Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Brookhaven Nursing Home
Name of provider:	Brookhaven Nursing Home Limited
Address of centre:	Donoughmore, Ballyraggett, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	03 September 2024
Centre ID:	OSV-0000207
Fieldwork ID:	MON-0043961

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 3 September 2024	09:00hrs to 17:00hrs	Mary Veale	Lead
Tuesday 3 September 2024	09:00hrs to 17:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors. Based on the observations of the inspectors, and discussions with residents and staff, Brookhaven Nursing Home was a nice place to live. Residents' rights and dignity were supported and promoted by kind and competent staff. The inspectors spoke with 15 residents and four visitors in detail on the day of inspection. Residents spoken with were very complimentary in their feedback and expressed satisfaction with staff, the activities programme, food served and with the standard of environmental hygiene. Interactions observed were seen to be respectful towards residents.

Brookhaven Nursing Home is a two storey building situated on the outskirts of the village of Ballyragget, in County Kilkenny. The design and layout of the premises met the individual and communal needs of the residents'. The centre was observed to be safe, secure with appropriate lighting, heating and ventilation. There was a choice of communal spaces. For example, residents had access to a large reception area, three day rooms, two large dining rooms, a lounge, a sitting room, an oratory, visitor's rooms, an aromatherapy room and a hair salon. The day rooms had televisions, large tables and were spaces in which residents' could read the newspaper, listen to music or partake in activities. The centres production kitchen, laundry, staff changing facilities and maintenance rooms were situated to the rear of the centre. There was an indoor smoking room for residents who chose to smoke. The first floor of the building was not part of the designated centre. The first floor contained the centres administration office and staff accommodation. There was an on-going schedule of works taking place to upgrade the premises.

The centre was divided into four wings which were called after local areas, the Attanagh wing, Donoughmore wing, Kilminan wing and Rosconnell wing. Bedroom accommodation consisted of 63 single and four twin bedrooms, all with en-suite shower, toilet and wash hand basin facilities. The privacy and dignity of the residents in the multi-occupancy rooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings. Pressure reliving specialist mattresses, cushions and fall prevention equipment were seen in some of the residents' bedrooms. Assistive call bells were available in both the bedroom and en-suite for residents' safety.

Finishes, materials, and fittings in the communal areas and resident bedrooms struck a balance between being homely and being accessible, whilst taking infection prevention and control into consideration. However, excessive infection prevention and control signage on display in some parts of the centre detracted from the homely atmosphere. For example, one shared toilet had four hand hygiene posters displayed and several bedroom doors had personal protective equipment (PPE) posters on display.

The ancillary facilities generally supported effective infection prevention and control. Staff had access to two dedicated housekeeping rooms for the storage and preparation of cleaning trolleys and equipment. Cleaning carts were equipped with a locked compartment for storage of chemicals. The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process.

There were two treatment rooms for the storage and preparation of medications, clean and sterile supplies and dressing trolleys. These rooms were observed to be clean and tidy. However, clinical hand washing sinks in both treatment rooms were multipurpose and were heavily stained. The main kitchen was clean and of adequate in size to cater for resident's needs. Residents were complimentary of the food choices and homemade meals made on site by the kitchen staff. Toilets for catering staff were in addition to and separate from toilets for other staff. There were two sluice rooms for the reprocessing of bedpans, urinals and commodes. However, improvements were required in the management of bedpans and urinals. Findings in this regard are presented under Regulation 27.

Wall mounted dispensers for aprons, masks and gloves were available along corridors. Conveniently located alcohol-based product dispensers along corridors facilitated staff compliance with hand hygiene requirements. However, facilities for and staff access to clinical hand wash sinks did not promote effective hand hygiene. There was limited access to dedicated clinical hand wash sinks for staff use. Findings in this regard are also discussed under Regulation 27.

Residents had access to courtyard garden areas from all wings and an outdoor space to the front of the building. The enclosed outdoor spaces were readily accessible and safe, making it easy for residents to go outdoors independently or with support, if required. The inspectors were informed that garden areas had recently been maintained and residents were encouraged to use the garden spaces when the weather allowed. The courtyards had level paving, comfortable seating, tables, and flower beds.

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

The inspectors observed the dining experience for residents in both the oak dining room and ash dining room. The oak dining room tables were covered with white cloth table clothes and had a fine dining room atmosphere. The meal time experience was quiet and was not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times. The inspectors observed homemade soup and baked snacks been offered to residents outside of meal times.

The inspectors observed residents interacting with staff, attending activities, and spending their day moving freely through the centre from their bedrooms to the communal spaces. Residents were observed engaging in a positive manner with

staff and fellow residents throughout the day and it was evident that residents had good relationships with staff. There were many occasions throughout the day of inspection in which the inspectors observed laughter and banter between staff and residents. Many residents had build up friendships with each other and were observed sitting together and engaging in conversations with each other. The inspectors observed staff treating residents with dignity during interactions throughout the day. Residents' said they felt safe and trusted staff. A number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspector. These residents appeared to be content, appropriately dressed and well-groomed.

Residents' spoken with said they were very happy with the activities programme in the centre. The weekly activities programme was displayed on notice boards in all wings. The residents in the day room on the Attanagh wing were observed enjoying a French themed morning tea and bingo was observed taking place in the afternoon on the day of inspection. The inspectors observed staff and residents having good humoured banter during the activities.

Visitors whom the inspectors spoke with were complimentary of the care and attention received by their loved one. Visitors were observed attending the centre on the day of inspection. Visits took place in the residents' bedrooms. There was no booking system for visits and the residents who spoke with the inspectors confirmed that their relatives and friends could visit anytime.

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

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

Capacity and capability

Inspectors found that on this inspection, while there were management systems in place further actions were required by the registered provider to comply with Regulation 27: Infection prevention and control and areas of Regulation 5: Individual assessment and care planning, Regulation 23: Governance and management, and Regulation 28: Fire precautions. Improvements were found in care planning, the premises and the complaints procedure since the previous inspection in February 2024.

Brookhaven Nursing Home Limited was the registered provider for this centre. At the time of inspection there were four directors in the company. The centre was part of a group of five nursing homes and had access to group resources, for example; finance, human resources and facilities management. The person in charge reported

to the regional manager to which reported upwards to the clinical operations director who reported to the registered provider representative.

A the time of inspection the person in charge was on leave and the clinical nurse manager was managing the centre in their absent with the support of the regional manager and clinical operations manager. The post of assistant director of nursing (ADON) had been vacant since the 19th August 2024, a person had been recruited to the ADON position and was due to commence on the 4th September 2024. The person in charge was supported by a team consisting of an assistant director of nursing, a clinical nurse manager, registered nurses, health care assistants, kitchen staff, housekeepers, activities staff, administration and maintenance staff. Since the previous inspection, changes had been made to the management structure and the person in charge had support from a regional manager and clinical director who attended the centre one day a week. The post of quality and compliance manager had been filled and was providing support to the centre. There were good management systems in place to monitor the centre's quality and safety. There were clear reporting structures and staff were aware of their roles and responsibilities.

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

There was an ongoing schedule of training in the centre and the person in charge had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was mostly up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, medication management, and infection prevention and control. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safeguarding procedures.

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

The centre had an extensive suite of meetings such as local management meetings, head of department meetings and staff meetings. There were high staff attendance at meetings in the centre. Meetings took place monthly in the centre. Meeting records were detailed containing agenda items, discussion that took place, actions required, the person responsible and the time frame to complete the outcome of the item. The person in charge completed a weekly report which included items such as

key performance indicators (KPI's), training, fire safety, actions required from audits, complaints feedback and clinical risks.

Improvements were required in the audit process to ensure a safe, appropriate, consistent and effective service was provided in the centre. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example; infection prevention and control, care planning and medication management audits. Infection prevention and control audits covered a range of topics including hand hygiene, environment hygiene and sharps management. Audits were scored, tracked and trended to monitor progress. High levels of compliance had been achieved in recent audits. However, all elements of standard infection control precautions were not included in the audits. Details of issues identified are set out under regulation 23.

The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and color coded cloths to reduce the chance of cross infection. Cleaning records viewed confirmed that all areas were cleaned each day and deep cleaned on a regular basis. A deep clean had been completed after the recent norovirus outbreak.

Inspectors followed up on the provider's progress with completion of the actions detailed in the compliance plan from the last inspection and found that they were endeavouring to improve existing facilities and physical infrastructure at the centre through ongoing maintenance. A new hand washing sink had been installed in a housekeeping room and a number of damaged bed tables had been replaced. However procedures for reprocessing urinals and bedpans had not been reviewed. Findings in this regard are presented under Regulation 27.

Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the Clinical Nurse Manager, who had been nominated to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. Surveillance of multi-drug resistant organism (MDRO) colonisation was undertaken and had identified a small number of residents colonised with Extended Spectrum Beta-Lactamase (ESBL) and Vancomycin-resistant Enterococci (VRE). This was communicated to staff on handover reports.

A review of notifications submitted to the Chief Inspector found that the outbreaks were reported in a timely manner. The centre had experienced a norovirus outbreak in June 2024. A total of 40 residents and 18 staff developed symptoms consistent with norovirus infection. A comprehensive review of the management of the outbreak of had been completed by the person in charge. The review identified and issues identified on the day of the inspection that may have contributed to the outbreak included inadequate staff hand washing facilities and ineffective decontamination of commodes and urinals. An action plan to address these and other issues identified in the outbreak review had been developed.

The management team had a good understanding of their responsibility in respect of managing complaints. The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents spoken with were aware of how to make a complaint and whom to make a complaint to.

Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the residents' needs. There was a minimum of two registered nurses and four health care assistants on duty in the centre at all times for the number of residents living in the centre at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

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

Judgment: Compliant

Regulation 21: Records

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

Judgment: Compliant

Regulation 23: Governance and management

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

The statement of purpose which Brookhaven Nursing Home Limited was registered against states that there should be 30 whole time equivalent (WTE) health care attendants and 7 senior health care attendants. On review of the rosters provided to the inspectors on the day of inspection and calculation of WTE hours worked by staff. The following WTE vacancies were identified:

- 2.5 WTE senior health care attendant posts
- 8 WTE health care attendant posts

This was a repeated finding following the February 2024 inspection.

Management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored required improvement. For example;

- Infection prevention and control and antimicrobial stewardship governance arrangements generally ensured the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship however further action is required to be fully compliant. Such as, there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services. Local infection prevention and control audits did not include all elements of standard infection control precautions such as equipment, waste and laundry management.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and notification events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the

investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre.

The complaints procedure also provided details of the nominated complaints and review officer. These nominated persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life. Staff were seen to be respectful and courteous towards residents. On this inspection further improvements were required to comply with infection prevention and control and areas of care planning, and fire safety.

A sample of care plans and assessments for residents were reviewed. Comprehensive assessments were completed for residents on or before admission to the centre. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre and reviewed at intervals not exceeding four months. Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. However, a review of multi-drug resistant organism (MDRO) care plans found that sufficient information was not recorded to effectively guide and direct the care residents that were colonised with MDRO's. Findings are presented under Regulation 5.

The overall premises were designed and laid out to meet the needs of the residents. Bedrooms were personalised and residents had ample space for their belongings. Improvements were found to the premises since the previous inspection. Overall, the general environment including residents' bedrooms, communal areas and toilets appeared visibly clean and well maintained.

Some positive indicators of effective infection prevention were identified by inspectors. For example, the number of residents with indwelling urinary catheters had reduced by almost half since January 2024. This in turn reduced the risk of urinary catheter associated infections. Staff were observed to apply basic infection prevention and control measures known as standard precautions to minimise risk to residents, visitors and their co-workers, such as appropriate use of PPE and safe handling and disposal of used linen and waste. Resident equipment was generally clean with some exceptions. For example, a bedpan, urinal and wheelchair (which was tagged as "clean") were visible unclean.

Some examples of good antimicrobial stewardship practice were also identified. For example, antibiotic use was monitored and tracked each month. There were no

residents prescribed prophylactic antibiotic antibiotics on the day of the inspection, which is good practice.

Prescribers had access to relevant laboratory results required to support timely decision-making for optimal use of antimicrobials. A review of resident files found that clinical samples for culture and sensitivity were sent for laboratory analysis as required. However, staff were not engaging with the national "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance.

Repeated findings were found in fire safety following the previous two inspections. The centre had automated door closures to all compartment doors, all bedroom doors on Rosconnell wing and a small number of bedroom doors on Donoughmore wing. On previous inspection in February 2024, the inspector was informed that the provider had employed a fire safety engineer to complete a fire door audit and assurances were received in the compliance plan that works would be undertaken to replace fire doors in the centre by the end of July 2024. This is discussed further under Regulation 28.

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

There were systems in place to safeguard residents and protect them from the risk of abuse. Staff were supported to attend safeguarding training. Staff were knowledgeable of what constituted abuse and what to do if the suspected abuse. All interactions by staff with residents were observed to be respectful throughout the inspection.

There was a rights based approach to care in this centre. Residents had the opportunity to meet together and discuss relevant issues in the centre. Residents had access to an independent advocacy service. Residents' rights, and choices were

respected. Residents were actively involved in the organisation of the service. Residents has access to daily national newspapers, weekly local newspapers, books, televisions, and radio's. Mass took place in the centre weekly which residents said they enjoyed.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 17: Premises

The registered provider provided premises which were appropriate to the number and needs of the residents living there. The premises were clean, well maintained and conformed to the matters set out in Schedule 6 Health Act Regulations 2013.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services. This had been incorporated into the providers electronic document management system.

When residents returned from the hospital, inspectors saw evidence that relevant information was obtained upon the residents' readmission to the centre.

Judgment: Compliant

Regulation 26: Risk management

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

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27; infection control and the National Standards for infection prevention and control in community services (2018), however further action is required to be fully compliant. For example:

- Two bedpan washers were not connected to an appropriate detergent. This may have impacted the effectiveness of decontamination.
- Staff reported that they manually emptied and cleaned commodes/ bedpans prior to placing them in the bedpan washer for decontamination. This increased the risk of environmental contamination and the spread of MDRO colonisation and infection including Norovirus. This was a repeat finding.
- Barriers to effective staff hand hygiene were identified during the course of this inspection. There was a limited number of dedicated hand wash sinks in the centre and the sinks in the resident's en-suite bathrooms were dual purpose used by residents and staff. There was no risk assessment in place to support this practice.
- Staff told inspectors that residents wash basins were emptied and rinsed in residents en-suite sinks. This practice also increased the risk of environmental contamination and the spread of MDRO colonisation and infection including Norovirus.
- The provider had introduced a tagging system to identify shared equipment that had been cleaned. However, this system had not been consistently implemented at the time of inspection. For example some items of equipment were not tagged and a wheelchair that was labelled as clean was visibly unclean.

Judgment: Not compliant

Regulation 28: Fire precautions

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

- Assurances are required that the works as identified and recommended in a fire door audit completed by a competent person in May 2023 will be completed. This is a repeated finding following the previous inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. However, further action is required to be fully compliant. For example;

- Relevant information, including the site and date of colonisation was not recorded in care plans to effectively guide and direct the care residents colonised with MDROs including including VRE and and ESBL.
- Accurate infection prevention and control information was not recorded in two resident care plans to effectively guide and direct the care of residents that were colonised with an MDRO.

Judgment: Substantially compliant

Regulation 6: Health care

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

A number of antimicrobial stewardship measures had been implemented to ensure antimicrobial medications were appropriately prescribed, dispensed, administered, used and disposed of to reduce the risk of antimicrobial resistance.

Judgment: Compliant

Regulation 8: Protection

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

for reporting concerns. The centre did not act as a pension agent for any of the residents.

Judgment: Compliant

Regulation 9: Residents' rights

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

Discussions with residents and a review of minutes found that residents were consulted on and kept informed of the infection prevention and control measures and the reason for these measures during outbreaks. Residents were reminded about cough etiquette and encouraged and facilitated to clean their hands and were actively assisted with this practice where necessary.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brookhaven Nursing Home OSV-0000207

Inspection ID: MON-0043961

Date of inspection: 03/09/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Register Provider acknowledges the feedback provided regarding staffing resources, specifically the implementation of the staffing structure as outlined in our Statement of Purpose under Regulation 23 (a).

We recognize that, as observed during the inspection, our current roster differs from the specified 30 WTE health care attendants and 7 senior health care attendants due to adjustments made based on our current occupancy. On the day of inspection, our staffing levels were sufficient to meet the needs of our resident population effectively. However, we understand that the Statement of Purpose is designed to reflect WTE staffing levels based on full occupancy.

To address this, we have added an additional section to our staffing table that distinguishes between WTE requirements for our current occupancy and the full occupancy levels. Additionally, as part of our proactive staffing strategy, we maintain a panel of relief HCA's, ensuring we have immediate access to qualified personnel for any unexpected staffing needs. This approach enables us to provide consistent and reliable care, aligned with the high standards detailed in our Statement of Purpose. (Completed)

Our local IPC audits are currently under review to enhance their effectiveness. Moving forward, these audits will comprehensively cover critical elements such as waste management and laundry practices. This review will ensure that our IPC protocols align with best practices, further reducing the risk of contamination and infection spread within the facility. This action will be completed by 20/11/2024.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• Bedpan Washers
Both bedpan washers have been connected to appropriate detergent supplies to ensure effective decontamination of bedpans and urinals. This corrective action was completed on the inspection day. Any detergent considered unsuitable has been discarded.
Completed 03/09/2024

• Staff Training and Correct Cleaning Procedures
On 30.10.2024, staff meetings were conducted with all relevant departments to reinforce the correct cleaning protocols. The outdated cleaning process poster was removed from both sluice rooms on 03.09.2024, and updated posters displaying the correct techniques have been installed. During these sessions, staff received additional re-education on the proper disposal of bedpan/urinal contents and resident washbasins, further reducing the risk of environmental contamination and minimizing MDRO colonization and infection spread.

• Risk Assessment for Dual Usage of Sinks in Resident Bedrooms
A comprehensive risk assessment has been carried out to address the dual usage of sinks in resident bedrooms. As part of our action plan, we are increasing the number of dedicated hand-wash sinks by installing one in each wing. The expected completion date for these installations is 29.11.2024.

• Improved Accountability and Monitoring of Communal Equipment Cleaning
The Management Team have implemented a signing sheet to ensure the correct use of the "I Am Clean" tagging system for communal equipment, such as hoists and wheelchairs. This measure enhances staff accountability for proper cleaning procedures. The management team closely monitors compliance through daily walkaround audits, ensuring adherence to hygiene standards and allowing for immediate daily corrective actions when necessary.
Completed by 07/11/2024

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A contractor has been engaged to repair any non-compliant fire doors to ensure they meet the required fire resistance rating of at least 30 or 60 minutes. The completion of

this work is scheduled for March 31, 2025.

In the interim, mitigation measures have been implemented to ensure safety. These include daily inspections of all doors to identify any immediate issues, such as damaged seals, with prompt repairs conducted as necessary. We are also ensuring that all doors remain unobstructed and have reinforced the importance of keeping doors closed through education for both staff and residents. Additionally, frequent fire safety training sessions and simulated fire drills are being conducted to maintain preparedness.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

A comprehensive review of all Care Plans is currently underway to ensure that each plan provides detailed information, including the specific site and date of colonization for residents with MDRO or multiple colonizations. This review aims to ensure that infection prevention and control measures are explicitly outlined, allowing staff to deliver informed and targeted care. The review is scheduled for completion by November 29, 2024.

The importance of thorough documentation and accuracy in recording care plan details was also reinforced during our recent nurses' meeting on October 30, 2024. This emphasis supports all nursing staff in aligning with documentation standards that promote effective infection control.

Additionally, monthly audits will be conducted by the local management team, complemented by spot audits overseen by the Group's Clinical Director, to ensure consistent compliance.

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 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	09/09/2024
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.	Substantially Compliant	Yellow	20/11/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of	Not Compliant	Orange	29/11/2024

	healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	31/03/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	29/11/2024