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:	Bridhaven Nursing Home
Name of provider:	Bridhaven Nursing Home Limited
Address of centre:	Spa Glen, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	20 November 2024
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0041669

About the designated centre

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

Bridhaven Nursing Home is a designated centre located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 182 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in six suites: on the lower ground floor - (1) Clyda is a dementia-specific unit with 18 bedrooms all single rooms with full en suite facilities of shower, toilet and wash-hand basin); on the ground floor - (2) Lee (33 beds – two twin and 29 single with en suite facilities), (3) Blackwater (37 beds – six twin and 25 single full en suite facilities) 4) Lavender (13 beds - all single full en suite bedrooms); on the first floor - (5) Bandon (45 beds – four twin and 37 single with en suite facilities), (6) Awbeg (36 beds – seven twin and 22 single with en suite facilities). Each suite had a day room and dining room and there are additional seating areas located at reception and throughout the centre. There is a large seating area upstairs for resident to relax with views of the enclosed bonsai garden and also the entrance plaza. Residents in Clyda have access to a well-maintained enclosed garden with walkways, garden furniture and shrubbery; there is a second enclosed garden accessible from the Blackwater day room. Bridhaven Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	126

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 20 November 2024	09:00hrs to 17:30hrs	Breeda Desmond	Lead
Tuesday 19 November 2024	09:00hrs to 17:30hrs	Caroline Connelly	Support
Wednesday 20 November 2024	09:30hrs to 17:30hrs	Siobhan Bourke	Support

What residents told us and what inspectors observed

This was an unannounced one-day inspection. Inspectors met many residents during the inspection and spoke with 12 residents in more detail, and 11 visitors. Residents gave positive feedback and were complimentary about the staff and the care provided; they reported improvement in the quality of food served and that they enjoyed their meals; a number of residents said they were happy and one resident said she was very content as she had company, there was always something going on and the staff were good fun and kind.

There were 126 residents residing in Bridhaven at the time of inspection. Bridhaven is a three storey facility with resident accommodation set out in six units over the three floors: Clyda (dementia specific unit) was located on the lower ground floor; Blackwater, Lee Side and Lavender Cottage (dementia specific unit) on the ground floor; Bandon and Awbeg upstairs (Bandon was currently closed for renovations). Management and HR offices, the main kitchen, maintenance and facilities, staff facilities, laundry, and storage areas were accommodated on the lower ground floor.

Initially, inspectors visited all the units and saw that some residents were receiving personal care, others were being escorted to the different days rooms, while others were still in bed. Some residents remained in bed throughout the day and staff had ensured their music was playing at an appropriate volume and inspectors saw residents were relaxed in their environment. One resident explained that he preferred to stay in his bedroom in the mornings to read the newspaper in quietness and later he would go up to the activities. A few residents on Blackwater, Leeside and Awbeg were seen to have their breakfast in the dining rooms, but most had their breakfast either in bed or in their bedrooms; residents in Clyda were seen to enjoy their breakfast in the dining room.

Throughout the day inspectors observed staff interaction with residents. Many of these interactions were respectful and kind with positive engagement, chat and social conversation. Regarding activities, additional activities staff were appointed and the variety of activities had improved following the findings of the last inspection. At 10:30am, residents watched mass live-streamed from Mallow church, on television in dayrooms. This was followed by staff offering residents beverages and snacks including freshly made scones, a selection of juices as well as tea and soup. One resident was seen to make their own coffee in the pantry upstairs. Staff facilitated a sing-song where staff were seen to gently encourage resident participation while singing and dancing to the music. Children for the local playschool arrived mid-morning and visited Awbeg and entertained residents there, who were observed to really enjoy the activity.

Dinner time was observed on different units and while the inspectors observed some positive engagement by staff when providing assistance with meals where meals were served in a normal social manner, on another unit, mealtime was hap-hazard and disorganised. Residents began coming to the dining room from 12:20hrs but

were not served until after 13:10hrs. During lunch time, staff were seen to prepare the adjoining dayroom for the remembrance mass in the afternoon and dragged chairs across the floor creating excessive noise which took from the social dining experience. In the afternoon, during the mass in the day room, staff continued to wash-up and stow away in the pantry, and despite the inspector requesting staff to desist due to the noise level, pantry staff continued with their tasks, which took from the solemnity of the remembrance mass. In general, the noise level was high and some residents and a visitor highlighted the noise level to the inspector.

The activities boards were a colourful display with easily accessible information for residents; they were displayed on each unit as reminders for residents of the activities on each unit such as arts and crafts, bingo, 'sit & get fit' games and an array of movie nights for example. Other publications and information on display included the monthly Bridhaven news letter, statement of purpose, complaints procedure and advocacy services; the advocate was on site on a weekly basis to support residents, including residents under 65yrs. The residents' guide was displayed on the wardrobe in each bedroom so residents had access to their individual copy. Bookshelves with a variety of books and games were seen in all dayrooms and the small sitting room on Awbeg; additional reading material was provided by the local community library for residents. There were large colourful displays on each unit regarding 'Safeguarding' and what that means for all service users.

Further improvement was seen regarding the premises since the previous inspection with painting, redecorating both inside and outside the building. Residents personal storage in their bedrooms comprised a double wardrobe and bedside locker; some residents had an additional chest of drawers and an additional single wardrobe. Low low beds, crash mats, specialist mattresses and cushions, and assistive equipment such as hoists were available. Each resident had their own sling for use when being transferred.

The hairdressers room, which was relocated on the last inspection was a big hit with residents spoken with; one resident had got her hair up-styled the previous day and she was delighted with the hair salon. A new self-service coffee station was installed beside the hair salon and visitors were seen to avail of the coffee while visiting their relative. A second coffee doc was installed in Awbeg during the inspection.

The smoking shelter was located in the garden in Blackwater; it had seating, fire blanket, fire extinguisher, cigarette butt disposal, and the fire retardant aprons were re-located to the shelter for easier access. Even though the outdoors temperature was freezing a few residents were seen to independently access the outdoors and walk around the garden while having a cigarette. The raised flower beds and walkways were well maintained. There was a call bell outside to enable residents call for assistance.

There was a separate secure entrance to Clyda so that visitors could access the unit without needing to go through the centre. The reception area here had infection control precautionary facilities along with a sign-in sheet. Residents had access to the enclosed garden via patio doors in the day room. This was a large well

maintained space with walkways, shrubberies, raised flower beds and seating for residents to rest.

Alarm bells were wall mounted at the end of each corridor for easy access by staff and residents to call for help; they were also available in communal rooms should the need arise. Residents using oxygen had signage indicating oxygen in use in their bedrooms.

Throughout the inspection, it was noted that the premises was generally very clean. There were hand-wash hubs on all units at different locations at the start and end of corridors. All had advisory signage to explain how to wash hands appropriately and other signs displayed included the 'five moments of hand hygiene' as reminders to staff to wash their hands. Paper towel dispensers, hand soap and pedal bins were alongside each hand-wash sink. Dani centres were wall-mounted throughout the centre which enabled staff to easily access personal protective equipment (PPE) such as disposable hand gloves and aprons. Wall-mounted hand gel dispensers were available throughout the centre. Some bedroom furniture had been replaced, however, surfaces of some furniture such as bed frames, lockers, chest of drawers, doors and door frames were chipped and worn.

Laundry was segregated at source and laundry trolleys had pedal-operated function. There was a separate entry and exit to the laundry to prevent cross-over of dirty and clean laundry as well as specialist washing machines with a one-way operating system. Directional work-flow signage was seen within the laundry to mitigate the risk associated with cross infection. Laundry staff spoken with were knowledgeable regarding appropriate work-flows and infection control. Additional controls were put in place following the findings of the last inspection regarding labelling residents' clothing which had resulted in a reduction in missing laundry.

Emergency evacuation plans were displayed throughout the centre with a point of reference to indicate one's location in the centre; primary evacuation routes were detailed in the floor plans. Floor plans were orientated to reflect their relative position in the centre. Stairwells were seen to be free of clutter.

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 impact the quality and safety of the service being delivered.

Capacity and capability

This inspection was undertaken to monitor compliance with the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2013 (as amended) and to follow up on the findings of the previous inspection in April 2024. The regulator acknowledges the efforts made by the registered provider to strengthen the governance and management structure with additional managerial posts, nonetheless, this new structure will take time to embed. The findings of this

inspection showed that further action was required by the registered provider regarding effective management systems to ensure a safe service was provided for residents as repeat findings were identified relating to staff training, staff supervision, fire safety precautions, medication management, infection control, food and nutrition regarding serving of meals, and aspects of residents' care planning documentation. Additional areas of concern identified on this inspection are detailed under the relevant regulations in this report.

The inspectors followed up on a large number of statutory notifications and unsolicited information submitted to the Chief Inspector of Social Services in relation to care in the centre and safeguarding. Some of these issues were substantiated and these issues are detailed throughout the report.

Bridhaven Nursing Home is a designated centre for older adults and is registered to accommodate 182 residents. The provider is part of the Virtue group and the company has four directors' with one of the directors acting on behalf of the provider. The inspectors were informed on inspection that the management team was in the process of changing with the appointment of a new director. The appropriate notification regarding this change in senior management had not been received by the regulator at the time of this inspection. Nonetheless, a new regional director was appointed as person participating in management and they were on site three days per week to support the service.

The current management structure on site comprised the person in charge, two assistant directors of nursing (ADONs) with sanction for a third ADON post, five clinical nurse managers (CNMs), and senior nurses, staff nurses and healthcare assistants (HCAs). This service was supported by the health-care team, household, catering and administration staff. A human resources (HR) administrator, maintenance team and facilities manager supported the non clinical aspect of service. Two CNMs rotated on duty at weekends to support the governance structure; on night duty there was supernumerary CNM or senior nurse cover. The group clinical director provided training on site.

The CEO and COO facilitated weekly meetings and oversight was provided regarding the governance, operational management and administration of the service. The new person in charge and PPIM facilitated meetings with all staff to outline the vision for the service and regular meetings were planned as part of staff supervision and oversight. Weekly meetings were facilitated with the ADONs and CNMs as part of their quality strategy. Quality and safety monitoring systems in place included weekly collection of key performance indicators (KPIs) such as falls, restraints, infection, weights, pressure ulcers and complaints for example. An annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents. The newly appointed person in charge and PPIM had completed a regulations review with associated risk ratings, and had identified many of the issues found on inspection and had developed action plans to remedy concerns. Nonetheless, many of the issues identified were repeat findings of previous inspections. Further evidence of this is discussed throughout the report and detailed under Regulation 23, Governance and Management.

Duty rosters on each unit were reviewed and rosters showed adequate staff, on the day of inspection. A review of training records demonstrated that while training was scheduled in December for manual handling and lifting, safeguarding and responsive behaviours, mandatory training was not up to date for all staff as detailed under Regulation 16: Training and staff development.

The complaints procedure was displayed at different locations throughout the building; it was in an accessible format for residents. The complaints log was reviewed and issues were recorded in line with current legislation, followed up and investigated.

Regulation 14: Persons in charge

The person in charge was newly appointed to the service; she was full time in post and had the necessary qualifications and experiences as required in legislation. She was involved in the operational management and the day-to-day running of the service.

Judgment: Compliant

Regulation 15: Staffing

From a review of staff rosters, feedback of residents and observation on inspection, there were adequate staff to the size and layout of the centre and the assessed needs of residents. The number of staff designated for activities had increased following the findings of the previous inspection to enable meaningful activation in all units throughout the day.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required as mandatory training was not up to date for all staff and some staff were not appropriately supervised in the centre:

Regarding supervision:

- supervision of staff was required to ensure residents were served their meals in a timely and dignified manner.

Regarding training:

The following staff had not completed mandatory training in accordance with the centers policy:

- 22% fire safety
- 23% safeguarding
- 50% Responsive behaviours
- 25% infection control.

Judgment: Substantially compliant

Regulation 21: Records

Improvement was noted following the findings of the last inspection where confidential records were now stored securely in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

Additional efforts made by the registered provider to strengthen the management team were acknowledged, nonetheless, action was required to ensure that managerial systems were in place to ensure the service was safe, appropriate, consistent and effectively monitored, as follows:

- several repeat findings from previous inspections relating to the following required action -
    - residents' care documentation as detailed in Regulation 5, Individual assessment and care plan
    - wound care management
    - medication management
    - food and nutrition
    - fire safety precautions as detailed under Regulation 28
    - oversight of infection control as detailed under Regulation 27.

Judgment: Not compliant

Regulation 31: Notification of incidents

While notifications, correlating with incidents logged, were submitted, many were not submitted within the regulatory time-frame of three-day notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed throughout the centre. It was in an accessible format and was updated to reflect the change to legislation. A review of complaints logged showed that records were maintained in line with current legislation, issues were followed up in a timely manner, actions taken on foot of complaints to mitigate recurrence and the outcome of complaints were recorded.

Judgment: Compliant

Quality and safety

Feedback from residents and relatives was positive regarding care and welfare in the centre, and residents access to meaningful activities had improved on the previous inspection findings.

Records demonstrated that independent advocacy was accessed for residents in accordance with their wishes. A sample of residents' care planning documentation was reviewed and showed mixed findings. The daily narrative for both day and night duty was maintained on the resident's status and progress. Touch-screen devises were displayed on corridors to enable staff record care delivered to residents. A one-page resident's summary was available which provided information about each resident and their care needs to inform safety pauses and daily handovers. Monthly weights were completed and information trended to ensure appropriate interventions such as referral to speech and language therapy with associated care plans. While validated risk assessments were in place to enable staff to assess residents care needs, these were not comprehensively or consistently completed to adequately inform the care planning process. This was further discussed under Regulation 5, Individual assessment and care planning.

The GP was on-site Monday – Friday, and out-of-hours GP cover was provided by South Doc. Residents were seen to have good access to health and social care professionals such as a dietician, dental, physiotherapist, occupational therapist (OT), speech and language therapist (SALT), tissue viability nurse specialist, to enable better outcomes for residents. Access to the mobile diagnostic unit enabled residents to have x rays within the centre and negated the requirement to go to an accident and emergency department with the associated anxiety and upset.

Residents notes demonstrated that they had access to tissue viability nurse specialist to support wound care, however, supporting wound care management documentation was not always in place. Residents had access to palliative care services. Exercise programmes were held on a weekly basis as part of their positive aging programme to help residents maintain their level of muscle tone and mobility.

Behavioural support charts were in place to support the relevant residents which included narrative of the residents normal behaviour, examples of behavioural disturbances and potential triggers, the possible non-pharmacological interventions to support the resident along with the pharmacological interventions.

A sample of controlled drugs records were examined and these were maintained in line with professional guidelines. Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. A record of 'as required' (PRNs) psychotropic medications were maintained as part of medication management; these records showed the rationale for administration of PRNs. Inspectors joined two separate medication rounds where a sample of medication management administration records were examined. Residents had photographic identification and allergy status details. While some medications requiring crushing were individually prescribed in line with best practice, others were not; this is further discussed under Regulation 29, Medicines and pharmaceutical services.

An up to date record of residents with previously identified multi-drug resistant organism (MDRO) colonisation (surveillance) was not maintained. This meant that the provider was unable to monitor the trends in development of antimicrobial resistance within the centre. [The was a repeat finding.] Findings regarding this are presented under Regulation 27.

A review of the dining experience required review to ensure dining was in line with a social model of care. This is further discussed under Regulation 18, Food and Nutrition.

The advocate was on site on a weekly basis. Residents availed of this service including residents under 65yrs. Family meetings had commenced and the first meeting with the new person in charge was held just before the inspection in November. Residents meetings were facilitated and the new management had reviewed the minutes of previous meetings and implemented changes such as a review of the activities programme to ensure the wishes and preferences of residents.

Regarding the premises, lots of equipment was updated with new wheelchairs and hoists, some flooring was upgraded and painting and decorating was ongoing; and inspectors were informed that a complete new call-bell system was to be installed. In general, the premises was well maintained, however, there were a few areas identified that required attention and these are outlined under Regulation 17: Premises.

Emergency evacuation floor plans were displayed throughout the centre. Evacuation routes with point of reference were detailed and they were orientated to reflect their

relative position in the centre and were easy to follow. A sample of fire doors were checked and found to be in good working order. Records demonstrated that weekly fire alarm testing was completed. Current service records were available regarding mobile fire equipment and quarterly testing of emergency lighting system. Nonetheless, issues were identified regarding fire safety, and these are detailed under Regulation 28: Fire precautions. Current service records were available for gas appliances and electrical equipment.

Regulation 11: Visits

Visiting was facilitated in line with the requirements of the regulations. Visitors were welcomed into the centre and inspectors saw that visitors were familiar with the risk management procedures upon entering the centre of signing in and hand hygiene. There was ample room for residents to meet their relative in private if they wished. A new coffee doc was located by the main entrance and a second upstairs in Awbeg. Visitors were seen to avail of this lovely new amenity.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had good access to personal storage space with a double wardrobe, bedside locker and many residents had an additional chest of drawers. Improvement was noted regarding laundry services and a review of current complaints demonstrated there was no issue with laundry services.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure the premises was maintained in line with the requirements of Schedule 6 of the regulations as follows:

- call bells in Clyda could not be used in many residents' bedrooms as sensory alarm mats were in use
- the door into the dining room in Blackwater banged continuously during the inspection and required action.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Action was required regarding oversight of food and nutrition and the dining experience for residents as follows:

- the dining experience on one unit was hap-hazard with residents in the dining room at 12:20pm and not served until after 13:10pm
- tables were not appropriately set before residents came to the dining room
- the noise level in the dining room on Blackwater and Lavender was very loud and not conducive to a social dining experience
- the dining experience for residents that stayed in the Awbeg day room was not conducive to a social dining experience.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did not comply with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services (2018). Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example:

- information relating to MDROs was not routinely included in residents' pre-admission assessments
- an up to date record of residents with previously identified multi-drug resistant organism (MDRO) colonisation (surveillance) was not consistently maintained throughout the centre, consequently, management and staff were unaware of which residents were colonised with MDROs. Lack of awareness meant that the provider was unable to monitor the trends in development of antimicrobial resistance within the centre or that appropriate precautions may not have been in place to prevent the spread of the MDROs within the centre, [this was a repeat finding]
- while three staff completed the IPC lead programme, the national standards had not been implemented into practice regarding antimicrobial stewardship and MDRO oversight
- notwithstanding the capital project plan in place to address the environment and equipment concerns, the following issues remained outstanding which had the potential to impact the effectiveness of infection prevention and control with the associated risk of transmitting a healthcare-associated infection within the centre: surfaces to furniture such as bed frames, lockers, and bed tables were worn so effective cleaning could not be assured
- some of the carpet flooring on Clyda was malodorous and stained

- sharps containers were not closed in accordance with best practice safety guidelines.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was necessary to ensure fire safety precautions as follows:

- full compartment simulated evacuations had not been completed in all units to be assured that a full compartment evacuation could be completed in a timely and safe manner by all staff
- evacuations were not completed routinely so it could not be assured that all staff could complete an evacuation in a timely and safe manner
- the fire safety information had not been updated to reflect the new management details regarding emergency contacts
- the practice of locking some bedroom doors required review and risk assessing, to ensure correct and safe evacuation.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The following records required action to ensure residents' medication records were maintained in line with professional guidelines and regulatory requirements:

- Staff were not always administering medications in line with the directions of the prescriber: while some medications requiring crushing were individually prescribed in line with best practice, others were not, and staff were crushing medications even though the instruction to crush was not part of the prescription. Inappropriate crushing of some medications could result in residents receiving sub-optimal effective dosages of medications, and in contravention of manufacturer's guidelines. This was a repeat finding.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were examined and these showed mixed findings. Some had personalised information to inform individualised care while

many others did not have this detail and required action to enable staff provide individualised care. For example:

- a resident's breathing and circulation assessment and care plan did not detail the resident's significant cardiac and circulatory medical history; there was no information or clinical indication in their care records to explain their use of an inhaler
- other significant medical histories, included in the speech and language therapist (SALT) report, were not detailed in any care documentation
- depending on which assessment was being reviewed, a resident had a MUST nutritional score of 0, 3 and 4, with no change to their appetite and no weight loss even though the resident had lost weight and was under weight the report following review by SALT detailed the resident required a specified fluid restriction, low salt and low sugar diet, however, this was not included in any care documentation
- a rest and sleep assessment stated the resident required aids to sleep, but the care plan did not detail what these aids were
- a spirituality and end of life assessment did not have any information to inform care planning, even though the resident's medical records detailed they were for full resuscitation
- the assessment and care planning moving and handling information was different as one reported that the resident required one staff for transfer and care provision, while the second stated the resident required the assistance of two staff
- assessments and care plans were not updated in line with specified regulatory requirements or in accordance with the changing needs of residents; for example, one resident's care plan was last updated 07/04/23 even though the daily narrative showed that their condition had deteriorated in the past few weeks.

Judgment: Not compliant

Regulation 6: Health care

Action was necessary to ensure residents' healthcare needs were met in accordance with a high standard of evidenced based nursing care as follows:

- wound care management was not in line with professional guidelines; while the residents' care plan identified they had a pressure ulcer, the skin map did not identify the wound and there was no information to inform the care or progress status of the wound,
- while a 'sskin-care bundle' [surface, skin, keep (moving) incontinence & nutrition] was in place for a resident regarding wound care, this had not been updated since 17/09/24

- there were long gaps noted in other sskin bundles so it could not be assured that the resident was receiving the necessary care to prevent pressure damage to their skin.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

From observation, inspectors saw that staff had the knowledge and skills to respond to and manage behaviors that challenge; this was particularly evident in Clyda and Lavender dementia specific houses. The least restrictive practices were seen to be implemented such as alarm mats and cushions. Residents had behavioural support plans to enable best outcomes and these included non-pharmacological interventions to support residents.

Judgment: Compliant

Regulation 9: Residents' rights

Improvement was noted regarding residents' access to meaningful activation. Additional staff were appointed to the activities programme and a review of this programme showed a variety of activities such as the walking club, The Bridhaven choir comprising residents, family members and staff, music, movie evenings, exercise programmes, newspaper reading and one-to-one time with residents who preferred this to group sessions. Children from the local play school, primary and secondary schools attended the centre and children from the nearby play school visited during the inspection.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0041669

Date of inspection: 19/11/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Effective from January 2nd, the centre will employ two HR administrators. One is specifically assigned to handle all staff training and development initiatives. This dedicated role will ensure that training programs are organized, tracked, and evaluated monthly. The RP, PIC together with the HR staff member have conducted a thorough review of current staff training. A tailored training program has been developed to meet the specific needs of the staff to ensure that all regulatory requirements are met. Staff knowledge and application of the training will be overseen by the clinical management team. A member of the clinical management team has been assigned for all staff including new staff with a formal induction program for new employees, covering regulatory requirements including any necessary policies, procedures, and safety protocols. This also includes role-specific training. This will ensure that all current and new employees are properly equipped with the knowledge and understanding they need. The centre has a number of identified inhouse trainers in varying topics to support staff induction and training. The HR team has tracker system in place for ongoing monitoring of training and professional development, including mandatory refresher training. This is reviewed monthly as part of Governance and Management oversight. Internal staff will be assigned to attend external courses, conferences, or workshops for broader skill development, this includes Gerontology, Sonas, Imagination Gym, Infection Control, Safeguarding. This will ensure that all staff maintain up-to-date knowledge in their fields and continue developing professionally throughout their employment. The introduction of competency books for staff will ensure that training is applied effectively in the centre with regular performance reviews to assess the transfer of knowledge. All internal training programs will be evaluated to assess their effectiveness, this will ensure that training remains relevant and effective and will allow for continuous	

improvement based on feedback and performance outcomes.
The Clinical Nurse Managers are allocated to oversee the mealtime experience to ensure that the atmosphere, environment and social experience is appropriate and pleasant for residents. Introduction of QUIS assessments will monitor the quality of mealtimes and the related engagement between staff and residents. The findings will be shared as part of leaning and QIP's.
The HR staff member responsible for training will regularly review and stay updated on any changes to relevant regulations (such as Regulation 16). This will be overseen by PIC and Registered Provider. This will ensure that all training and development initiatives remain compliant with current regulatory standards, helping to mitigate any risks associated with non-compliance.
Specific training on the Dining room experience has been scheduled for 29th and 30th of January. This training provides an insight into the importance of a dignified dining experience. Mandatory training is now above 95%.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
It was recognized during an audit completed on October 1st that more consistent monitoring was required to ensure a safe service. An action plan was commenced on 14th October which included the recruitment of more CNM`s to enhance the oversight of the governance and management within the service. A social care manager has also been appointed to ensure ongoing improvements with activities within the center.
The areas for improvement recognized during the HIQA inspection were also recognized during our internal audit.
A. Currently an audit is taking place regarding resident's care plans, this will be completed by 31st January 2025, action plans will be developed and initiated.
B. A Wound care review has been completed this review will run monthly and findings have been actioned.
C. A review of medication management was completed and Digicare will be fully implemented by 30th January 2025. Currently 2 houses in the center have Digicare in place.
D. A robust action plan regarding the dining room experience has already been initiated as discussed under Regulation 18.
E. As discussed under Regulation 28, all areas recognized during this inspection have been actioned.
F. As discussed under Regulation 27, all areas recognized during this inspection have been actioned and some will be ongoing. IPC will be monitored by our IPC committee and overseen by the PIC.
G. Training for CNM/ADON on our Audit system has been scheduled for January 2025. This will ensure more oversight of our audits to ensure safe and effective services.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notifications going forward will be submitted within the three-day notification.
The PIC and Registered Provider are aware of the changes coming into effect in March 2025.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Service records for Kitchen extraction were in date and will expire in April 2025.

The door in the dining room of Blackwater has been serviced.

Whilst the calls bell system in Clyda are working an attachment has been sourced which will ensure that the call bells can be used in conjunction with the sensory alarm mats.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A Dementia specific program to assist with the training of staff on the "Dining room Experience" has been booked for 29th and 30th January 2025. This will assist in recognizing noise levels and ensuring a more pleasant dining experience.

A designated person is now assigned to monitor and audit the dining room prior to and during mealtimes. This will ensure the dining room is prepared in an orderly way, which will be conducive to a positive experience for all residents.

Initiatives for 2025 have been planned with a focus on the "dining room experience".

These include opening a breakfast bar with a focus on choice for the residents.
The introduction of a "breakfast club".

Further dementia training on the dining experience will continue to take place throughout 2025.
The recommencement of QUIS audit has assisted in identifying further areas for improvement with associated QIP`s.
Also, the dining experience in Awbeg is focusing on supporting residents to attend the dining area and should residents not wish to do so, the designated area in the main communal space is set up to ensure a social experience at mealtimes. This is monitored by the Clinical Management team daily.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
MDRO are included in the preadmission assessment form. Going forward our relationship manager will complete a full handover with staff on each new admission. This will ensure that MDRO are recorded on admission in the resident's care plan.

A MDRO tracker is completed in the center. This will be audited under the KPI`s monthly with appropriate action plans and shared learnings identified.

The staff that completed the IPC link training have commenced an internal IPC committee. This involves monthly meetings with robust action plans. This will be monitored by the PIC.

An audit on all furnishings was completed, replacement furniture has been ordered and all furniture that required replacement will be replaced in 2025 as part of our capital refurbishment plan.

A deep cleaning schedule for the carpets in Clyda was already in place. Following the introduction of a replacement plan only 3 bedrooms are left for completion. These will be completed by 28th February 2025.

Daily Monitoring is completed on all sharp containers, and this has improved since the introduction of IPC meetings.

Regulation 28: Fire precautions	Substantially Compliant

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

It is recognized in the center that some residents request their bedrooms doors locked both during the day and night. This is documented in the risk register and in the resident's care plan. The nurse on duty has the master key for these bedrooms and a fire evacuation drill has been carried out from these specific bedrooms.

Fire safety information has been updated to reflect the new management structure including their contact details.

It was recognized in the center that unoccupied bedrooms rooms were locked, all unoccupied bedrooms are now open.

Full compartment stimulated evacuations have now been completed in all units on a weekly basis this will continue.

Fire training from our external training company has taken place, the next training is booked for 9th January and will continue through 2025.

Fire training is now above 95%.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A full review of resident's medication has been completed to ensure that residents who require medication to be crushed is recorded. Digicare is presently being implemented in the centre. To date two houses are currently using Digicare, with the plan to have Digicare in all the houses by 30th January 2025. Medication rounds are currently supervised by the CNM to ensure adherence to our policy. Ongoing the medication Kardex is reviewed by GP 3 monthly or if any change to the prescribed medication.

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:
Currently there is an audit of care plans taking place to assess their completeness, accuracy, and alignment with regulatory standards. This audit should be completed by 31st January 2025. This will identify current missing or outdated information,

inconsistencies, or areas where the care plans are not meeting resident's needs.
Based on the findings from the audit, action plans are being created. These have included priority areas for immediate attention, responsible parties, timelines with realistic deadlines and resources if necessary for example training. Monitoring will be completed by the CNM/ADON and will be overseen by the PIC.
A schedule has also been put into place to review residents care plans with the MDT and the resident and or their nominated person minimum every 4 months and or if there are changes to the resident condition
To ensure ongoing improvement evaluation will be completed by assessing the impact on resident care through KPI monitoring and QUIS assessment tools, staff performance and compliance with the regulations and using the lessons learned to inform future action plans.
We recognise that this process will be ongoing and will require input from all clinical staff.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
In October, a comprehensive review of all wounds was conducted. The findings from this review led to the creation of a detailed action plan, which has been effectively implemented by all managers. The center has 2 nurses trained in wound care. A committee was established in December to review residents skin integrity, share learnings and lead on QIP's. Actions from the wound care committee have been communicated with the nursing team. As part of clinical governance, weekly KPI includes review of resident's skin integrity and management of wounds.
As a result, all wound care plans have been reviewed and updated to reflect the latest recommendations.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/03/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/03/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/02/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared,	Substantially Compliant	Yellow	28/02/2025

	cooked and served.			
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	28/02/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	28/02/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting	Substantially Compliant	Yellow	30/12/2024

	equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	30/12/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30/01/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	30/12/2024

Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/01/2025
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.	Not Compliant	Orange	31/03/2025
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 the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/03/2025

Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	31/01/2025