Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Brookhaven Nursing Home
Centre ID:	OSV-0000207
Centre address:	Donaghmore, Ballyraggett, Kilkenny.
Telephone number:	056 883 0777
Email address:	info@brookhaven.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Brookhaven Nursing Home Limited
Provider Nominee:	Gearoid (Gerard) Brennan
Lead inspector:	Ide Cronin
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	63
Number of vacancies on the date of inspection:	8

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Compliance 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 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:	To:
13 September 2016 09:15	13 September 2016 17:45

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Substantially Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures		Non Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The inspection also followed up on progress of the action plan from the last inspection of the centre and reviewed notifications and other relevant information.

The centre did not have a dementia specific unit and at the time of inspection there were 27 of the 63 residents living in the centre that had a formal diagnosis of dementia. Inspectors observed that many of the residents required a high level of support and monitoring due to their individual needs and dependencies.

The provider had submitted a completed self assessment tool on dementia care to the Health Information and Quality Authority (HIQA) with Schedule 5 policies and procedures requested prior to the inspection. The provider had assessed the

compliance level of the centre through the self assessment tool but the findings of inspectors did not accord with the provider's judgements. However, inspectors observed that the management team and staff working in the centre were committed to providing a quality service for residents with dementia.

Inspectors met with residents and staff members on this unannounced inspection. They reviewed the assessed care needs of residents and tracked the journey of a sample of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using validated observational tool. Inspectors also reviewed documentation such as care plans, policies relating to dementia care, medical and nursing records and staff files.

Overall, inspectors found improvements were required in the six outcomes specific to the thematic inspection with a major non compliance found under Outcome 2 and moderate non compliances in Outcomes 3, 4 and 5. Outcome 1 and 6 were found to be substantially compliant. Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.

Compliance with Section 41(1)(c) of the Health Act 2007 and 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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors tracked the journey of residents with dementia and also reviewed specific aspects of care such as nutrition, wound care, end-of-life care and management of behaviours that challenge. Inspectors found that there were systems in place to optimise communications between the resident/families, the acute hospital and the centre. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, that relevant and appropriate information about their care and treatment was readily available and shared between providers and services. Pre admission assessments were undertaken by the person in charge, deputy director of care or the clinical nurse manager.

Comprehensive nursing assessments, using validated assessment tools were carried out on admission of all residents including those with dementia. Each resident had a care plan developed to address their individual needs. Residents' care plans were reviewed and updated if necessary every four months or more frequently in response to their changing needs. Care plans for residents with dementia or behaviours that challenge were very person centred and specific to guide staff and manage the needs identified.

Inspectors saw that residents with dementia had good communication plans in place to guide all staff. Inspectors observed that where a small number of residents exhibited aspects of behaviour that challenged, which were related to the behavioural and psychological symptoms of dementia (BPSD) the care plans described effective positive behavioural strategies for use by staff to manage these behaviours.

Staff demonstrated good knowledge and understanding of each resident’s background in conversation with inspectors. Staff told the inspector that residents/relatives were involved in the care planning process and there was documentary evidence that residents or their representative were involved in the development and review of their care plan. The clinical nurse manager had responsibility for auditing care plans which had been completed in July 2016.

Arrangements were in place to meet the nutritional and hydration needs of residents

with dementia. A food and nutrition audit had been completed in August 2016. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Menus were available and all residents were offered choice at each meal. There was evidence of efforts made to ensure residents with dementia had their individual food tastes and choices met as observed by inspectors.

Residents were discreetly assisted with their meals by staff that were observed to encourage residents to maintain their independence with eating and drinking. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. A food and fluid chart was maintained as observed by an inspector. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and reviews. Recommendations from the dietician were communicated to the kitchen staff that were aware of each resident's dietary requirements.

There were no residents in the centre in receipt of end of life care on the day of inspection. Staff spoken with demonstrated an understanding of the principles that underpinned the centre's approach to end-of-life care and also an individual commitment to those principles of dignity and respect for the wishes and preferences of residents at the end of their lives. There was an end-of-life care policy. Palliative care services were available to support residents and staff with symptom control, including pain management. The nurse manager said that the support provided by the palliative care team was very good. However, there was inconsistent evidence that the end of life needs and wishes of all residents' with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan.

There were arrangements in place to review accidents and incidents within the centre and residents were regularly assessed for risk of falls. A system was in place to highlight and communicate the risk rate to all staff. Inspectors saw that falls were discussed at team meetings. Care plans specific to the identified falls risk had been put in place for residents and/or updated following a fall. The clinical nurse manager had just commenced the process of a root cause analysis in relation to falls.

There were written operation policies relating to the ordering, prescribing, storing and administration of medicines to residents and disposal of unused or out-of-date medicines. Medication prescriptions and administration records for the most part were complete in accordance with professional standards. The inspector reviewed a sample of residents' individual medicine prescription charts and there was evidence that residents' prescriptions were reviewed at least three monthly by a medical practitioner. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland. A pharmacist visited the centre on a regular basis conducting audits of medication management practice in the centre the last one had been completed on 17 May 2016.

Administration was observed to be safe and in line with the nursing guidelines. There was adequate and secure storage for medication, with medication requiring refrigeration

stored appropriately, and monitored daily. Controlled drugs were stored and managed in accordance with legislative requirements and a register of these medicines was maintained with the stock balances checked and signed by two nurses at the end of each working shift. Procedures around the crushing of medicines were seen to be individually prescribed by the residents' GP. However, in a medication chart reviewed by the inspector the signature of the prescriber was not in place for a drug which was prescribed on 8 September 2016.
.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were measures in place to ensure residents were safeguarded and protected from abuse. There was a safeguarding policy in place. Improvements were required in the policy on the protection of residents from abuse. The policy did not reference the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (2014). The necessary referrals to external agencies were not included nor was there any reference to the designated contact person within the safeguarding team. From a review of training records inspectors observed that 41 staff out of 62 had up to date training in elder abuse.

The inspector was also informed that five staff members whose Garda vetting applications were not fully processed were rostered to work. The person in charge was advised that any staff without a declaration of Garda vetting and clearance should not be working in the centre. Assurances were given verbally and via email to comply with this directive and alternative staffing arrangements were put in place to ensure that all staff rostered to work in the centre had Garda clearance.

There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. The person in charge was well known to residents as observed by inspectors. Staff confirmed that there were no barriers to raising issues of concern.

There was a policy in place for behaviour that is challenging. 48 staff out of 62 staff had received training on understanding and managing challenging behaviour. Staff spoken to by the inspectors were knowledgeable regarding interventions that were effective in managing such behaviours including redirection and engaging with the residents.

Residents had been regularly reviewed by their GP and there was access to psychiatric services for further specialist input as observed by inspectors

In conversation with several residents all confirmed they were happy living in the centre. All were full of praise for staff working in the centre and felt safe and well cared for. Inspectors observed interactions between residents and staff were mutually respectful friendly and warm. It was noted that there was a culture of promoting a restraint free environment. Incidents where restraint was used were notified to HIQA. There was a policy on the management of restraint. There was a restraint register and twenty residents out of 62 residents were using bed rails at night. The inspector observed that in the new extension all of the15 beds that had been purchased were low low beds. Checks were in place for the use of restraint and inspectors saw that these were recorded.

The centre maintained day to day expenses for some residents and there was a policy on the security of residents' accounts and personal property. However, this was dated in 2010 and had not been reviewed since. All transactions were appropriately documented with lodgements and withdrawals co-signed by the resident and staff member as observed by an inspector.

Judgment:
Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Resident's privacy and dignity was respected, including receiving visitors in private.

There were systems in place to support residents to exercise their religious, civil and political rights. There were notice boards available in the centre providing information to residents and visitors. The activities coordinator informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities. There was a residents' committee in operation. Inspectors reviewed the minutes of the last residents' meeting which had been held on 9 September 2016. Records were maintained of issues raised by the residents at these meetings such as activities within the centre and the menu options were discussed. It was clear that residents were individually given the opportunity to raise their own issues at these meetings. The inspectors saw that there was an external independent advocate available to residents or relatives should they wish to obtain help to make a complaint or require assistance to express their views.

Inspectors observed that residents were well dressed. Personal hygiene and grooming were well attended to by care staff. The inspectors observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times. Residents told inspectors that they were able to exercise choice regarding the time they got up and were able to have meals at a time that suited them. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the communal area or their rooms.

Inspectors saw that residents had access to televisions and radios. Newspapers were widely available to residents. There were opportunities for residents to participate in activities. However, inspectors found that the activity programme was limited to Monday to Friday. Overall, a total of 27 hours was allocated to resident activities. Weekend activities and/or stimulation was dependent on health care staff to facilitate for residents.

Staff told inspectors that most of the time they could not facilitate recreation at weekends as there was no time. Inspectors spoke with the activities coordinator who informed them that dementia relevant activities were limited to sonas, imagination gym or hand massage on an individual basis. Group sessions were not carried out as the activities coordinator did not have the capacity to attend to a group session. In total out of the 27 hours allocated to activities, approximately 25 residents would avail of recreational therapy per week according to the activities coordinator. Inspectors were told that day trips/outings did not take place.

Inspectors observed that there was limited use of other techniques such as reminiscence, reality orientation or use of sensory equipment for residents with dementia. Inspectors formed the judgement that meaningful self expression for residents with dementia was not facilitated by adequate occupational, recreational physical or sensory stimulation.

Inspectors used a validated observational tool to rate and record at five minute intervals the quality of interactions between staff and residents in the centre. The observation tool used was the quality of interaction schedule or (QUIS) These observations took place in the lounge areas and in the dining areas of the centre. Each observation lasted a period of 30 minutes and inspectors evaluated the quality of interactions between staff and residents with dementia.

Some positive interactions between staff and residents were observed during the inspection. However, inspectors observed that some staff did not avail of opportunities to socially engage with residents. It was also observed that many staff did not engage residents in conversation except when engaging in tasks. There were periods during the observation when the communal room was left unsupervised.

Overall, observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a neutral/task orientated nature. Inspectors observed that for the majority of the residents in the communal area, there were limited meaningful interactions with staff. Some residents were not engaged, or were asleep in their chairs with no

stimulation for periods of time.

During the lunch time period staff were observed for the most part to offer assistance in a respectful and dignified manner. Inspectors observed that when interactions did take place they were task orientated, such as asking the resident if they wished to have a drink or what they wished to have for their lunch. Inspectors found that during the observation periods that practices were led by routine and resources. Inspectors discussed these findings with the person in charge, provider nominee and assistant director of care at the feedback meeting post inspection.

Satisfaction surveys had been completed in 2015 which indicated overall satisfaction with the services provided. There was a communication policy in place. As outlined under Outcome 1 there were very detailed communication plans in place for residents with dementia.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Improvements were required in relation to the complaints procedure to ensure that complaints were managed and recorded appropriately.

While a complaints policy was available, it had not been reviewed since 2014 and did not correspond with the summary of the complaints policy that was on display at the entrance of the nursing home. Both the policy and its summary required updating to ensure that the name of the complaints officer reflected the person that was currently carrying out the role.

A copy of the complaints procedure was included in the Resident's guide, and the person in charge and deputy director of care told inspectors that they discuss the complaints process with families at meetings to ensure that they are aware of it.

There was a nominated person to deal with complaints as well as a nominated person to ensure complaints are appropriately recorded and responded to. The centre maintained a complaints log, which was made available to inspectors for review. While records contained details of the complaint, the outcome of the complaint and the satisfaction of the complainant with the outcome, further information was required in relation to investigations undertaken, and to evidence that complaints were closed out promptly.

An appeals process was in place, which was outlined in the complaints procedure. Inspectors spoke with staff on the day of the inspection, all of whom were able to outline the complaints procedure and how they would assist a resident to make a complaint.

While the complaints procedure stated that an audit of complaints was completed annually, there was no evidence available on the day of the inspection to support that this was being completed. However, the person in charge outlined actions that had been taken in 2016 in response to recurring complaints regarding misplaced items of residents' clothing.

Judgment:
Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were appropriate staff numbers and skill mix to meet the assessed needs of residents, improvements were required in staff training and documentation in relation to recruitment of staff.

While a training programme was in place for staff, training records evidenced that all staff had not received mandatory training as required by the Regulations. Eleven staff members were not up to date in fire safety, while nineteen staff members were not up to date with training in moving and handling practices. Further training was required to promote person centred care in order to avoid task orientated practice and support staff to fully connect with the person when working with people who have dementia.

A sample of staff files was reviewed by inspectors. Three of five files reviewed did not contain all of the information as required by the Regulations, including documentary evidence of qualifications and written references. Garda vetting was not in place for all staff on duty on the day of the inspection, this is discussed further in Outcome 2.

There were a number of volunteers providing various services to the centre. Volunteers' roles and responsibilities were not set out in writing, and garda vetting was not fully processed for one of the volunteers.

There was a comprehensive induction and supervision process for newly recruited staff, with feedback given and performance reviews held after designated periods of time. The

person in charge told inspectors that staff appraisals were ongoing for 2016, and planned to introduce self-appraisals for staff.

Minutes of staff meetings were provided to inspectors, which indicated that meetings for nurses and care staff had taken place in 2016. Staff who were not available to attend these meetings had signed copies of the meeting minutes after reading them.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The inspector reviewed the roster which reflected the staff on duty.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The layout and design of the centre was suitable for its stated purpose and met the needs of the residents. Additional improvements in relation to signage would promote the dignity, wellbeing and independence of residents with dementia. While the premises promoted the safety of residents for the most part, sluice rooms were found to be unlocked on the day of the inspection, one of which contained an unlabelled bottle of chemicals, which posed a potential risk to residents.

The centre is a purpose-built single storey building comprised of several wings. An array of communal spaces were available to residents including dining rooms, a relaxation room, an oratory and a spacious activity room. A smoking room was available, with appropriate ventilation in place. Several secure external gardens were easily accessible across the premises. Corridors in the centre were wide and spacious, and seating had been placed at intervals along corridors. Hand rails were in place along all corridors to support independent movement of residents. Paintings and photos of residents were displayed on corridors throughout the premises, and signage was also displayed on some toilets and at junctions to direct residents to communal rooms. However, further use of contrasting colours and improved signage would support residents in navigating the centre.

Sixty one single bedrooms and 5 double rooms provided accommodation to residents, all of which had ensuite facilities. Bedrooms were spacious and comfortably furnished, and some bedrooms were found to be personalised by residents with possessions and furniture. Bedrooms contained suitable storage, a call bell and any assistive equipment that a resident may require. While some residents had personalised signage in place on

bedroom doors, further improvement was required to support all residents with dementia in locating their bedrooms.

There was a sufficient number of toilet, shower rooms and bathrooms available to residents. Efforts had been made by the provider to install grab rails of a contrasting colour in these rooms when renovations were occurring, which was evident on the day of the inspection.

Laundry facilities had been upgraded in the last year, and these were found to be suitable for its purpose.

Judgment:
Substantially Compliant

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:

Ide Cronin
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[1]

Centre name:	Brookhaven Nursing Home
Centre ID:	OSV-0000207
Date of inspection:	13/09/2016
Date of response:	03/10/2016

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inconsistent evidence that the end of life needs and wishes of all residents' with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan.

1. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
•Residents, whose end of life needs and wishes were not documented in their care plans at the time of the inspections are now so documented.
•going forward, the end of life needs and wishes of all new residents will be documented on admission. This will be carried out with each resident and/or their next of kin as appropriate.
•all residents approaching end of life are provided with the appropriate care and comfort which addresses the physical, emotional, social, psychological and spiritual needs. This is reflected in individualised care plan.

Proposed Timescale: 03/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In a medication chart reviewed by the inspector the signature of the prescriber was not in place for a drug which was prescribed on 8 September 2016.

2. 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 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:
•All nurses will remind general practitioners that any medications prescribed for residents must be signed for in the residents medication chart by the prescribing GP.
•pharmacy audits will be carried out every 4 – 6 weeks.

Proposed Timescale: 03/10/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a policy on the security of residents' accounts and personal property. However, this was dated in 2010 and had not been reviewed.

3. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(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.

Please state the actions you have taken or are planning to take:
The policy had been reviewed annually; however on the day of inspection, the front sheet outlining review dates had not been given to inspector.

Proposed Timescale: 03/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The safeguarding policy did not reference the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (2014) in accordance with best practice.

4. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(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.

Please state the actions you have taken or are planning to take:
A new policy “Safeguarding Vulnerable Persons at Risk of Abuse”, is currently being devised and will be implemented immediately.

Further staff education and training will be carried out on safe guarding and elder abuse.

Proposed Timescale: 31/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Fourteen staff had not received training on understanding and managing challenging behaviour.

5. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Training for remaining staff who require training in “The Understanding and Managing Behaviour that is Challenging” will be undertaken.

Proposed Timescale: 31/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were five staff members whose Garda vetting applications were not fully processed were rostered to work.

6. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
No new member of staff will be rostered for duty until their Garda vetting disclosure has been fully processed and received by the person in charge.

Proposed Timescale: 03/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
From a review of training records inspectors observed that 41 staff out of 62 had up to date training in elder abuse.

7. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
Training for remaining staff in the detection and prevention of and responses to abuse will be undertaken.

Proposed Timescale: 31/10/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Findings did not confirm that residents were given opportunities for participation in meaningful, purposeful activities to suit their assessed and documented activation needs, preferences and capacities.

8. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
A new activities co-ordinator, with increased hours has commenced employment in Brookhaven on 26 September 2016. This role will also be supported by a support activities co-ordinator and both will facilitate activities in Brookhaven seven days a week.

All staff will ensure that residents are given every opportunity to participate in meaningful, purposeful activities in accordance with their interests, preferences and capacities. Each resident will have this documented in a care plan.

Proposed Timescale: 26/09/2016

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure the complaints procedure and its summary are reviewed to reflect the current practice of managing complaints in the centre, and includes the current complaints officer.

9. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
Complaints policy reviewed to reflect current practice and this includes the current "Complaints Officer".

Proposed Timescale: 03/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that the details of investigations into complaints is recorded.

10. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
Brookhaven's complaints process has been reviewed and revised to better reflect all details including outcome of complaints and residents satisfaction.

Proposed Timescale: Immediate.

Proposed Timescale: 03/10/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure that all staff are trained in safeguarding vulnerable adults, fire safety and moving and handling practices.

Further training was required to promote person centred care in order to avoid task orientated practice and support staff to fully connect with the person when working with people who have dementia.

11. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Any staff members requiring training in safeguarding vulnerable adults, fire safety and moving and handling practices will receive such training.

Proposed Timescale: 31/10/2016

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Ensure that all of the documentation required by Schedule 2 of the Regulations is in place for all staff members, specifically written references and documentary evidence of relevant qualifications or accredited training.

12. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
No person will commence employment in Brookhaven Nursing Home until all documentation set out in Schedule 2, 3, 4 is obtained and verified by the PIC.

Proposed Timescale: 03/10/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure that the roles and responsibilities of volunteers are set out in writing.

13. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
Alll volunteers operating within Brookhaven Nursing Home will receive their roles and responsibilities in writing.

Proposed Timescale: 03/10/2016

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure access to sluice rooms is restricted.

14. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:

Coded locks will be put on all Sluice Room doors.

Proposed Timescale: 14/10/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further use of contrasting colours and improved signage would support residents in navigating the centre.

15. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
In conjunction with Brookhaven's activity co-ordinator and painter better use of contrasting colours to the corridors will be carried out.

Dementia friendly signage/pictures which will support and guide our residents in getting more familiar with their surroundings will be posted in all areas with "ease of view".

Proposed Timescale: 31/10/2016