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:	29 March 2022
Centre ID:	OSV-0004455
Fieldwork ID:	MON-0034319

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 and is located within the suburban setting of Mallow, Co. Cork, close by to shops and other amenities. It is registered to accommodate a maximum of 184 residents. It is a three-storey facility with three lift and two stairs to enable access throughout the centre. It is set out in five suites named after local rivers: 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) and is located on the lower ground floor 2) Lee (41 beds – two twin and 37 single with en suite facilities) located on the ground floor 3) Blackwater (44 beds – six twin and 32 single full en suite facilities) located on the ground floor 4) Bandon (45 beds – four twin and 37 single with en suite facilities) located on the first floor upstairs 5) Awbeg (36 beds – seven twin and 22 single with en suite facilities) located on the first floor upstairs. Additional assisted toilet facilities are located throughout the centre adjacent to communal areas. 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 smaller 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:	125

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 29 March 2022	09:30hrs to 18:00hrs	Breeda Desmond	Lead
Wednesday 30 March 2022	09:30hrs to 18:00hrs	Breeda Desmond	Lead
Tuesday 29 March 2022	09:30hrs to 18:00hrs	Siobhan Bourke	Support
Wednesday 30 March 2022	09:30hrs to 18:00hrs	Siobhan Bourke	Support

What residents told us and what inspectors observed

Overall, the inspectors found that the person in charge and staff were working to improve the quality of life and promote the rights and choices of residents in the centre. The inspectors met many residents on the days of the inspection and spoke with 12 residents in more detail, and three visitors. Residents gave positive feedback about the centre and were complimentary about the staff and the care provided. In general inspectors observed that staff were considerate and respectful when interacting with residents and treated them with dignity.

Inspectors were welcomed to the centre by reception staff and were guided through the infection prevention and control measures by a member of staff. This included hand hygiene, face mask wearing, electronic temperature check and a signing in process. Following an opening meeting with the management team, inspectors were accompanied on a walkabout of the centre by the director of nursing and person in charge.

There were 125 residents residing in Bridhaven at the time of inspection. Residents spoken with said that staff are always encouraging them to talk up and say what's going on because 'if we don't know what's wrong, we can't fix it'. They reported that their call bells are answered quickly and they are never waiting long. One resident said that the place was open and relaxing and was very happy there as there was a 'freedom about the place'.

An opening meeting was held with the person in charge which was followed by a walk-about the centre with the person in charge. Bridhaven was 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. Management and HR offices, main kitchen, maintenance facilities, staff facilities, laundry, and hair dressers room were also accommodated on the lower ground floor.

The entrance to the centre was a large bright space that was wheelchair accessible. There were two comfortable seating areas by reception and both were beautifully decorated; the seating area to the right was a larger space and had an open-plan display unit with books and ornaments giving the area a homely feeling. Residents spoken with here said they loved this space as the could watch the 'comings and goings' of the centre and chat with people as they were passing by. They said there was always something happening. Staff were seen to actively engage with them with lovely banter in a respectful manner. Staff were observed to bring news papers, tea and coffee and medication to these residents as per their daily routine. There was a large white board on the main concourse displaying the weekly activities in the centre.

Lee Side and Blackwater were located to the right of reception. The Blackwater day

room and dining room here were adjoined and made an expansive room. The day-room had been re-decorated and residents reported that they loved the soft colours. There was a comfortable seating area to one side and large 'magic' table which facilitated activities such as art and drawing. Several residents spoken with here said they really enjoyed these sessions and showed off their art work which was displayed on the wall of the day room. The activities co-ordinator facilitated the art class and at the same time engaged with residents in a local knowledge quiz. As she was not from the area residents had great fun 'educating' her on the local knowledge and the 'Cork' ways. It was obvious that there was a good rappore between them. There was a small enclosed garden off the day room on Blackwater. Newly constructed raised flower beds were ready to be planted up with large bags of peat seen beside them. There were additional raised flower beds where residents had planted annuals. Construction work was in progress to enlarge this space and extend the garden and it was hoped that it would be ready before the summer. The smoking shed had a protective apron, fire blanket and fire extinguisher.

Pictorial signage as well as written information was displayed on large white boards in each unit with the daily menu choice. Table menus were seen on some units with the main meal and tea time choices displayed on each table. Tables were set for mealtimes with cutlery, glasses and napkins. Mealtime was observed on different units. Lunch was supposed to be served at 12:30hrs and inspectors observed that at 12:20hrs, many residents were half way through their meal. Residents were complimentary about the food and inspectors saw that residents were offered choice. Modified diets were well presented and appetising. In general, appropriate assistance was provided to residents but occasionally, staff sat beside a resident facing the same direction as the resident rather that looking in the direction of the resident to enhance their dining experience.

Lavender Cottage was in the process of being re-configured at the time of inspection. This was proposed as a dementia specific unit and had keypad coded entry. This unit comprised 13 single bedrooms. There was a day room and separate dining room with kitchen for residents' comfort; the nurses' station was located towards the entrance to the unit. There were no sluicing facilities here at the time of the inspection. This unit was due to be completed in the weeks following the inspection.

Clyda was upgraded on the last inspection and looked really well. The atmosphere here was relaxed and all staff were seen to actively engage with residents in a respectful way, providing encouragement and distraction in line with residents' needs. Memory aids such as large pictures were displayed to orientate residents to rooms such as toilets, bathrooms and the dining room. Large clocks were displayed in the day room and dining room. Staff explained that residents' memory boxes were previously in residents' bedrooms and they found that full advantage was not taken of these; an open-shelved unit was designed and made and placed in the day room and displayed the beautifully coloured memory boxes with each resident's name on the front of their box. One staff member was observed engaging with a resident looking at their photo album and chatted about the photos and the memories that they evoked for the resident. Access to the the enclosed garden was 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. Staff were seen to bring residents around the garden chatting about the flowers and decorations and having fun.

Upstairs, there was an expansive connecting corridor between Awbeg and Bandon, with views of the bonzai garden on one side and the enclosed garden on the other side. Residents were seen here throughout both days chatting with their friends and said they loved this area as it was bright and airy and had lots of space. One resident said they were 'happy out'; they had been rehabilitated and walking again following an injury and were delighted with the rehab care they received following admission to the centre. Transfer of residents from wheelchairs to chairs was observed in different locations, and due care and consideration was given to residents during the transfers. Each resident had their own sling for use when being transferred. Low low beds, crash mats, specialist mattresses and cushions, and assistive equipment such as hoists were seen. An external company was on site on the first day of inspection servicing hoists.

Orientation signage was displayed on walls so when looking down long corridors there was no signage to direct you to areas such as dining and day rooms or nurses' station for example. Alarm bells were wall mounted at the end of each corridor for easy access by staff and residents to call for help. Residents using oxygen had signage indicating oxygen in use in their bedrooms.

Many bedrooms were seen by inspectors and in general, residents had access to appropriate personal storage of a double wardrobe and bedside locker; some residents had an additional chest of drawers. Twin bedrooms were also viewed and it was noted that in some of these rooms, neither resident had clear over-head lighting when their privacy curtains were pulled around their bed. Surfaces of many bed frames, lockers and bedside tables were seen to be worn. Some beds were awaiting to be dressed and mattresses were seen to be worn. Three large boxes of clinical dressings were stored on the floor of one resident's bedroom and these were removed to a more appropriate place during the inspection.

Laundry was segregated at source and new laundry trolleys were in place with pedal-operated function. There were dedicated laundry staff for day and night duty. There was a separate entry and exit to the laundry to facilitate infection control and prevent cross-over of dirty and clean laundry as well as specialist washing machines with a one-way operating system. There was no signage on the laundry doors to indicate the 'dirty' and 'clean' side as reminders to staff of the appropriate entry point.

Throughout both days of inspection, staff were observed to wear PPE appropriately including wearing mask. Appropriate hand hygiene including hand washing and hand sanitisation was observed throughout the inspection. There were new 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. Some of these sinks were not in compliance with recommended

national guidance. The communal bathroom on Bandon had five armchairs, laundry bins and the household cleaners' trolley inappropriately stored here.

Dani centres were wall-mounted throughout the centre and many of these were seen to be without the personal protective equipment (PPE) such as disposable hand gloves and aprons. Some small sweeping brushes were worn and mop heads unclean. There was a mobile nurses' station in the corner of the day room on Lee Side unit which had not been set up in line HPSC guidance as sanitising wipes were not available to clean the equipment between staff using the computer. Sanitising wipes and pedal waste bin were brought following highlighting this to staff.

Visiting was facilitated on a booking schedule and visitors were able to book on line or ring the centre to book visits. Inspectors saw that visitors were screened on arrival to the centre. Visitors spoken with said they had no bother booking and could come to their friend any time. Residents said they were happy with visiting arrangements.

Sluice rooms were secured to prevent unauthorised access. Each sluice room had a sluicing sink and separate hand-wash sink, storage racks and macerates. Most clinical areas were secure, however, one was not secured appropriately allowing free access to clinical supplies.

A residents' monthly news letter was displayed on the units. This was a colourful publication with lovely pictures of residents enjoying parties and activities. A game of bingo was observed on one unit and staff here actively engaged with residents to support them enjoying the game. Staff encouraged residents in a kind and respectful manner in accordance with their needs to participated in the game. Following the bingo, residents enjoyed a beverage and snack. There was a live music session in the afternoon on another unit. One staff member was observed to interact with residents to support them to enjoy the music, however, the other staff did not interact with residents. In general, staff actively engaged with residents, but there were occasions when staff were seen to stand and supervise in day rooms and dining rooms, residents rather than engage with residents in a social manner.

Emergency evacuation plans were displayed throughout the centre with a point of reference to indicate one's location in the centre; evacuation routes were detailed in the floor plans. In general, floor plans were not orientated to reflect their relative position in the centre.

In conclusion, overall, a rights-based approach to care was supported where residents' choices were respected and their independence promoted.

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

Capacity and capability

Overall, this was a good service where a person-centred approach to care was promoted. Inspectors reviewed the actions from the previous inspection and found that actions were taken in relation to submission of notifications, medication management, staffing levels, aspects of infection control; and refurbishment of the premises had begun. Further attention was necessary regarding regulations relating to personal possession and residents' access to appropriate storage space for their personal belonging in twin occupancy bedrooms, aspects of infection control, fire safety precautions, the premises and residents' care planning documentation.

Bridhaven Nursing home was a designated centre for older adults and registered to accommodate 184 residents. The provider was part of the Virtue group and the company had three directors. One of the directors acted on behalf of the provider and attended the feedback meeting at the end of the inspection. The centre was managed by an appropriately qualified person in charge, who was knowledgeable of the responsibilities of the role. On site, the person in charge was supported in the delivery of care by a quality manager, a director of nursing and two assistant persons in charge, five clinical nurse managers (CNMs), the health-care team, as well as household, catering and administration staff. CNMs were appointed to each unit and one CNM rotated on duty each weekend to provide management oversight and support the service. A resident and family liaison manager was appointed to support families and residents with the transition into long-term care; the social care manager promoted a social model of care. A national quality manager was newly appointed to support the group as well as the overall governance of the centre.

The provider had effective systems to monitor the quality and safety of the service through auditing and weekly collection of key performance indicators (KPIs) such as falls, restraints, infection, weights, pressure ulcers and complaints for example. Where deficits were identified, action plans were developed, with progress recorded. This information fed into the monthly clinical governance meetings, where issues such as human resources, family matters, incidents, audits, and key performance indicators were discussed and monitored. The annual schedule of audit was evidenced with audits completed at regular intervals to monitor the quality and safety of care delivered to residents.

The first meeting of the directors of nursing (DONs) meetings within the group had commenced in December 2021 and was envisaged that these would occur on a quarterly basis. The premise underpinning this was support for DONs in the group, share ideas and learning from areas such as incidents, complaints and inspection findings for example.

Regional 'Quality Safety and Risk' meetings were facilitated and chaired by the recently appointed national quality lead. Monthly 'Social, Clinical and Transition' meetings were convened. Agenda items for these meetings comprised quality improvement plans, key performance indicators, transitional management of residents, risk management and attendees included the on-site senior management. Minutes of staff meetings per unit were seen and showed good information sharing

with staff.

A post COVID-19 outbreak review was completed by the assistant director of nursing with responsibility for infection control. This was undertaken and completed in December 2021 following the declaration by Public Health that the outbreak ws over in November 2021. This was a thorough review of the management of the outbreak from the assessment of the preparation phase to the declaration by Public Health. The evaluation identified what worked and strengths acknowledged, as well as weaknesses and opportunities for improvement, with lessons learned and the actions taken immediately to mitigate risk identified.

The resident and family liaison manager completed the pre-admission assessment of residents, and following admission, she met with residents and their families over the following six weeks to provide support with the transition into long-term care. The social care manager liaised with the activities staff to promote meaningful activities and pastoral care. Ongoing review and assessment of the dining experience occurred and events such as religious occasions, festivals, live music and afternoon tea for example, were encouraged and facilitated.

The risk management policy was up to date and contained information on the specified risks as detailed in the regulation. Risk registers were maintained relating to clinical and non clinical risks associated with the centre. Risk assessments had been completed for actual and potential risks including risks associated with COVID-19 with control measures to keep residents, staff and visitors safe. Schedule 5 policies and procedures were being updated at the time of inspection.

Staff training records were reviewed and these showed good oversight of training completed and training needs. Mandatory training was up to date for all staff. Ongoing training was provided by the ADONs for safeguarding, manual handling, hand hygiene, infection control, and fire drills. A sample of staff files were reviewed and these were updated on inspection to ensure compliance with regulatory requirements.

One of the assistant director's of nursing was delegated responsibility for complaints. The complaints log was examined and records maintained were in compliance with regulatory requirements.

The statement of purpose was updated on inspection to ensure it was in an accessible format and information could be easily read by residents and relatives. The directory of residents was maintained in line with regulatory requirements.

Regulation 14: Persons in charge

The person in charge was full time in post and had the necessary qualifications and experiences as required in legislation. She actively engaged with the regulator and was knowledgeable regarding her role and responsibility as person in charge.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, inspectors found that there were sufficient staff on duty in the centre to meet the needs of residents. Staff were assigned per unit to mitigate the risk of viral transmission between units. In addition, when required, staff teams were allocated in a unit to care for suspected or COVID-19 positive residents and were allocated their own facilities including entry to the unit in line with current HPSC guidance to prevent transmission of infection.

Management staff rotated on duty at weekends to support governance and oversight of the service over the seven days.

The addition of the resident and family liaison manager and social care manager enhanced the staff complement to support a rights-based approach to care delivery.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the training matrix which demonstrated good oversight of training needs. Mandatory staff training was up to date and other role-specific training was completed such as medication management and cardio-pulmonary resuscitation. Ongoing training was facilitated on a weekly basis for areas related to infection control such as hand hygiene and appropriate wearing of personal protective equipment (PPE).

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents had the requirements as listed in the regulation.

Judgment: Compliant

Regulation 21: Records

A sample of staff files were reviewed. One reference detailed a different name to the staff member in question and this was remedied on inspection.

Judgment: Compliant

Regulation 23: Governance and management

While action plans were developed from completed audits, the action plan relating to activities did not include arrangements relating to staff allocation to support the activities programme and activities co-ordinators.

One quiz observational audit was seen and this was an observation session of the fit-for-life class. Observational audits were not seen for times where no structured activities were scheduled; this would provide valuable information of staff interaction with residents, and support the quality of life programme.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was updated on inspection to ensure it was in an accessible format and include –

- the organisational structure
- deputising arrangements for times when the person in charge was absent from the centre
- details of the pre-admission assessment
- the current layout of the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of incidents was maintained in the centre. Based on a review of incidents, inspectors were satisfied that notifications were submitted as required. An analysis of incidents was undertaken to mitigate recurrences and care plans were updated following incidents such as falls. There was also evidence of learning from incidents to improve the quality of care and safeguard residents and staff.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were seen to be recorded in great detail and each element of the complaint was documented. The outcome and whether the complainant was satisfied with the outcome was recorded. Complainants were advised of the appeals process and had used this if they were dissatisfied with the outcome of any complaint.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures were being updated at the time of inspection with the addition of local addenda to support centre specific practices. Policies submitted post inspection referenced national guidelines, however, some did not include current legislation such as the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013; another policy was not referenced to demonstrate that it was research-based. This would provide assurances that staff had access to a high standard of current information to guide their practice to deliver a high standard of evidence-based care.

Judgment: Substantially compliant

Quality and safety

Overall inspectors found that residents were enabled to have a good quality of life in Bridhaven Nursing home. Residents had good access to medical and health care services. A rights-based approach to care was promoted; both staff and management promoted and respected the rights and choices of residents living in the centre. However, improvements were required in relation to infection prevention and control, fire safety, premises and care planning documentation. These will be addressed under the relevant regulations.

A sample of residents' care planning documentation was reviewed. Personal emergency evacuation forms were in place for all residents. There was good detail in the daily narrative for both day and night duty, providing person-centred information on the individual's status and progress. Residents who smoked had appropriate risk assessments completed along with interventions to mitigate the

associated risks. Residents' needs were assessed using validated tools to inform care plans and residents had their activities of daily living assessed and additional risk assessments were completed when the resident's needs required, such as falls risk. Where a resident was assessed as being a falls risk, a referral was routinely made to the physiotherapist who was on site on a weekly basis. Access to other health and social care professionals such as a dietician, dental, occupational therapist (OT), speech and language therapist (SALT) and tissue viability nurse (TVN) was available to residents who required these services. However, in one resident's documentation, the resident was assessed as requiring referral to the dietician and dentist on admission in February but these referrals were not sent. The assessment and care planning documentation required review to ensure that all residents were appropriately assessed and care plans met the individual needs of each resident. While some care plans and assessment did not reflect individualised needs, the daily narrative did show good insight into residents and their individual care needs and the language used to describe interactions with residents was caring, thoughtful and empathetic. Residents had COVID-19 care plans to support their needs. Residents notes demonstrated that they had access to tissue viability nurse specialist to support their wound care. The nutritional status of residents was monitored through regular weights and nutritional assessments. 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.

Quarterly medication advisory meetings were facilitated with the pharmacist and GPs attending the centre to provide support and guidance to the service. Residents' responses to medication were monitored to ensure best outcomes for them.

Residents' views were sought on the running of the centre through regular residents' council meetings and resident focus groups. It was reported that regular residents' surveys were undertaken. One resident survey was available in the audit folder and this was completed in Awbeg, however, the number of residents surveyed was not included so resident participation could not be determined. A dining room survey was completed and feedback included in this and the residents' meeting reported that meal times were too early and this was observed on inspection as the main meal was served before 12:30hrs.

Admissions to the centre had re-commenced following assessment and due process relating to COVID-19 precautions. Cognisant that there were a number of vacant beds, residents were admitted to shared rooms and even though residents were COVID-19 tested prior to admission, COVID-19 was detected in one resident sharing a bedroom following admission.

While the centre was visibly clean, surfaces of furniture such as bed frames, lockers and chest of drawers were worn so effective cleaning could not be assured. Some flooring was replaced but other floor surfaces were worn and stained and looked unsightly.

Dedicated hand hygiene hubs were available throughout the centre, however, some did not comply with current recommended specifications for clinical hand wash sinks as specified in document HBN-09 infection control in the built environment (DoH

2013). There were no separate treatment rooms with suitable hand washing facilities for the storage and preparation of medications, clean and sterile supplies and dressing trolleys.

Quarterly and annual fire certification was completed in March 2022. Extinguishers were serviced in July 2021. Daily and weekly fire safety checks were comprehensively maintained. During the walkabout on Awbeg, a gap was identified in one fire door preventing appropriate closure and this was remedied before the end of the inspection. However, other issues were identified regarding fire safety precautions and these were discussed in more detail under Regulation 28. Staff spoken with were knowledgeable regarding fire drill procedures however some had not part-taken in simulated evacuation procedures.

As part of their risk management oversight, photographs of residents at high risk of absconscion was discretely maintained behind the desk in reception. A folder was also maintained there of residents with identifiable information should a resident abscond. This information was held by An Garda Siochana should a resident abscond and their assistance was required.

This service was not a pension agent for any resident. Petty cash records were examined and required further attention to ensure records were comprehensively maintained to safeguard both residents and staff. The template used to record a transaction asked the purpose of the cash withdrawal. This was highlighted on inspection as being an infringement of a resident's right to privacy. The template was updated on inspection with this information request deleted from it in line with a rights' based approach to care delivery.

Controlled drug medications were maintained in line with professional guidelines. Inspectors joined two separate medication rounds where a sample of medication management administration records were examined. Residents had photographic identification and allergy status details. Residents requiring PRN as required psychotropic medications had this information recorded along with the rationale for the prescription. Additional information of the non-pharmacological interventions which may work for that individual were detailed and provided easily accessible valuable information to staff. However, further review of monthly medications was necessary to mitigate the risk of omission of administration of prescribed medications.

Regulation 10: Communication difficulties

Effective communication was observed throughout the day and in particular on Clyda the dementia specific unit. Here, staff actively engaged with residents, used distraction techniques and sensory aids to engage with residents. Inspectors saw that staff knew residents really well and the individual interaction and interventions required to engage with residents, while at the same time maintaining respect and dignity of the resident.

Judgment: Compliant

Regulation 11: Visits

Visiting was facilitated in line with current (March 2022) HPSC guidence. Visitors were welcomed into the centre and staff guided them through the COVID-19 precautions. Relevant HPSC information notices were displayed at the entrance to the centre providing details to visitors of current protocols when visiting.

Judgment: Compliant

Regulation 17: Premises

A three-phase programme of works was underway to upgrade the premises. This included extending the accessible outdoor space for 164 residents (18 residents in Clyda have a large enclosed garden). It was hoped that the garden would be completed before the summer, but to date, the outdoor space available to 164 residents was inadequate.

While some flooring had been upgraded, other flooring was worn, stained and unsightly.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The main meal of the day was observed to be served before 12:20hrs on one unit which is not a reasonable time for one's main meal and not in keeping with a normal social occasion.

Judgment: Substantially compliant

Regulation 26: Risk management

A risk register was maintained which contained an assessment of individual clinical and non-clinical risks. The risk register had been updated to include the risks associated with the COVID-19 pandemic. The risk management policy was reviewed

and it contained details of the specified risks as detailed in the regulation.

Judgment: Compliant

Regulation 27: Infection control

There were a number of empty beds in the centre at the time of inspection. Short-term care admissions had re-commenced, and while pre-admission assessment included COVID testing, people were admitted to shared bedrooms and one resident tested COVID-19 positive following admission.

A number of issues were identified which had the potential to impact the effectiveness of infection prevention and control within the centre. For example:

- surfaces to furniture such as bed frames, lockers, bed tables and armchairs were worn so effective cleaning could not be assured
- work-flows in the laundry required review to mitigate the risk of cross infection; advisory signage in the laundry indicating dirty and clean rooms would assist this as well as implementing the 'one-way' operation system which was reported to be in place
- the clinical waste bin in the dirty laundry situated between two industrial washing machines was too big and could not be opened easily, or when opened, it could not close
- a mobile nurses' station did not have any hygiene precaution measures in place such as sanitising wipes or hand gel, these were implemented on inspection
- many dani centre throughout the centre were empty so staff did not have quick and easy access to PPE such as disposable gloves and aprons
- hand-wash hubs were being upgraded at the time of inspection, however, some of the hand-wash sinks being installed did not comply with the Dept of Health clinical wash-hand basin guidance
- there was no housekeeping room on the units inspected; household trolleys were seen to be stored in a communal shower room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire safety signage in the laundry required review as both exit doors (dirty and clean laundry rooms) were designated as evacuation doors, however, there was just one sign on the corridor indicating a safety route out of the dirty laundry room and none indicating an escape out of the clean laundry room. In addition, there were

large mobile units on the corridor and in both laundry rooms obstructing exits.

Fire safety evacuation signage was required on the connecting corridor in Awbeg to indicate a fire escape route.

Staff spoken with were well-versed in fire drill procedures, however, some staff spoken with had not taken part in simulated evacuation procedures. Assurances were required that all staff could complete evacuation procedures in a timely manner.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Further oversight of medication practices was required to ensure compliance with professional guidelines and current legislation. For example,

- where a resident was prescribed monthly medication, this was not included in the monthly administration record to ensure the resident received the medication in accordance with the prescription
- when residents did have the monthly medication included in the monthly administration template, the date was not indicated when the resident was to receive the monthly dose, so there was a potential risk of omission.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of care plans were examined and these showed mixed findings. Some had personalised information to inform individualised care while others did not have this detail. Occasionally, information seen in residents' assessments did not inform care planning to ensure individualised care was provided in accordance with their needs. On the other hand, some care plans did not have an associated assessment to inform the care planning process. Some goals set out in care plans did not reflect a 'rights-based' approach to care but a clinical approach. The skin assessment in place was a wound identification assessment chart and not a skin assessment. One resident with a skin condition did not have their skin assessed or a plan to support her skin care needs; the resident's skin condition was not included in any assessment. The social and activities care plan of one resident did not reflect the resident's history, preference or current status and the care plan did not reconcile or reflect the resident's personality, therefore it was not sufficiently detailed to direct the residents care.

Judgment: Substantially compliant

Regulation 6: Health care

Following a food and nutrition and oral assessment, one resident's notes showed the resident had not been referred to a dietician or dentist even though it was clinically indicated.

While it was reported that residents had their temperatures checked twice a day, records showed they were recorded once a day, which was not in keeping with their policy regarding care of residents with suspected or confirmed COVID-19 infection.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

From discussion with the staff and observations of inspectors, there was evidence that residents who presented with responsive behaviours were responded to in a dignified and person-centred way by staff. This was reflected in the detailed responsive behaviour care plans.

The principles of a restraint-free environment were promoted by the person in charge and staff at the centre. Alternatives to restraint were readily available.

Judgment: Compliant

Regulation 8: Protection

Residents petty cash records were examined. While it was reported that these were audited regularly, dual signatures were not see always seen in transaction receipts; balance of a transactions were not routinely included. This practice was found not to be sufficiently robust to protect the residents or the staff.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The following Issues were identified which did not protect the rights of residents and

promote a rights-based approach to care:

- some residents in twin bedrooms did not have access to appropriate lighting when their privacy curtains were engaged; some residents did not have easy access to their bed chairs and bedside lockers in the bedrooms
- there was inappropriate storage of large boxes of dressings on the floor of a resident's bedroom
- there was inadequate advisory signage throughout the centre to orientate residents and visitors around the centre
- the location and size of the hairdressers' salon did not lend itself to promoting a 'salon-type' experience. As the room was in the basement and away from any thoroughfare, there were no reminders to residents to look forward to the hairdresser coming to the centre to add to their enjoyment,
- residents' main course and desert were served together which would not be in keeping with a normal dining experience. Many resident chose ice-cream for their desert and as it was a really warm day, ice cream had melted and did not look appealing
- while most observation showed lovely kind interaction of staff with residents, other observations showed little or no engagement of staff even though it was reported to inspectors that care staff were involved in supporting the activities programme.

Judgment: Substantially 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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bridhaven Nursing Home OSV-0004455

Inspection ID: MON-0034319

Date of inspection: 30/03/2022

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: Staff are allocated to support the activities programme. All audits and action plans going forward will be discussed and reviewed with the Director of Nursing and signed off on at the monthly governance meetings. Quis audits are completed monthly. These are completed at various times throughout the day to capture staff engagement.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: A new suite of policies and procedures have been finalized by the group Director of Quality, Safety and Risk, which are evidenced based and reference current legislation such as the Health Act 2007. These policies will be implemented in the Nursing Home during the month of May.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: All Residents in the home have access to both the Clyda and Blackwater Garden and avail of this amenity as per their preferences. Construction and planting of the new courtyard garden in Blackwater has now been completed. The new railings are on order to make the space more secure with an expected date of instillation by June 30th 2022. There is a planned phased programmed of works to refurbish the home, which includes replacement of worn flooring, some of which has been completed since the inspection.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: It is our policy that lunch will not be served before 12.30pm unless otherwise specified by a resident. All staff have been reminded and educated on this, Memo has been circulated to each house and the kitchen to remind them of our scheduled mealtimes. This will be monitored closely by CNMs and ADONs along with the Chef Manager.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A schedule of maintenance has been put in place to sand and varnish worn items of furniture to ensure effective cleaning can be done. A review of workflow in the laundry has been completed. Additional signage has been implemented to indicate "dirty in" and "clean out" and the one-way operational system defined with additional signage. The clinical waste bin identified on the day of inspection has been removed as is no longer required in this area. Mobile Nurses stations - Hygiene precaution measures were put in place on the day of inspection, with a wall mounted hand sanitizer, sanitizing wipes and waste bins located beside both desks. Memo sent to staff regarding the process for sanitizing the nurse's station before and after each use. All dani centers will be checked and stocked with gloves and aprons by the night HCAs	

and refilled as required during the day. Memo circulated to staff regarding their duty list which includes their responsibility to maintain stock levels.

A phased programmed of works is underway to upgrade the premises, which includes the replacement of sinks in compliance with Dept of Health clinical wash-hand basin guidance.

We have three designated housekeeping rooms across the home, this is a clean are where the housekeeping staff prepare their cleaning solutions. In addition, we have dirty utility rooms in each house.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Additional fire exit signs to be installed in Awbeg and in the basement to clearly identify the Fire exit routes. The mobile storage units in the Laundry have been relocated to ensure the egress remain clear.

As per our comprehensive annual plan we conduct two simulated fire drills per month, all staff participate in a complete fire drill of the largest compartment in their house using the minimum number of staff to ensure confidents and compliance in the event of an evacuation. All staff on Induction participate in a simulated evacuation procedure which ensures compliance for all staff. Bridhaven maintains an attendance matrix for these drills. A schedule is in place to ensure all staff participate in a simulated evacuation.

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 review of the monthly pharmacy ordering process was undertaken. The administration date for monthly medications is now included by the CNM on the monthly medication order form to pharmacy. On receipt of the MAR sheet from pharmacy the due date of administration is now included, and the Pharmacist conducts a monthly audit to ensure accuracy and compliance.

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:
Since the inspection two of our Clinical Nurse Managers have attended additional training in care planning and now hold this portfolio. Further education on care planning has been scheduled for all nurses. A full review of all resident's care plans has been scheduled, to ensure sufficient details of individual care needs is identified to direct appropriate delivery of care.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A Memo has been circulated to all nursing staff to reinforce the referral process to Allied Health Services when clinically indicated.

Bridhaven's policy for monitoring covid 19 residents has been re-circulated to nursing staff and compliance will be monitored by our Clinical Nurse Managers.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The procedure for handling of petty cash has been reviewed and revised. A new form has been created to include dual signatures and the balance of transactions. This process has been explained to the staff who manage petty cash. A monthly audit, will monitor correct management of resident's petty cash.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Brídhaven have an ongoing maintenance schedule to maintain the upkeep of the building

along with enhancing the physical environment to ensure a safe, fresh, inviting, and pleasing environment for our residents. Part of this will be to review all double rooms and the layout of rooms to ensure they have adequate space for chairs and bedside tables, appropriate lighting, and access to adequate wardrobe space.

These boxes were removed from the resident's room on the day of inspection and stored in the designated area. Each House has an area for storage of Resident's dressings.

A Signage Steering Committee, involving both staff and residents, was set up in August 2021. New dementia friendly signage (accredited by University of Stirling) had been purchased and installed in one of the Households, with an installation program underway for each Household as it is refurbished. Areas have been identified that require additional signage. Feedback on the new signage from the residents and staff has been very positive.

The hairdressing salon will be reviewed as part of the upgrade plan for the home, however in the meantime communications regarding the salon and availability of bookings and associated services will be advertised and made available in residents' rooms and common spaces.

All staff have been reminded and educated on promoting a good dining experience for the Residents. A Memo was circulated to all staff including kitchen staff as a reminder to serve each course separately. This will be monitored closely by CNMs, ADONs & Chef Manager, and is part of the dining experience audit.

Staff are allocated and involved daily in the resident's activity programme. Quis audits are completed monthly, these are completed at various times throughout the day to capture staff engagement.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2022
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	03/05/2022
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	30/05/2022
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/12/2022

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/06/2022
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	Substantially Compliant	Yellow	30/05/2022

	resident's pharmacist regarding the appropriate use of the product.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2022
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.	Substantially Compliant	Yellow	30/08/2022
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	Substantially Compliant	Yellow	30/09/2022

	admission to the designated centre concerned.			
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	03/05/2022
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	03/05/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	03/05/2022
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned	Substantially Compliant	Yellow	30/12/2022

	so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/12/2022