<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Brookfield Care Centre</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000206</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Leamlara, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 464 2112</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:brookfieldcc@eircom.net">brookfieldcc@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Brookfield Care Services Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Clodagh Drennan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary O’Mahony</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 04 September 2014 11:30  To: 04 September 2014 19:00

The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 09: Medication Management</th>
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<tr>
<td>Outcome 14: End of Life Care</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
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Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection by the Health Information and Quality Authority of Brookfield Care Centre, which focused on two specific outcomes, End of Life Care, and Food and Nutrition. In preparation for this thematic inspection the provider had attended an information seminar provided by the Authority. The centre had received evidence-based guidance and had undertaken a self-assessment in relation to both outcomes.

The person in charge and staff members had completed the self assessment questionnaires. The inspector reviewed relevant documentation prior to the inspection. The inspector met residents, relatives and staff and observed practice on inspection. Documents in the centre were also reviewed such as, training records, residents' care plans, medication management charts, menus and also records pertaining to deceased residents.

The inspector spoke with residents and relatives and they all expressed satisfaction with the food, the times of meals and the overall care in the centre. The inspector was present for dinner and tea and assessed the dining experience by sitting with the residents. Residents expressed how happy and content they were in the centre. Overall, the inspector noted that a person centred and homely environment existed in the centre.

There was evidence that the findings of the self-assessment questionnaires were being implemented. Staff were knowledgeable about the residents and were observed caring for residents respectfully and in a quiet manner which served to maintain their privacy and dignity.
The provision of end-of-life care was assessed through interviews with staff, residents and relatives as well as information in the care plans of residents. The inspector also viewed information in the care plans of residents who had died in recent months.

The inspector’s findings were of compliance as regards end-of-life care and compliance as regards nutrition in line with the Regulations set out by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and National Quality Standards for Residential Care Settings for Older People in Ireland 2009. However, the inspector found evidence of non-compliance in the area of medication management.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
This outcome is addressed only in so far as it concerns outcome 15: Food and Nutrition.

Subcutaneous fluids had been administered to a resident by a member of staff. This was prescribed for the resident. However, the staff member failed to see that the fluids had been prescribed on the current prescription sheet and used an old prescription sheet from which to administer the fluids. This is not in line with best practice as outlined by the professional guidelines of An Bord Altranais agus Cnaimhseachais na hÉireann Guidelines for nurses on Medication Management (2009).

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support
Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Care practices and facilities in the centre were designed to ensure that residents received end-of-life care in a way that met their individual needs and respected their dignity and autonomy. There were written operational policies and protocols in place and staff with whom the inspector spoke were familiar with these. These policies were the subject of ongoing review and improvement and the person in charge told the inspector that the policy had been updated to comply with best practice guidelines circulated by the Authority.

Staff had initiated discussions with residents and relatives, on admission on some occasions, to ensure that their wishes were documented and subsequent end-of-life care plans were seen by the inspector in the files of residents. Residents had signed the care plan where this was possible and relatives were consulted to ascertain the wishes of residents who were cognitively impaired. The inspector was shown minutes of meetings with the families and also shown documentation which indicated that end of life wishes were reviewed on a regular basis with residents and relatives where appropriate. The inspector spoke with family members who said that the person in charge was very approachable and that the staff and the GP would give advice and regular updates on the care being provided at all stages.

Religious and cultural practices were respected and services were held in the centre weekly. Family and friends were facilitated to be with the resident when they were at the end of life stage. A visitors' bedroom was available upstairs for relatives to stay overnight if required. Residents from a range of religious denominations were visited by their Ministers as required. The 'HSE (Health Services Executive) Guidelines on Multicultural Care' practices at end of life was available for staff reference. Residents, with whom the inspector spoke, told the inspector that the rosary was said daily for those who wished to participate. Other prayers and hymns were recited when residents requested or initiated this. The inspector spoke with one resident who was facilitated to move to another room as he did not wish to participate in these events. These practices were seen to be operational in the centre during the inspection.

The senior staff nurse informed the inspector that residents had a choice as to their preferred place of death and this could include dying at home if the appropriate care was available. Links were maintained with the community palliative care team who had a good relationship with the GP (general practitioner) and would see residents on request. The GP was supportive of families and residents when making decisions and the inspector saw that he had been involved in these discussions and had signed end of life care plans. The centre had a syringe driver which could be used to administer symptom relieving medication at the end of life. Staff had received training in its use. One of the clinical nurse managers (CNM) had undertaken a train-the-trainer programme in palliative care and was providing training on aspects of end-of-life care to staff relevant to their role. The inspector viewed completed training records for end of life care and saw that further training was planned.
Staff with whom the inspector spoke said that they thought that the care at the end of life was attentive and personal and that families had written to the centre to express their thanks. The person in charge told the inspector that she had postgraduate qualifications in the ethics of end of life care. She explained to the inspector their protocol of placing a black ribbon on the room door of the deceased resident. Other residents could pay their respects and the room would be locked and left undisturbed for at least two days afterwards. Belongings and possessions were respectfully packed in special boxes and the inspector observed that there were updated inventories of the residents' possessions in the care plans. Family were provided with leaflets and information about what to do in the aftermath of the death. The inspector reviewed the files of residents who were on a palliative care plan on the day of inspection. There was evidence of input from the specialist palliative care team. The inspector saw that residents had been given pain relieving medication when the need arose and that the quality of life was maintained by relatives and staff cooperating to fulfil any wish they may have expressed. The inspector saw that all aspects of their care was addressed in the care plan which was holistic in its approach.

One resident with whom the inspector spoke said that he not hold strong religious beliefs but that he was taken out fishing, to local matches and to the farm by staff members and that he enjoyed the spiritual feeling he got from nature. The inspector noted that the gardens in the centre were well maintained and the centre was built in a peaceful setting. Residents, with whom the inspector spoke, commented on the scenic views from their bedroom windows. Single rooms were available for residents and there was accommodation provided if the family wished to stay overnight. Catering staff informed the inspector that the families or friends would be given their meals and allowed to visit whenever they wished.

The inspector viewed the file of a recently deceased resident and saw that the GP had participated with staff in planning the care with the family. The senior nurse spoke movingly about the experience of the family members who were all able to express their views. She informed the inspector about the plan of care that was put in place and said that the resident had died peacefully and pain free which had been his wish. Thirty nine residents had died in the previous two years and of these people four were transferred to the hospital at the end of life. The inspector was informed by staff members that they would receive support from the management team following a death of a resident in the centre.

**Judgment:**
Compliant

**Outcome 15: Food and Nutrition**
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

**Theme:**
Person-centred care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The variety, quality and presentation of meals were found to be of a high standard. This was confirmed by the inspector who sampled the food. Residents expressed satisfaction with the food and the dining experience. There were colourful tablecloths and napkins on the tables and vases of fresh flowers were seen, providing a homely ambience. There were three separate dining rooms where lunch and tea were served to all residents. The main dining room was used for residents from all three units with lower dependency levels and those who required minimal assistance. The other two units had their own dining rooms and were used by residents who required assistance or who chose to remain on their own units. The staff informed the inspector that there were two meal times sittings. This was introduced to ensure all residents would receive full assistance from the staff during mealtimes. The inspector observed that as a result residents' dietary requirements were met with dignity and in a relaxed way. Staff in all dining rooms were observed enabling residents to remain as independent as possible. Mealtimes were observed to be calm and unhurried, with many residents remaining at the table after their meal to socialise.

The inspector joined residents in the main dining room at 13.00hrs which was the time for the second dinner sitting. Residents informed the inspector that they could choose to have their meals in their rooms if they wished. They said that breakfast was served from 08.00 onwards and that most people had chosen to have this served in their bedroom. They spoke about the 'food choice form' that was circulated daily and filled in for each meal. The inspector saw that gravy was served separately affording choice to the residents. Wine was offered to residents with their dinner and the inspector was informed by staff that this occurred daily. The inspector observed that different types of glasses and cups were being used depending on the residents' abilities. At the end of each meal a wet cloth was offer to each resident which was used to wipe their hands and freshen up. The inspector noticed that these were heated before being offered to residents. One resident with whom the inspector spoke said that she felt they got "5 star treatment". This was echoed by family members, with whom the inspector spoke, throughout the day.

There was evidence of good communication between the catering staff and the nursing staff. The inspector noted that the chef was able to identify those on special diets and was aware of the likes and dislikes of residents. There were adequate supplies of dry goods, fresh and frozen meat, home baking, fruit and vegetables in stock. The food was sourced from reputable local suppliers and the inspector was shown a list of these. Food for those on special diets, such as gluten free, was segregated. The inspector viewed the menus and saw that there was a variety of food on offer at all mealtimes. The kitchen was large and seemed very organised. The inspector observed that relevant advice and notices were prominently displayed. The chef and the kitchen staff had received training relevant to their roles and they were aware of infection control practices and food safety guidelines. The chef also informed the inspector that the dietician had provided guidance on fortifying the food such as the addition of butter, cream or high calorie supplements. The inspection reports from other relevant
authorities were available for viewing by the inspector.

Insulin was stored in the medication fridge for a diabetic resident and the inspector noted that this was prescribed by the GP and administered to the resident. This resident was seen to have blood sugar checks taken and recorded and staff informed the inspector that residents would have individual glucometers (an instrument used to measure the blood sugar level) supplied if required. One staff member with whom the inspector spoke was knowledgeable about the specific type of supplement that was in used for residents with diabetes. He also informed the inspector that snacks were offered at 11.00, 15.00, at 19.00 and whenever a resident would wish, including during the night. The inspector observed these snack trolleys in use and residents and relatives, spoken with by the inspector, confirmed the fact that food could be availed of at any time.

Residents’ files seen by the inspector indicated that weights were recorded monthly and changes were reported and discussed with staff. The MUST (Malnutrition Universal Screening Tool) tool was utilised to ascertain the nutritional status of residents. Nutritional assessments were completed and dietary advice was obtained from a dietician from a nutritional company. Supplements were available for residents who required additional nutritional support. The inspector saw that these were prescribed by the GP in the centre and they were documented as given by the staff nurses. Nutritional care plans were seen in residents’ notes and there was a regular review of these care plans by the multidisciplinary team (MDT). The speech and language therapist (SALT) had prepared nutritional plans for any residents who had swallowing difficulties and there were instructions in the care plan on the correct consistency for food and fluids. This was in written and visual form. These modified diets were presented attractively to residents and the chef informed the inspector that there was a choice available for residents on modified diets also.

The residents were supported to avail of dental services and the inspector saw evidence in the residents’ care plans of the results of annual oral care assessments. The dentist was available to visit the centre or on an outpatient basis. The person in charge highlighted to the inspector that she found it difficult to obtain the services of an occupational therapist and said that the physiotherapist would support staff where required in positional seating and in the dining room. There was a plentiful supply of water and juices available for residents in the centre. In the dementia specific unit there was a separate kitchenette which the inspector saw was stocked with fruit, cakes and drinks. There was a microwave and kettle there also which staff said were used if a resident or family member requested tea of a hot snack. The inspector joined residents in this unit at tea time, which was served from 16.30 onwards. The residents were offered a choice and staff were observed to be knowledgeable about the residents’ preferences and usual pattern of behaviour at meal times. Food was served hot and there were adequate staff available to support the residents. Staff, with whom the inspector spoke, were aware of what to if the resident refused food and they informed the inspector that they had received training in nutrition and in dementia care. The inspector saw residents being supported to avail of fluids and these drinks were also accessible to those residents who were spending time in their bedrooms. Fluids were seen to be thickened where this was indicated. There was evidence in the minutes seen by the inspector of staff and family meetings that any dietary modifications were
discussed. Any issues that were raised concerning food, in the minutes of residents' meetings, were seen to be addressed. The residents confirmed this with the inspector.

The centre had a policy on the administration of subcutaneous (subcut) fluids. The inspector was informed that some residents would receive extra fluids in this manner if they were found to have an inadequate daily fluid intake. The inspector checked the prescription of one of these residents. The resident had received subcut fluids administered by a member of the nursing staff. The inspector saw the administration date and the signature of the staff member. However, the inspector noted a discrepancy in the administration of subcutaneous fluids in that they were administered from an old prescription chart. This was addressed under outcome 9, medication management. Staff informed the inspector that training had been provided by the dietician, SALT and the senior staff nurse, in nutritional aspects of care. Staff, with whom the inspector spoke, were aware of how to intervene if a resident appeared to be choking. The inspector viewed the training records and saw that training had been carried out as described and dates for further sessions were outlined.

**Judgment:**
Compliant

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**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Mary O'Mahony  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
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<tr>
<th>Centre name:</th>
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<td>Centre ID:</td>
<td>OSV-0000206</td>
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<tr>
<td>Date of inspection:</td>
<td>04/09/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22/10/2014</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication was administered from an out of date prescription sheet and not from the prescription which was current on the day the drug was administered.

Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
When investigating this incident it turned out that the medication administered was charted but the staff member did not see it on the current prescription chart. Despite the fact that the fluids were prescribed the staff member still did not follow correct medicine management procedures, outlined in our policy, by using an old prescription sheet. The staff member in question will attend a medicine management course and all staff have been reminded of the importance of complying with medicine management best practice.

**Proposed Timescale:** 22/10/2014