriate documentation was maintained for daily, weekly, monthly and yearly checks and servicing of fire equipment. The fire alarm system met the L1 standard which is in line with current guidance for existing designated centres. Annual fire training had taken place in 2021 and was attended by all staff. All newly recruited staff had been inducted in fire safety procedures.

### Regulation 11: Visits

Inspectors found that the registered provider had ensured that visiting arrangements were in place in line with the current HPSC guidance. Visits were encouraged with appropriate precautions to manage the risk of introduction of COVID-19. Visitors were required to show their COVID-19 Vaccination Record or other proof of immunity prior to entering the centre. Residents were satisfied with the current procedures in place.

Judgment: Compliant

### Regulation 25: Temporary absence or discharge of residents

Inspectors tracked the files of residents who had been admitted to an acute setting from the centre. The electronic system in place generates a comprehensive transfer letter that contains all relevant information about the resident to the acute hospital. Additional information relevant to the rationale for transfer was also communicated. For example, the list of current medications.

Judgment: Compliant

### Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The risk register that was kept under review by the management team was

comprehensive and detailed. The risk register identified risks and included the additional control measures in place to minimise the risk.

Judgment: Compliant

### Regulation 27: Infection control

The inspectors spent time observing staff practices regarding the use of PPE and found good practice. Staff were familiar with the five moments of hand hygiene. Training records reviewed indicated that all staff had completed infection prevention and control training.

The building was found to be clean. Following on from the last inspection a review of practices and the provision of staff was completed. The provider had implemented quality improvements measures specific to infection prevention and control. All areas of the premises were cleaned daily. Inspectors were informed that infection prevention and control audits had been completed. The audits were not available for review on the day of inspection and were submitted the following day.

The management team had put in place the following measures to protect residents:

- appropriate signage was in place to remind staff of the need to complete hand hygiene and observe social distancing when appropriate
- appropriate use of face masks was observed by staff
- on the day of inspection there were sufficient supplies of PPE in stock
- there was hand hygiene gel dispensers strategically placed along corridors.
- equipment used by resident was visibly clean.
- individual slings for resident manual handling needs.

Judgment: Compliant

### Regulation 28: Fire precautions

Systems were in place for monitoring fire safety. Fire extinguishers, the fire alarm and emergency lighting had preventive maintenance conducted at recommended intervals. There were daily checks of means of escape and weekly sounding of the fire alarm. Fire drills were conducted at regular intervals and simulated both day and night time scenarios.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the centre. Comprehensive assessments were completed that in turn informed the care plans. In the main, care plans reviewed were personalised and updated regularly and contained detailed information specific to the individual needs of the residents. Some gaps were identified on day one of the inspection specific to pain assessment and the development of care plans to direct care. This was discussed with the person in charge and care plans were in place on day two. There was evidence of ongoing discussion and consultation with the families in relation to care plans. Multiple residents informed inspectors that they had recently had a discussion with nursing staff about their care plans.

Inspectors were informed that all residents have their temperature taken twice a day. The rationale is part of the risk management strategy in place for the management of early detection of any residents being suspicious of having COVID-19. The system in place required review as it was not effective. While record templates were in medication files the temperatures levels were not routinely recorded. There were multiple gaps. This non compliance is actioned under regulation 21 Records.

Judgment: Compliant

## Regulation 6: Health care

The inspectors found that residents had access to medical and allied health care support to meet their needs. Residents had a choice of general practitioners (GP).

In house visiting by health care professionals was occurring. There was access to a physiotherapist five days a week. Services such as speech and language therapy and dietetics were also available. Records reviewed evidenced that advice received was followed which in turn had positive outcomes for the residents. For example: advice received from a tissue viability nurse specialist had resulted in the healing of a wound. Photographic evidence was available that tracked the healing process that had occurred.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

The centre has residents who have responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort,

or discomfort with their social or physical environment) due to their medical condition. A positive approach was taken to support these residents' care needs. Each resident had a detailed, person-centred behaviour support care plan in place that clearly identified their support needs and informed prevention management strategies. Compassionate, sensitive and supportive care from staff positively impacted on their wellbeing and quality of life in the centre.

At the time of inspection there was a small number of residents with dementia that were at risk of absconsion and were a high risk of leaving the centre unsupervised. Care plans reviewed guided the staff on how best to support residents. As a result of incidents, residents were commenced on location monitoring charts whereby staff check the current location of residents. However, a review of the system in place specific to the completion of location charts was required as the records evidenced significant gaps. This non compliance is actioned under regulation 21 Records.

The provider had systems in place to monitor environmental restrictive practices. In the main, the centre was working towards a restraint-free environment in line with local and national policy. Records showed that where restraints specific to the use of bedrails were used these were implemented following robust risk assessments and alternatives were trialled prior to use.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents had access to information and news, a selection of national and local newspapers, radio, television and Wi-Fi were available. Mass had recently been held in the centre and was also available via live video link.

Independent advocacy services were made available and at the time of inspection a small number of residents were availing of the external service.

There was evidence that resident meetings took place on a monthly basis. The meetings were chaired by the residents and a variety of agenda items were discussed such as the staffing levels in the centre and the provision of food.

In the main, residents who spoke with the inspectors reported that they felt safe in the centre and that their rights, privacy and expressed wishes were respected. Inspectors spent time observing residents and staff engagement. The atmosphere in the centre was calm, relaxed and welcoming.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Brampton Care Home OSV-0005812

Inspection ID: MON-0035020

Date of inspection: 09/12/2021

## 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 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:            There are devices that are the property of Brampton Care Home available for staff to use to take photographs of residents. At the time of inspection when this matter was brought to the attention of the PIC, action was immediately taken to ensure that only Brampton Care Home devices were used for this purpose.</p> <p>The system to record resident temperatures has been reviewed. Resident temperatures are now recorded contemporaneously by the Nurse twice daily</p> <p>The documents used to record the location of residents that are at high risk of absconsion are now being completed at the time of the checks and are reviewed by the Nurse on duty to ensure that the documentation is complete.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The system for the delivery of clothing was reviewed in consultation with laundry staff on the 10th December 2021 and a system is now in place to ensure that all clothing left into the home is labelled so that it can be identified and returned to residents after sending to the laundry. Residents and their family members also made aware of the need for clothing to be labelled before sending to the laundry. This is being monitored by the Director of Nursing</p> <p>A reflective review of the service will take place in January 2022. This review will also</p>	

include an action plan developed based on resident feedback and will detail plans for continuous quality improvement in 2022

An Assistant Director of Nursing has been appointed and has commenced in their post. Following a period of induction, the ADON will support the PIC in ensuring that care is monitored, that standards are improved on a continuous basis. This will include ensuring that audits are completed and the results are reviewed at monthly clinical governance meetings, heads of department meetings and staff meetings

Meetings are held to ensure that information is communicated between all departments and all staff.

Staff meetings have been held in October, November and December. Feedback from resident meetings and results of audits are discussed at these meetings. Resident meetings continue to be held monthly and their feedback on the running of the home is taken on board. The heads of Department (which includes all departments) meet monthly to discuss all matters relating to the running of the home, and there is a clinical governance meeting held monthly which include the Director of Brampton Care Home, Registered Provider, PIC, ADON, CNM's and physiotherapist. These meetings have a set schedule for the year.

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	03/01/2022
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	03/01/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	01/01/2022

	consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	31/01/2022