

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Brookfield Care Centre
Centre ID:	OSV-0000206
Centre address:	Leamlara, Cork.
Telephone number:	021 464 2112
Email address:	brookfieldcc@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Brookfield Care Services Limited
Provider Nominee:	Clodagh Drennan
Lead inspector:	Mary O'Mahony
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	62
Number of vacancies on the date of inspection:	1

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 January 2017 09:00	18 January 2017 18:00
19 January 2017 10:00	19 January 2017 18:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application by the provider, to the Health Information and Quality Authority (HIQA), to renew registration of the designated centre. During the inspection there were 61 residents in the centre and one vacant bed.

The inspector observed practices and reviewed governance arrangements, including

clinical and operational documentation. This included policies, procedures, risk assessments, residents' care plans and training records. The management team demonstrated knowledge of regulatory requirements and they were found to be committed to providing person-centred, evidence-based care, to residents. Residents received a comprehensive assessment on admission and care plans were developed, based on this assessment.

Prior to the inspection, questionnaires were forwarded to the centre, for distribution to residents and relatives, on behalf of HIQA. A number of these were reviewed by the inspector and feedback on all aspects of care was positive. Residents and relatives, spoken with by the inspector, were complimentary of the care and of the staff in the centre. Family involvement was encouraged. Relatives described how staff were always respectful and welcoming. One resident stated that she had 'no worries' and that she could do 'whatever she wanted'. All residents were complimentary about their bedroom accommodation and of the food provided. The centre was finished to a high standard and there was appropriate use of suitable furniture and soft furnishings, which created a homely environment. The dementia-specific unit was decorated with beautiful wall murals and other decorative items, which created areas of interest and colour, throughout the unit.

The healthcare needs of residents were addressed. Residents had access to general practitioner (GP) services and a range of allied health services. However, GP access for all residents was limited, in January, as discussed under Outcome 11: Health and social care needs. Staff supported residents to maintain their independence, where possible.

The inspector identified some issues requiring improvement, to enhance the findings of good practice, on this inspection. These are discussed throughout the report. These improvements were required, to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland, 2016. The provider was required to submit an action plan, to address these areas.

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector viewed the statement of purpose which accurately described the service that was provided in the centre. It contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. It was reviewed on an annual basis.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The quality of care and experience of residents was consistently monitored. Medication management, falls, health and safety and infection control were audited, by the management team, the person in charge and the team of clinical nurse managers. Effective management systems and sufficient resources were in place, to ensure the

delivery of a quality care service. There was a clearly defined management structure in the centre, which identified the lines of authority and set out roles and responsibilities. The inspector viewed the annual review of the quality and safety of care, delivered to residents. Improvements were brought about as a result of learning from the monitoring review. There was evidence of consultation with residents and their representatives. Minutes of staff meetings were viewed and staff issues were addressed.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
The regulatory resident's guide was available to residents. It contained all the required information. In a sample of residents' files reviewed, the inspector found that a contract of care had been signed and agreed on admission. Each resident's contract outlined the care and services available, in the centre. The contracts specified the fees to be charged for care and outlined the services which were to be paid for by residents, for example, hairdressing fees, and chiropody and pharmacy charges.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge had been in the centre since 2012. He had held the position of

person in charge since 2015. He worked full time in the centre and was a nurse with experience in the care of the older person. The person in charge demonstrated clinical knowledge by ensuring suitable and safe care. He was found to be knowledgeable of the legislation and of his statutory responsibilities. He was engaged in the governance, operational management and administration of the centre, on a regular and consistent basis. He met daily with the provider and stated that he met with his deputy, on a twice weekly basis. The person in charge organised audits and analysed outcomes, to improve practice. He explained to inspectors that he was engaged in continuous professional development and promoted continuous improvement for residents, by utilising best evidence based practice. He had qualifications in staff training, infection control, health and safety and management skills.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained accurately and were easily accessible to the inspector. The designated centre was adequately insured against accidents or injury to residents, staff and visitors. Insurance certification was viewed by the inspector. This was due for renewal in 2017. Most policies required under Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) were in place and were seen to be updated three yearly, as required. However, the policy on communication and the policy on the creation, access to, and retention of records, required updating. Staff were aware of the policies and the person in charge stated that these were implemented in practice. Complaints and incidents were documented. Copies of medication errors were maintained in the centre. A copy of the statement of purpose, the resident's guide and previous inspection reports, were available to residents.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The provider was aware of her statutory duty to inform the Chief Inspector of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre, during his absence. There was a suitably qualified person in place, to deputise, in the absence of the person in charge.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Policies and procedures were in place for the prevention, detection and response to abuse. This made reference to best evidence based practice and updated national policy guidelines. Staff with whom the inspector spoke were knowledgeable of the types of abuse and what to do in the event of an allegation, suspicion or disclosure of abuse. Staff stated that they received regular training and refresher courses. Records were reviewed and these indicated that staff had received training. Further training was seen to have been scheduled for February 2017. Residents stated they felt safe and attributed this to the caring and kindness of staff.

Systems were in place to safeguard residents' money and these were monitored by the provider and the administrator. Two staff signed for any money lodged or withdrawn. Residents' money and any valuables, were securely stored in a safe. A sample of records checked were seen to be in order. Each resident had a separate record and invoices viewed were correct.

The use of bedrails was notified to HIQA, as required by the regulations and these were checked regularly, when in use. Consent for their use had been signed and the inspector viewed the associated risk assessments and documentation.

A policy on managing behaviour, which was related to the behavioural and psychological symptoms of dementia(BPSD), was in place. Efforts were made to identify and alleviate the underlying causes of such behaviour. Documentation was in place to indicate that distraction and de-escalation techniques were employed as a first response, if required. Staff spoken with were aware of this policy. Most of the staff had received updated knowledge and skills in this area, from the person in charge and external trainers. A number of new staff had been scheduled for training, in March 2017.

Judgment:
Substantially Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be comprehensive. Fire evacuation instructions were displayed throughout the centre. Fire safety training was provided on an annual basis. Regular fire drills were undertaken, as required by legislation. Monthly checks of emergency lighting were carried out by the deputy, support service manager. This member of staff explained that quarterly servicing of emergency lighting was undertaken, by a suitably qualified person. He stated that the fire extinguishers and other fire equipment had been serviced on 23 August 2016. This was confirmed by the inspector. Staff, with whom the inspector spoke, was aware of what to do in the event of a fire and spoke with the inspector, about the fire drill process. The provider and person in charge informed the inspector, that a number of staff had just completed fire management training. Meetings were planned, to discuss a cohesive approach to fire safety management, as each of these staff members would act as fire wardens.

However, similar to previous inspection findings, the documentation on fire drills was not sufficiently detailed, to identify the outcome and learning, from each drill. In addition, similar to previous findings, a number of designated fire doors were held open with door wedges. The person in charge stated that these doors were kept open, to enable supervision of vulnerable residents. However, he stated that suitable magnetic door holders were being installed, on a phased basis. This project was due to be completed by 31 March. However, the inspector found that daily fire safety checks and weekly fire alarm checks had not been recorded, as required by legislation. The provider was directed to the fire safety guidelines available on the HIQA website. This was printed off during the inspection, for referral. The person in charge stated that these best practice guidelines would be followed, in conjunction with advice, from suitably qualified persons, in fire safety management.

There were policies in place for the prevention and control of healthcare associated infections. The premises were found to be clean and hand-washing facilities were plentiful. Staff were trained in hand hygiene and infection control practices. Arrangements for the disposal of domestic and clinical waste, were in place. Sluice rooms and cleaning rooms were locked. These rooms were clean and all chemicals were appropriately stored.

Records viewed by the inspector indicated that staff had received up-to-date moving and handling training. There were a number of different hoists available. These hoists were serviced on a regular basis. The provider had contracts in place for the regular servicing of all equipment and the inspector viewed a sample of these records. The health and safety statement was comprehensive and had been updated in 2016. Risk assessments were undertaken, including falls risk assessment, smoking, kitchen management, moving and handling. All risk assessments were updated, including clinical risks assessments.

There was a comprehensive log of all accidents and incidents in place. Medical attention was seen to have been sought where appropriate and notifications had been submitted to HIQA, where required.

Judgment:

Non Compliant - Moderate

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:

Medicines management was found to be robust and in line with, an Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives, on Medication Management (2007). Policies, relating to the ordering, prescribing, storing and administration of medicines, were in place in the centre. The processes employed, for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation.

Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, return and disposal of medicines. The inspector saw that controlled drugs were stored securely. Stock levels were recorded at the beginning and end of each shift.

A system was in place for reviewing and monitoring safe medication management practices. An audit and review system, that included input from the clinical nurse managers, the general practitioner (GP) and the pharmacist, was in place. Actions identified, were addressed.

Medicine administration was clearly documented and a signature sheet was maintained for nurses who administered medicines.

Judgment:
Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

A record was maintained of all incidents which had occurred, in the centre. Quarterly notifications were submitted to HIQA ,as required. The provider and person in charge were found to be aware of the regulations, in relation to, notifications.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are

drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The person in charge explained that pre-admission assessments were undertaken for prospective residents, with further comprehensive assessments completed within 48 hours of admission. Care plans were developed for all aspects of residents' care, for example, mobility, skin integrity, cognition and nutrition. These were informed by the use of validated tools for evaluating pain, maintaining skin integrity and assessing mobility needs. A sample of care plans seen by the inspector was comprehensive. These guided staff in the delivery of person-centred care. Plans were updated on a four-monthly basis, or in keeping with any revised assessments. The person in charge explained that contact and communication with relatives or representatives happened on a daily basis, in person or on the phone. These conversations were recorded in the communication notes. Relatives, with whom the inspector spoke, generally expressed satisfaction with the quality and standard of care their relative received. When any concerns were brought to the attention of the person in charge, he was seen to be proactive in addressing issues. During the inspection, the inspector observed the person in charge arranging meetings with management and consultations with the doctors, for concerned relatives.

However, the provider stated that, due to the rural location of the nursing home, residents did not have access to their own GP who would have attended them, before admission. She stated that there was a good service available from two doctors. However, there were on-going challenges in recruiting new doctors for residents, as all the GP practices were very busy. 'South Doc' services were accessed in the evening, to support the current GP cover. Staff spoke about the challenges this presented, particularly for the period of time in January, when only one doctor had been available, to meet the needs of all residents.

The clinical nurse manager informed the inspector that daily handover reports ensured that all grades of staff were provided with comprehensive information, on any changes in residents' condition. For example, a member of the cleaning staff, who spoke with the inspector, stated that she was always told if a resident had an infection. Referrals for assessment, in relation to physiotherapy or occupational therapy (OT) were arranged, as required. Residents had access to relevant allied healthcare such as, physiotherapy, speech and language therapy (SALT) and the dietitian. The person in charge stated that residents were not regularly referred to the dietitian or SALT, as, at present, residents were maintaining their weight and nutrition status. If a need was identified however, residents would be referred. For example, if a resident developed a swallowing difficulty. A review of a sample of care plans, indicated that when a resident exhibited behaviour, related to the behaviour and psychological symptoms of dementia (BPSD), a

personalised care plan had been developed.

Records of clinical observations were maintained, for example, monthly blood pressure checks. Arrangements were seen to be in place, to support residents in accessing dental, chiropody and optician services. Psychiatric and geriatric consultant appointments were available, on referral.

The centre operated a system whereby key workers were assigned to residents' care, on a daily basis, to ensure consistency. Overall, staff and management at the centre stated that they were committed to providing a personalised approach to care, based on an assessment of each resident's needs. Staff spoken with, were found to be knowledgeable, of the needs and life stories of residents.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The centre was spacious, bright and furnished to a high standard. There was a homely, nicely decorated, comfortable entrance foyer in the centre, where residents could sit and watch visitors and staff passing. One resident explained to the inspector that this was her favourite place to sit. She enjoying the spacious environment and the fresh air, when the front door was opened. The inspector found that the design and layout of the building was suitable for the residents who resided there. Independence was encouraged and risks were well managed. The design of the three units allowed for easy access to each separate lounge and dining area. A large number of residents were also seen to gather together, in the main dining room, for each meal.

Bathroom and toilet facilities were sufficient, to meet the needs of residents. Most of the bedrooms had en-suite facilities. Bathrooms and shower rooms were available, for other residents. The person in charge stated that a number of residents, particularly in the dementia unit, enjoyed a bath rather than a shower. The inspector was shown the modern bath, which was accessible with support from staff and by using a hoist. The person in charge stated that this was found to be beneficial and relaxing for residents.

There was assistive equipment available, to meet the needs of residents, such as, electric beds, hoists, pressure relieving mattresses, wheelchairs and walking aids. Hoists, the lift and other equipment were serviced and these records were viewed by the inspector. Accessible, secure, garden space was available to residents, who informed the inspector that they enjoyed the garden, when the weather was mild. Plenty of external seating was provided for residents' and relatives' use.

Residents, in the dementia care unit, had access to a secure garden of their own. Most residents enjoyed their meals in the dining room and they sat together in two sitting rooms/areas. The layout of this unit allowed residents, who had the ability, to walk around and enjoy the murals and various rest areas. The inspector saw residents walking around the unit and also observed that visitors were accommodated. Toilet doors were clearly marked, to support residents in maintaining continence.

The centre was laid out in three units which were interlinked. The inspector spoke with the provider and person in charge about the lack of suitable signage around the hallways. This was highlighted, as all units were painted the same colour. As a result it was difficult to identify which hallway led to each unit. Signposting was not available, for example, with room numbers and unit name. The provider stated that she would look into the idea of providing signage, for residents and relatives.

Judgment:
Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
A policy and procedure, relating to the making, handling and investigation of complaints, was available and had been updated in August 2016.

The procedure identified the nominated person to investigate a complaint and the appeals process. The procedure was displayed in a prominent position and outlined in the residents' guide and statement of purpose. The person in charge was identified as the complaints officer. Should a person not been satisfied with the outcome of an internal complaint and following an unsuccessful appeal, they were directed to contact the ombudsman.

Contact details for the office of the Ombudsman were displayed. In general, the inspector found that complaints were well recorded, given prompt attention and the satisfaction or not of the complainant was documented. A number of concerns were brought to the attention of the inspector, during the inspection. These were recorded by the person in charge who undertook to address the concerns. He was aware of the concerns and had already been in contact with the people involved. For example, a resident was not happy with the time his morning drugs were being administered. This was attended to immediately.

Judgment:
Compliant

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:

Policy and procedures for end of life care were available, to guide staff and inform care practices. A multi-disciplinary approach to treatment and care, including a palliative care team, was accessible, if required. Residents' wishes, regarding care and treatment decisions at the end of life, were recorded. Their wishes were supported by the medical team and were discussed during the assessment and review process. There was evidence of residents' and relatives' involvement in end of life care planning.

The provider and person in charge stated that facilities were available, to support families, who wished to stay overnight with their relative. The management team confirmed they had good access to the palliative care team. These specialists provided advice on monitoring physical and psychological symptoms, on the administration of pain relief and other comfort measures, such as, the addition of subcutaneous fluids, if necessary. Staff had received training to support their practice.

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:

Records of residents' meetings reviewed by the inspector, reflected that residents were complementary of the food and the choices on offer. The inspector met with the head chef, who confirmed that she met regularly with the nursing staff, to receive an update on residents' nutrition status. She maintained a file containing information with regard to residents' dietary requirements, specific diets and modified diets. She outlined the system of cleaning and of record keeping, in relation to, food delivery and food cooking temperature. Audit had been undertaken by an external specialist into the management of kitchen hygiene. This was satisfactory. The chef had received appropriate training. She was aware of all residents' likes and dislikes and met each resident on admission, to ascertain their preferences. She baked home-made cakes daily and there was a great choice of food available, at each meal.

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 only minimal assistance. The other two units had their own dining rooms and were used by residents who required assistance or who chose to dine there. During the days of inspection, the inspector noted that staffing levels were adequate, to meet the needs of residents, during mealtimes. At dinner time, the inspector observed that sauces were served separately, or added to the meal on request. Staff were seen to be assisting residents, in a sensitive and discreet manner. Staff stated that mealtimes were seen as an opportunity to engage with residents. Staff demonstrated in-depth knowledge of residents' likes and dislikes. Light snacks, fruit, home baking and drinks were readily available throughout the days of inspection. Residents confirmed that they could request food at any time.

Residents had a Malnutrition Universal Screening Tool (MUST) assessment on admission and at regular intervals. A sample of medication administration charts reviewed, indicated that nutritional supplements were prescribed by the GP, if required. Residents' weights were recorded monthly, or more often. Assistive cutlery and crockery required for residents with reduced dexterity were available.

The main dining room was bright and spacious. The dining tables were suitably set, with tablecloths and flower arrangements, put together by residents, as part of the activity programme. Minutes of residents' meetings and survey results, indicated a high level of satisfaction, with all aspects of the dining experience. Residents, relatives and staff spoke with the inspector about the special occasions which were facilitated, such as, birthday parties and family parties. One resident described the food as 'brilliant' and said she was 'staying for the rest of her life'.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The inspector observed that staff spoke with residents in a kind and respectful manner. Residents' privacy and dignity was promoted by staff, who were seen to knock on residents' doors, before entering.

Closed circuit television (CCTV) was utilised at the entrance to the building, in corridors and in the grounds. The CCTV policy supported the use of these cameras and signage was in place, to alert residents, staff and relatives, to its use.

Links were maintained with the local community, through visitors, musicians, local schools and staff conversation. TV, DVD, mobile and landline phones, were available for use. Local choirs performed for the residents, on special occasions. Mass was said in the centre and communion was available weekly. All religious denominations were catered for.

Residents said that their visitors were always made to feel welcome. A number of residents spoken with, confirmed this and stated that, the communication from the staff and management team was consistent and effective.

There was a residents' committee in the centre and meetings were usually held quarterly. However, residents had not attended the last meeting, as they stated that everything was satisfactory, at that time. Minutes of the last meeting were viewed by the inspector. Issues relevant to residents had been discussed, such as, food, laundry, activities and care issues. Actions required to be attended to have been documented and completed. Residents, who spoke with the inspector, said that their views were taken into account in the centre.

External advocacy services were available and information on these services were on display, around the centre. An advocacy meeting was arranged, on a monthly basis, for the representatives of residents who were non verbal, or had cognitive challenges.

The activity co-ordinator spoke with the inspector and outlined the range of activities available, to residents. For example, movie time, knitting, bingo, music, art and craft,

baking, family days, exercise classes and newspaper reading. She also attended residents' meetings. She confirmed that residents' requests were facilitated. She described how some residents requested an evening drink. This was organised immediately. A newsletter was produced on a three-monthly basis. The inspector spoke with a health care attendant who was involved in setting up a men's club in the centre. He also described how he based activities around elements of the life stories of residents. In addition, a health care attendant was seen to bring a resident to the sun room and to read extracts from a book, in which the resident had been mentioned.

However, activities were restricted to the dementia unit, at the weekends. The activity co-ordinator stated that she felt residents would benefit from increased, weekend, activities.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Residents and relatives informed the inspector that they were encouraged to personalise their rooms. Residents' bedrooms were comfortable and spacious. Residents' had personal items of furniture, bed-linen, pictures and photos, on display. Storage space was provided for clothing and belongings. A lockable drawer was also provided for personal items.

Residents stated that they were generally happy with the laundry system. The laundry room was spacious and tidy. It was equipped with an adequate supply of machines. The laundry staff member was found to be knowledgeable of which items of clothing belonged to individual residents. She stated that she personally returned the clean items, to residents' wardrobes.

However, there were a number of complaints, in relation to residents' clothing going missing. A new system had been introduced, prior to the previous inspection, for managing residents' clothing. This involved the use of small identity buttons. A small number of residents and relatives stated that this system did not prevent items from getting lost. The inspector observed that there was a rail of lost-and-found clothing, in

the linen room. In addition, items of missing clothing were seen to be discussed at residents' meetings. However, the person in charge stated that some new clothing had been placed in wardrobes, before being sent to the laundry, for labelling, as required. In addition, the regular laundry personnel had not been available for a period of time. This had now been addressed.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The centre maintained policies on recruitment, training and development of staff, which had been updated in August 2016.

There was an adequate complement of nursing and care staff on duty, during the two days of inspection. However, the provider and person in charge stated that there were periods of staff shortage, due to sickness and staff leaving. Recruitment of new staff was on-going. Staff had the appropriate skills and experience to meet the assessed needs of residents. The supervision arrangements and skill-mix of staff were constantly reviewed, according to the person in charge. Staff appraisals had commenced, however a large number of staff were yet to be appraised. The new appraisal form was reviewed by the inspector. The person in charge stated that, the deputy person in charge was undergoing training, to facilitate appraisals. Staff supervision systems were robust, following the introduction of supervisors, for each role.

A sample of staff files, for each role, was reviewed. The files contained the documentation required under Schedule 2 of the regulations. There was evidence of vetting by An Garda Síochána (GV) for the staff files reviewed. The person in charge and the provider stated that all staff had GV in place.

Records were available confirming that nursing staff had active registration with An Bord

Altranais agus Cnáimhseachais na hEireann.

Staff had received appropriate training in fire management, infection control and safe moving and handling. Professional development courses were facilitated, such as continence care, medication management, health services management, end of life care and wound care. Training in manual handling, infection control and fire drills, was facilitated in-house, by the suitably qualified staff.

A training matrix was maintained to identify training requirements for each staff member.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Brookfield Care Centre
Centre ID:	OSV-0000206
Date of inspection:	18/01/2017
Date of response:	15/02/2017

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 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

A policy, required under Schedule 5 of the regulations, had not been reviewed within the three year timeframe, set out under the regulations.

1. 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

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

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 Communication Policy has been revised.

Proposed Timescale: 15/02/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A number of staff had yet to receive training in updated knowledge and skills in managing behaviour issues due to the effects of dementia.

2. 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:

Proposed Timescale: There is Dementia Specific and Challenging Behaviour Training booked for 2nd March. A standard has been agreed with HR that all new staff will access training on Dementia and Challenging behavior at the latest within the 6 months after their probation period.

Proposed Timescale: 02/03/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

A number of designated fire safe doors were found to be wedged open, which rendered them no longer fit for use to contain a possible fire.

3. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

Work on an approved hinging system for referenced fire doors will commence on February 13th and will be completed within a two week period post commencement

date.

Proposed Timescale: 28/02/2017

Theme:

Safe care and support

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

Daily and weekly fire safety equipment checks had not been undertaken or documented, as required by regulation.

4. Action Required:

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

A new template and schedule based on the HIQA Guidelines has been implemented. This revised template is currently being rolled out to the 9 staff members who completed Fire Manager Training on 12th January 2017 and their roles and responsibilities in relation to compliance is being clarified.

Proposed Timescale: 28/02/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents did not have adequate access to a choice of GP service due to the rural setting.

The person in charge stated that it was a constant challenge to maintain full GP cover for all residents.

Medication reviews were not undertaken on a consistent basis.

5. Action Required:

Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

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

Adequate medical cover is now in place through support from a second GP in the local area.

There is commitment that such cover will remain in place until the primary GP appoints an assistant to his practice.

Proposed Timescale: Issue from Jan 1st to Jan 19th 2017 only. Now resolved.

Proposed Timescale: 19/01/2017

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Items of clothing were not returned safely to all residents.

6. Action Required:

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

Daily audits of 10 wardrobes a day have been introduced to ensure clothing is properly labelled and not incorrectly stored. A designated lost and found area has been advised to residents and families in the news letter. A monitoring will continue through satisfaction outcomes on questionnaires and quality improvement meetings.

Proposed Timescale: 15/02/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff appraisals had yet to be completed for all staff.

7. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

A new Appraisal System has been formatted. The 3 Clinical Nurse Managers and Assistant Director of Nursing will receive training on its use. Once completed the appraisal system will be rolled out for longstanding staff. All newer staff currently have a six month review by the HR Manager.

Proposed Timescale: Implementation to commence April 2017 with all staff appraised by end of June 2017.

Proposed Timescale: 30/06/2017