Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Beaumont Residential Care
Name of provider:	Beaumont Residential Care Limited
Address of centre:	Woodvale Road, Beaumont, Cork
Type of inspection:	Unannounced
Date of inspection:	24 May 2022
Centre ID:	OSV-0000198
Fieldwork ID:	MON-0036460

About the designated centre

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

Beaumont Residential Care is a designated centre located within the suburban setting of Beaumont, Cork city. It is registered to accommodate a maximum of 73 residents. It is a two-storey facility with two lifts and five stairs to enable access to the upstairs accommodation. It is set out in three wings: the smaller East Wing is a dementia-specific unit with 10 bedrooms; the ground floor has 19 bedrooms; and the upstairs has 44 bedrooms. Bedroom accommodation comprises single rooms with en-suite facilities of shower, toilet and hand-wash basin. Additional shower, bath and toilet facilities are available throughout the centre. Communal areas in the East Wing comprise a comfortable sitting room, adjacent dining room, sensory room and window seating with views of the lovely enclosed garden. The main day room and dining room are located downstairs along with the reading room, TV room, visitors' room and hairdressing salon. Upstairs there is a lounge, smoking room, kitchenette and seating areas along corridors for residents to rest. Residents have access to two well-maintained enclosed courtyards with walkways, garden furniture and shrubbery. There are mature gardens around the building which can be viewed and enjoyed form many aspects of the centre. Beaumont Residential Care provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	68

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 24 May 2022	09:30hrs to 17:00hrs	Breeda Desmond	Lead
Monday 30 May 2022	09:30hrs to 17:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the person in charge and staff were working to improve the quality of life and promote the rights and choices of residents in the centre. The inspector met with many residents during the inspection, and spoke with two visitors. The inspector spoke with 8 residents in more detail to gain insight into their experience of living there. From what residents said and from what the inspector observed on inspection, residents were supported by staff to have a good quality of life. There was a rights-based approach to care delivery and residents reported choice in their care and living arrangements. Residents gave positive feedback about the centre and were complimentary about the staff and the care provided. One visitor spoken with spoke of the welcome and accommodating staff who facilitated visiting in a kind and friendly manner; the second visitor said she was very impressed with the service.

On arrival for this unannounced inspection, the inspector was guided through the infection control assessment and procedures by administration staff, which included a signing in process, electronic temperature check, hand hygiene and face covering. Hand sanitising foam, disposable face mask dispenser and hand wash hub were available at reception. Orientation signage was displayed throughout the building to guide residents to the dining room and bedrooms for example, to allay confusion and disorientation.

An opening meeting was held with the person in charge and assistant director of nursing (ADON), which was followed by a walk-about the centre with the person in charge. There were 68 residents residing in Beaumont Residential Care at the time of inspection. The centre was a large two-storey building with resident accommodation on both floors. The dementia-friendly unit accommodated 10 residents and was located on the ground floor. The premises was homely, warm and comfortable and communal areas were beautifully decorated. All areas were easily accessible with two lifts and five stairways.

At reception, there was a large notice board with information for residents and relatives including the activities programme, advocacy information, CCTV signage and a large sign with the day and date for residents to see and orientate them. Other information displayed included the statement of purpose, residents' guide and previous inspection reports for perusal. By reception, there was a lovely seating area where residents were seen to enjoy sitting there and watch the comings and goings to the centre and staff stopped to chat with residents resting there. There were many seating areas along corridors including low deep window sills with cushions for resident to rest while viewing the gardens outside. Gardens could be accessed from many points throughout the centre and doors were unlocked enabling independent access to the outdoor spaces.

There were several communal rooms available for residents to relax and enjoy on the ground floor with the visitors room, library sitting room, large TV room and

activities room, all beautifully decorated, and located in close proximity to the main reception. The main dining room was found to the left of reception and the second enclosed garden was seen from here. This courtyard was being power washed on the first day of inspection and was completely transformed by the second day and was much brighter and clean. The picket fence surrounding the shrubbery was colourfully painted and looked lovely and bright. There was no garden furniture here for residents to sit out and enjoy. The dining room was being refurbished at the time of inspection and the person in charge advised that new furniture was being researched as part of the overall upgrade of the dining room.There was art displayed at one end of the dining room which resident had created, of huge wings of various coloured fabrics and textures and created an elaborate colourful display to brighten that part of the dining room. This part of the dining room was seen to be used by staff; the remainder of the dining room was set out to accommodate approximately 20 residents. The main area was bright and welcoming and had art work displayed, but one table was up against the wall in the narrower area so residents had little to look at but wall.

Personal care delivery in the morning was observed to be calm; staff were heard to greet residents in a friendly and kind manner and offered and provided assistance respectfully while at the same time engage in conversation and fun. Staff brought residents to the communal areas and were seen to actively engaged with residents, asked where they would like to go, for example, some preferred the TV room, others the day room and a few residents relaxed and read the newspaper in the library.

Meal times were observed both upstairs, and downstairs in the dining room. In the dining room residents were offered choice with each course and each course was served separately. One resident was seen to request his bottle of white wine to be opened and he enjoyed pinot grigio with his dinner. Most staff actively engaged with residents at meal times, encouraging them and asking whether they enjoyed their meal; however, one staff member was seen to stand over a resident while assisting them in a perfunctory manner and did not engage with the resident; another staff member stood over and watched residents rather than sit discretely while residents had their meal and observe to ensure they were alright and provide immediate assistance where required. Observation of serving meals upstairs did not reflect the dining experience downstairs as residents were served their three courses together. Many residents had jelly and ice cream for desert and the ice cream was seen to be melting before trays were taken to residents' bedroom. Mealtimes were due to commence at 12:30hrs and the inspector observed that many residents upstairs were served by 12:20hrs.

In the afternoon of the first day of inspection the activities co-ordinator held bingo in the dining room. Residents were seen to enjoy the fun and banter and helped each other when numbers were called out. They enjoyed refreshments following the game. The activities co-ordinator called to residents in the morning and facilitated one-to-one activities. The activities programme was printed and displayed in residents' bedrooms as reminders of the programme for the week. There were very little activities on the second day of inspection as the activities staff was on leave and the care staff scheduled on activities was required for care duties as other care

staff were on sick leave.

Residents bedrooms were seen to be decorated in accordance with their wishes and preferences. Many had lots of photographs, vases of flowers, ornaments and mementos on display shelves; some residents had a large notice board displaying post cards and other correspondence. Many of the bedrooms had window seats with long cushions to sit and relax and many residents added their own soft furnishing to the window seat and room, making them homely and comfortable, bright and colourful.

One en suite bedroom facility had a shower but there was no rail to hang a shower curtain or a shower guard to prevent water flooding the en suite bathroom. This bedroom was reported to be deep cleaned but there were pieces of plastic on shelving.

Along corridors there were discrete cupboards which stored personal protective equipment (PPE) such as disposable gloves, plastic aprons, and disposable clinical wipes as well as alginate bags for laundry. Dani centre to store plastic aprons were available underneath these cupboards; at the time of inspection these were empty as there was no infection outbreak in the centre and aprons were readily available.

There were large mobile trolleys on each corridor with clean towels, face clothes, bed linen and incontinence wear for morning care. Laundry bins allowed for clothes to be segregated at source with three different colour-coded containers. One corridor had a mobile bin so that rubbish could be easily disposed of following delivery of morning care; and easily moved when staff were working their way along corridors. Other corridors did not have this facility and staff had either to walk a distance to the waste bin, or carry the waste bin to the corridor they were working.

Painting and re-decorating had commenced at the time of inspection and corridors upstairs were seen to be be prepared for painting with masking tape on skirting boards. Water fountains were located along corridors for people to easily access drinking water. There were hand sanitising dispensers in residents' bedrooms as well as on corridors with advisory signage demonstrating appropriate usage. The hairdressers was de-cluttered since the last inspection and had seating for residents to sit and enjoy each others company while waiting to have their hair up-styled.

The main kitchen was located opposite to the dining room with a large hatch for staff to serve food. During the walkabout, a non-kitchen staff member went into the kitchen to dispose of waste and was not seen to complete hand hygiene; she was also observed to go beyond the demarcated area designated for kitchen staff only.

The main laundry was located beside the kitchen. While there was a designated hand wash sink here, it was partially obstructed by clothes rail for drying clothes. A large mobile storage unit to hold clean towels and sheets was located on the dirty side by the washing machines. There was a large stock of clean mop-heads and household clothes on the laundry sink in the dirty area. While there was a sluice room in the dementia-friendly unit, there was no hand-wash sink available there. There was a hand-wash sink in the sluice room upstairs, however, there was no hand wash soap, paper towels for hand drying, or signage to indicate it was a hand-

wash sink.

The smoking room upstairs had a fire apron, blanket and emergency call bell. The electrical room was accessible when walking around and the inspector requested that this be securely maintained and this was immediately remedied. The cleaning store room on the ground floor accommodated household trolleys when not in use. The store room upstairs had boxes on the ground, one of which had a number of slings for hoists.

Overall, the premises was bright and well decorated and there was ample communal spaces for residents to enjoy. The premises was being painted and decorated at the time of inspection, and new furniture, including garden furniture was being procured to enable residents to sit outside and enjoy the good weather and fresh air.

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

Capacity and capability

Overall, this was a good service where a rights-based approach to care was adopted. Nonetheless, immediate actions were issued on inspection requesting the removal of door locks to some fire doors on stairwells, removal of large waste bins from evacuation pathways including the dementia-friendly unit, removal of paint tins stored in a room upstairs which also housed an emergency cut-off valve and was difficult to access due to the amount of items stored here. These were remedied immediately. Other fire safety issues were highlighted to the regional manager regarding evacuation of compartments as these had not been completed. A fire evacuation, cognisant of the largest compartment, was completed at the time of inspection and a weekly evacuation drill schedule was submitted with proposed fire drills with evacuations at different times of the day and night until such time as they were assured that this could be completed in a timely and safe manner.

Issued identified for action from the previous inspection were followed up and issues addressed included accessibility of staff files, controlled drug ledger, safety statement, issues relating to the statement of purpose, medication administration records, restrictive practice bed rail oversight. Areas for improvement identified on this inspection included fire safety precautions relating to evacuation of compartments, submission of notifications, transfer information when a resident was temporarily absent from the centre, aspects of infection control and safeguarding.

Beaumont Residential Care was operated by Beaumont Residential Care Limited. It was part of the CareChoice group which operated a number of designated centre throughout the country. The governance structure comprised the board of directors with the CEO appointed as the nominated person representing the registered provider. The management team within the centre was supported by a national and

regional management team of quality, finance, catering, facilities and human resources (HR).

The person in charge was newly appointed to the centre; one assistant director of nursing (ADON) was recently appointed and the second ADON was just appointed to the centre. While the on-site team was new to the service, they demonstrated good knowledge of the service, residents and their care needs, and staff. Observation showed that residents were familiar with the new management team and knew who they were and actively engaged with each other. There were two clinical nurse managers (CNMs) supporting the service as part of an effective management structure.

The registered provider had applied to re-register Beaumont Residential care. The application was timely made, appropriate fees were paid and prescribed documentation was submitted to support the application to re-register.

The incumbent person in charge and ADON had completed audits since commencing in the designated centre and reviewed audits undertaken since January, and had begun the process of addressing the issues found. For example, the medication audit highlighted that a comprehensive nurses' signature list was not in place. They were in the process of researching an electronic medication management system which would circumvent many potential issues relating to medication records. Submission of notifications was identified as an issue for attention as some notifications were not submitted in a timely manner. Following identification of this, the ADON was appointed with responsibility for the timely submission of notifications to the regulator. An annual schedule of audit was available to ensure oversight of the service with associated action plans to improve the service including the maintenance and upkeep of the premises.

Care staff levels were adequate for the size and layout of the centre and the number of residents accommodated at the time of inspection. Recruitment of staff was ongoing to ensure residents had appropriate access to an activities programme. While care staff were allocated to activities to support the programme, on the second day of inspection the care staff were unable to fulfil their activities roster as care staff were out sick and resident care was prioritised. The day following inspection the vetting disclosure was received for the proposed activities person which would enable a full activities programme.

The I.T. system in place enabled oversight of training needs with alerts when training was due. Training records demonstrated that a lot of training was up-to-date including infection prevention and control and fire safety. Training was scheduled for responsive behaviour, food safety, safeguarding, manual handling and lifting in June as staff were overdue this training.

Following appointment to their roles, the new person in charge and ADON undertook a review of complaints and identified areas which should have been notified to HIQA. One notification was subsequently submitted and the issue was addressed as safeguarding concerns, however, the second complaint was not identified as a safeguarding issue and not followed up as such; the information was

not trended to identify the commonality between the complaints.

Schedule 5 policies were available to staff and some were updated on inspection to ensure they were the current version to provide up-to-date information to staff. Nonetheless, the policy relating to the temporary absence of residents required updating.

Contracts of care and statement of purpose were updated on inspection to clearly reflect the fees to be charged along with possible additional fees charged of items and services not covered by the medical card GMS.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had applied to re-register Beaumont Residential care. The application was timely made, appropriate fees were paid and prescribed documentation was submitted to support the application to re-register.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was newly appointed to the centre and was a registered nurse with the required managerial and nursing experience specified in the regulations. He was actively engaged in the governance and day-to-day operational management, and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

There were adequate staff available on the days of the inspection to the size and layout of the centre and the assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The I.T. system in place enabled oversight of training needs with alerts when training was due. Training records demonstrated that a lot of training was up-to-date including infection prevention and control and fire safety. While staff were overdue training, this was scheduled for responsive behaviour, food safety, safeguarding, manual handling and lifting in June.

Judgment: Compliant

Regulation 21: Records

A comprehensive nurses' signature list as specified in an Bord Altranais agus Cnáimhseachais medication guidelines, was outstanding.

The restrictive practice daily check records were not comprehensively completed in line with regulatory requirements.

Judgment: Substantially compliant

Regulation 22: Insurance

A current insurance certificate was available as specified in the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Some management systems were not sufficiently robust and required action to ensure further oversight of the following issues identified:

- an immediate compliance plan was issued on inspection relating to fire safety precautions. This was further detailed under Regulation 28, Fire precautions,
- two concerns recorded in the complaints log were not recognised as safeguarding matters at the time of recording. This was further detailed under Regulation 8, Protection.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to reflect:

- the floor plans to reflect the current layout of the centre
- the room descriptors to include the facilities within rooms such as hand-wash sinks
- clarification regarding services provided under the GMS medical card scheme.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Three notifications were not submitted in a timely manner in line with regulatory requirements. Following review of the complaints records, a further safeguarding notification was not submitted. This was discussed under Regulation 8, Protection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were available to staff. These were updated on inspection in line with regulatory requirements. Nonetheless, the policy relating to the temporary absence of a resident from the centre did not include information on transfer and temporary absence to another health care facility along with the requirement to ensure comprehensive information was provided to the receiving centre.

Judgment: Substantially compliant

Quality and safety

In general, there was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. Oversight of residents' health care needs was good. Residents' health care needs were promoted by ongoing on-site access to their GP, health and social care professionals such as to speech and language and dietitian services when required,

and other specialist care such as psychiatry of old age.

Observation on inspection showed that staff had good insight into responding to residents' needs, including communication needs and in general staff responded in a respectful manner. Care plan documentation included behavioural support plans and observational tools to help identify reasons for anxiety or distress with controls and suggestions to mitigate recurrence. A sample of care planning documentation was examined and these showed mixed findings. The daily narrative reviewed showed really good monitoring of care needs as well as monitoring residents' responses to interventions including pain management. Risk assessments reviewed showed oversight of areas such as falls, pressure and skin integrity, personal emergency evauation plans (PEEPs), manual handling assistance and dependency for example. Some assessments contained valuable individualised information to inform personalised care, however, other were either incomplete or not completed.

Transfer letter with information on residents being transferred into the centre were seen to be comprehensive. While the national transfer template was used when resident were being transferred out of the centre were in place, copies of the transfer information were not maintained on-site.

Controlled drugs were seen to be maintained in line with professional guidelines. Nursing staff spoken with while completing medication rounds were knowledgeable regarding medication management, prescriptions, drug interaction and resident observation following administration of medications. A medication audit completed in March 2022 identified several issues relating to medication management, notwithstanding this, all bar one were remedied. For example, comprehensive administration records were seen in the sample examined; medications requiring to be crushed were individually prescribed, the maximum dosage for PRNs as required medications were stated, and medications were appropriately discontinued. A comprehensive nurses' signature list as specified in an Bord Altranais medication guidelines, remained outstanding.

Fire safety management was examined. An external fire safety consultant completed a fire risk assessment in February 2022 and the report detailed several recommendations. This report was discussed and the person in charge provided an internal report which evidenced that most of the recommendations were actioned or in the process of being actioned at the time of inspection. Where new equipment was required, quotes were sought and facilities department had oversight of this programme. While gaps were identified in the daily fire safety checks of November and December, daily checks were comprehensively completed since January 2022. Weekly and monthly fire safety checks were comprehensively completed. Appropriate maintenance certification was evidenced for servicing and maintenance. However, some issues were identified regarding fire safety precautions. For example, compartment floor plans upstairs did not reflect the building layout upstairs and could be confusing. Fire drill and evacuation records showed that drills were completed on a monthly basis, and while evacuations were undertaken, they simulated evacuations of a maximum of three residents; cognisant that the largest compartment was 14 residents, assurances were not provided that a compartment could be evacuated in a timely and safe manner. The recommendations of the drills

completed detailed that more practice was required and the inspection findings concurred with this.

The risk register was updated with newly identified risks in line with best practice and oversight of the service. The risk management policy was up to date and had emergency evacuation centres detailed should the need arise.

Minutes of residents meetings were seen following the incumbent person in charge taking up their post in April. The person in charge introduced himself and the new management team; minutes showed that he followed up and discussed the suggestions made in the January meeting. For example, the temperature of meals had improved with the addition of the new 'hot plate' to ensure food maintained its temperature. In addition, he outlined other initiatives such as cleaning and power washing the courtyards, researching garden furniture and a review of the activities programme was in progress to enhance eh quality of life for residents.

Regulation 10: Communication difficulties

The inspector observed that the staff were familiar with residents and their communication needs; interactions seen demonstrated that staff provided assurances to allay fears and anxieties; distraction techniques observed showed insight into residents' needs as well as kindness and understanding by staff.

Judgment: Compliant

Regulation 11: Visits

Visiting was facilitated in line with May 2022 HPSC guidance. Measures were taken to protect residents and staff regarding visitors to the centre. Information pertaining COVID-19 visiting precautions was displayed at the entrance to the centre. The inspector observed that visitors to the centre were familiar with the infection control precautions and each had their temperature checked, questionnaire completed, donned face covering and hand hygiene as part of their entrance to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' bedrooms had ample space to maintain their clothes and personal possessions, including double wardrobes, bedside locker and lockable storage space.

Some residents had an additional chest of drawers.

Judgment: Compliant

Regulation 17: Premises

While the centre was homely, clean, bright and easily accessible and provided adequate space to meet residents' needs and residents were observed to walk about freely and appeared comfortable in their surroundings, there was no garden furniture in the enclosed garden attached to the dementia-friendly unit to enable residents go outside, sit and relax and enjoy the good weather. Cognisant that the centre was registered to accommodate 73 residents (10 of whom were in the dementia-friendly unit), there was limited garden furniture in the second enclosed garden for residents to enjoy the outdoors.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Better oversight of meals and mealtimes was necessary to ensure the dining experience of residents as highlighted in the following:

Residents were offered choice at mealtimes and meals were seen to be well presented and appetising, including textured meals, however, one staff member was observed to stand over a resident while providing assistance with their meal with little engagement with the resident which did not promote the dignity or choice or the rights of the resident.

Dinner time was due to be served after 12:30hrs but the inspector observed that this had commenced well before 12:30hrs upstairs, with several meals delivered by 12:20hrs. This did not facilitate residents to have choice of a dinner served at a reasonable time.

While the dining experience observed in the main dining room was in keeping with normal dining where residents where served individual courses at a time and in general staff actively engaged with resident, when residents were being served in their bedrooms, all three courses were brought together on a tray. The inspector observed ice cream melting on the trolley before being taken to residents.

A review of one table in the main dining room was required to ensure it could facilitate a social dining experience.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

While the national transfer template was used when residents were being transferred out of the centre, copies of the transfer letters were not maintained on-site. Therefore it was not possible to be assured that comprehensive information was sent to enable residents to be cared for in line with their assessed needs.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy was available and included the specified risks as detailed in regulation 28.

Judgment: Compliant

Regulation 27: Infection control

The following issues were identified regarding infection prevention and control and required action:

- many of the protective surfaces of furniture and hand rails on corridors were worn so effective cleaning could not be assured
- not all clinical hand wash sinks were complaint with best practice guidelines
- there was no hand wash sink in the sluice room in the dementia-friendly unit
- the layout and work flows of the laundry were not in keeping the IP&C guidelines
- the area around the designated hand-wash sink in the clinical room upstairs was surrounded by items such as documentation, first aid box and testing equipment for example, so when the hand-wash sink was used these items would get splashed and wet and contaminated
- inappropriate entry to the kitchen by non-kitchen staff was observed
- the fridge in the kitchenette upstairs had a large layer of ice on the back of the fridge which would impede appropriate temperature control to ensure food was maintained at a safe temperature
- layout of showers and absence of either shower curtains or a shower guard to prevent water escaping and flooding en suite facilities
- oversight of terminal cleaning checks to ensure rooms and facilities were

cleaned to a high standard.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Immediate actions were issued on inspection requesting the removal of door locks to some fire doors on stairwells, removal of large waste bins from evacuation pathways including the dementia-friendly unit, removal of paint tins stored in a room upstairs which also housed an emergency cut-off valve and was difficult to access due to the amount of items stored here. These were remedied immediately. Other fire safety issues were highlighted regarding evacuation of compartments as these had not been completed. A fire evacuation, cognisant of the largest compartment, was completed at the time of inspection and a weekly evacuation drill schedule was submitted with proposed fire drills with evacuations at different times of the day and night until such time as they were assured that this could be completed in a timely and safe manner.

The fire panel was located by the main entrance. Emergency floor plans were displayed here which included a point of reference to orientate people to the building layout. However, floor plans displayed upstairs did not reflect the current building as the hairdressers room was detailed upstairs but it was relocated to downstairs.

Emergency evacuation floor plans did not detail primary and secondary evacuation routes.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A sample of medication administration records were examined and improvement was noted since the previous inspection as no gaps in administration records were noted providing assurance that residents received medications as prescribed.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Some assessments contained valuable individualised information to inform personalised care, however, other were either incomplete or not completed.

Cognisant that assessment and care planning documentation was to be completed no later than 48 hours after admission, the admission records of one resident recently admitted showed that their health profile was started on 15/05/22 but was incomplete; their comprehensive assessment was commenced on 17/05/22 where the communication assessment had commenced, however, the remainder assessments were blank; the mental test score was dated 30/05/22**.** There were some care plans to direct care and the ones activated had good information to inform personalised care, however, there were no care plans relating to maintaining a safe environment, medications, self-image, or sleep and rest.

The advanced care directive was not completed in another residents' care planning records to facilitate the resident's stated wishes regarding their care when they became unwell.

Judgment: Substantially compliant

Regulation 6: Health care

Records demonstrated that residents had timely access to medical care, specialist care and allied health care professionals. Referrals were seen and recommendation reports following assessment by speech and language therapist for example.

Wound care management was seen to be thorough with progress notes and ongoing skin assessment as part of maintaining skin integrity and pressure ulcer prevention. Notes showed that the GP and tissue viability nurse specialist were involved in care to enable best outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Alternatives to bed rails were seen such as low low beds and crash mats in bedrooms. The ADON had commenced a review of restrictive practice such as bed rails and had initiated discussions with residents regarding bed rail usage. Discussions were also facilitated with families providing them with information on bed rails. One of the nurse's discussed and sought clarification on consent and bed rail usage and it was evident that the topic was to the fore of care delivery and staff were promoting a restraint-free environment.

Judgment: Compliant

Regulation 8: Protection

The ADON had undertaken an audit of complaints logged and identified that one complaint required notification to the regulator as an allegation of misconduct. The complaint that the resident had made was not recognised as a possible safeguarding concern. While an investigation followed and was resolved, a second similar complaint was not followed up as a possible safeguarding concern. The information was not trended and analysed to inform the investigation process. The responsibility for undertaking investigations regarding any incident or allegation of abuse was delegated to the Human Resource (HR) department rather than the person in charge as required and specified in Regulation 8. There were no records to demonstrate that HR staff undertaking such investigations had completed safeguarding training.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector identified that residents rights were not fully upheld and action was required in the following:

- while a new activities staff was being recruited at the time of inspection, there was just one activities co-ordinator in place for several weeks; while care staff were allocated to activities duties, staff were unable to fulfill activities duties as other care staff were out sick and staff were needed to provided personal care. Therefore there was limited activities seen on the second day of inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beaumont Residential Care OSV-0000198

Inspection ID: MON-0036460

Date of inspection: 30/05/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • There is a robust medication management policy CL039 in place which includes the necessity of maintaining a comprehensive nurses' signature list and the PIC has implemented an up-to-date nurses signature list which is available in clinical rooms and accessible to the nursing team. • There is a daily check in place for restrictive practice which is completed by the nursing team and the PIC & Clinical Management team has implemented a weekly spot check.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The home has a robust policy on Fire Safety Management CL044 and support in managing Fire is provided to the PIC and management team in the home by the Group H&S officer and an external Fire Consultant. • The PIC has undertaken to ensure that nurse in charge check all pathways and exits at the beginning and end of their shift, all staff have been reminded of the importance of not tampering with doors, ensuring pathways are clear, and storage of potential flammable items. • All storerooms have been reviewed and cleared to ensure that each room is safe. • All doors have been reviewed to ensure that all access/egress systems meet requirements with no unnecessary door closures/locks in place. • The H&S officer has issued a memo to be shared with staff on the safety precautions around the good housekeeping.	

• The home has a policy on managing and reviewing complaints (CL004) and a policy on Safeguarding (CL018) and the details have been shared and disseminated to staff. There are weekly KPI's in place to monitor complaints and all complaints are recorded in the electronic system. The PIC ensures that all complaints reported are reviewed at a minimum twice weekly and assessed with regard to submitting appropriate notifications. Complaints are discussed at the monthly Operations Meeting and trended as part of the Quality Governance in the home. The PIC has overall responsibility of investigating complaints related to resident care and they work closely with a member of the HR team in the event of employee performance/disciplinary matter. The PIC will ensure all notifications are submitted.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose does include the floor plans to reflect the current layout of the centre.

• The SOP includes listing of facilities and services which are to be provided by the registered provider for residents.

• The Statement of Purpose had been reviewed to provide clarification regarding services under the GMS medical card scheme and updated to the below: Additional charges will be levied for services specified in Schedule 1 of the contract of care.
· GP services not covered by the "General Medical Scheme"
· Physiotherapy: On site for group sessions, initial assessments and/or assessment post fall.
· Occupational Therapy: general seating and environmental assessments
· Catering adaptive equipment (special crockery and cutlery)
· Mobility equipment (individual hoist slings / bed wedges)
· General social and individual activities within the home.
· Falls Sensory equipment (chair/bed/ IR sensors)

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The home acknowledges that an NF01 was submitted late.

• The home recognizes that following review by management of complaints/incidents, two complaints requiring NF06 notification were submitted late between January – March 2022.

• The PIC and clinical management team will examine all incidents/complaints on a daily basis to make sure that allegations are addressed promptly and follow up completed and appropriate actions.

• A review of notifications submitted has been completed and the inspector has been provided with an update on all notifications as requested.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The nursing home has a full suite of written policies and procedures in place and these have been disseminated to staff via staff huddles. The policies and procedures are available to all staff on the employee electronic records system. The policies misplaced from the policy folder at the time of inspection were replaced on the day of inspection as the inspector has recorded. The PIC has checks in place to ensure that the policy folder is updated in accordance with the Issued policies from the Quality Department.

• There is a policy in place which meets the regulation and includes details as per Schedule 5 on Resident Transfer/Temporary Absence & Discharge CL014. Part 9.0 covering Transfer to another Healthcare Facility to include:
The resident has all the information required regarding the reason for transfer and transfer arrangements. A copy of the resident's transfer form should be retained by CareChoice and placed in the resident nursing records.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• At the time of inspection the garden courtyards were being deep cleaned and landscaping had been procured and scheduled. The PIC was in the process of purchasing suitable dementia friendly new garden furniture, which is now in place. There are three garden areas in the nursing home, two of which are enclosed and one is on the grounds outside the main sitting room at the front.

• The second enclosed garden area has five garden benches, seating for ten persons and the garden area outside the sitting room has seating for 6 - 8 persons. • The PIC will undertake a review to assess what increased garden seating is required .

Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • The clinical management team will continue to complete QUIS assessments as part of continuous improvement. Communication on appropriate assistance has been communicated to all staff and supervision and observation of the dining room is in place. • Delivery of meals to residents had commenced on the day 12:20 slightly before 12.30 as per the inspector. The PIC has reviewed this and it is not a regular occurrence. Consultation with residents has been completed and the residents are satisfied with their mealtime and choice. • The PIC has undertaken a review of the dining room. The dining room has seven tables and provides seating for twenty-eight residents at any one sitting.	
Regulation 25: Temporary absence or discharge of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents: • The PIC and clinical management team have provided training to the nursing team on how to save copies of transfer letters related to residents onsite as per the homes process.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection	

control:
There is a policy in place on Infection Prevention and Control CL003 and the information has been shared with all staff. The policy is readily available to all staff and is reviewed and updated by the Quality Team to reflect national policy. Auditing of IPC is completed regularly by the home management team in addition to a quarterly QIPC audit conducted by the Regional Quality Manager. Action plans are in place post auditing to address items requiring improvement. The PIC continues to oversee the monitoring of action plans.

• There is a continuous maintenance plan in place for the environment, at the time of inspection planned decorating was underway which included repainting of the handrails. The handrail surface had been damaged by the ongoing cleaning and disinfecting and there is a robust system in place to ensure the surfaces are cleaned effectively. The painting of the handrails has been completed on 10th June 2022. A review of the furniture surfaces will be undertaken during July and a schedule of works made for implementation on a phased basis so as to minimize disruption to residents.

• There are robust hand hygiene systems in place to include handgel dispensers. A review of all clinical hand wash sinks is underway and sinks deemed not to meet with best practice guidelines will be replaced.

• The sluice room will be reviewed with facilities manager and a hand wash sink is planned.

• The layout and work-flows of the laundry have been reviewed to ensure that there is clear segregation of the clean/dirty areas. The clinical management team check the area daily to ensure that IPC guidance in segregation of clean/dirty is maintained.

• The clinical room upstairs has been rearranged to ensure that the area around the designated hand-wash sink is clear and there are no items left beside the sink.

• Communication has been issued to all staff as part of safety huddles reminding them of inappropriate entry to the kitchen by non-kitchen staff. The head chef and catering team are aware not to allow staff to the kitchen.

• There is a record for defrosting the fridge in the kitchenette upstairs and also documentation to ensure that the temperature is recorded daily. The fridge is maintained to a good working order.

• The PIC has undertaken a review of all shower units to ensure that all showers have an appropriate shower curtain.

• There is a robust recording procedure for maintaining housekeeping records. The PIC ensures that the terminal clean of rooms are completed to a high standard and verification of oversight is recorded. Staff have received further information on the standard of cleaning required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The home has a policy on Fire Management CL044 and support in managing Fire is provided to the PIC and management team in the home by the Group H&S officer and an external Fire Consultant. Staff have received training in Prevention and Management of Fire and there are daily and weekly checks completed as part of Fire Risk Register.

• The PIC has undertaken to ensure that nurse in charge check all pathways and exits at the beginning and end of their shift, all staff have been reminded of the importance of not tampering with doors, ensuring pathways are clear, and storage of potential flammable items.

• All storerooms have been reviewed and cleared to ensure that each room is safe. All doors have been reviewed to ensure that all access/egress systems meet requirements with no unnecessary door closures/locks in place. The H&S officer has issued a memo to be shared with staff on the safety precautions around the good housekeeping.

• Part 4 of the Emergency Plan for Beaumont Residential Care Home sets out how the home will manage a fire incident and an evacuation safety.

• As part of the ongoing monitoring and fire prevention plan, Safety Memos are issued to each home to update and support the Fire Safety Management System.

• Full compartment evacuation drills have now been completed of all compartments.

• The nursing home undertook a review of the Emergency floor Plans displayed on the first floor. The revised evacuation floor plans reflect the current building layout and are applicable to each floor. The emergency floor plans are displayed with reference to "you are here" orientated relative to the person viewing the plan and show both primary and secondary direction of escape routes to final exits.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
There is a policy in place for Assessment and Care planning CL009. This policy is available to all staff and has been disseminated to staff as part of staff huddles.

• There is a comprehensive suite of scheduled assessment and care planning in place which includes safe environment, medications, self-image, sleep and rest and end of life

care. The clinical management team have allocations implemented to ensure that nursing team are assigned to individual residents and careplans are reviewed at a minimum four monthly and/or if the resident experiences any changes to their health status.

• The home has rolled out the "Let me Decide" programme around residents advanced care directive. The clinical management team continue to audit the advanced care directive and the residents end of life care plan will detail the resident's stated wishes regarding their care when they became unwell.

• Monthly audits of assessments and care plans are completed by the clinical management and the feedback provided to the nursing team with ongoing monitoring in place. The ADON on each floor checks will ensure that each new resident has appropriate assessments and care plans completed in full no later than 48 hours as per the regulation.

• Nursing team have received training in completing individualized assessments and careplans and how to complete them in association with the resident. There is a documented guide available to all nurses.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The home has a policy on Management of complaints CL004 and a policy on Safeguarding & Elder Abuse CL019 and the details have been shared and disseminated to staff. The home has access to an independent SAGE advocate for residents and this persons information is displayed in the communal area.

• There are weekly KPI's in place to monitor complaints and all complaints are recorded in the electronic system. The PIC ensures that all complaints reported are reviewed at a minimum twice weekly and assessed with regard to submitting appropriate notifications. Complaints are discussed at the monthly Operations Meeting and trended as part of the Quality Governance in the home. The PIC has overall responsibility of investigating complaints related to resident care.

• Policies and procedures relating to CL019 are currently under review. The management team in the home understand that there are often two parts to an alleged incident or complaint e.g. Part 1 management of safeguarding which is completed by the clinical team in the home and part 2 Performance and Disciplinary procedures which is managed by the HR department in consultation with the PIC. The clinical management team in the home follow the National Standards of Safeguarding Adults and consult with the regional safeguarding team as appropriate.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The home has a policy in place covering the provision of activities for residents i.e. Promotion of Psychosocial Well-being (Activities) CL020 and this is shared with all staff.

• There is a team of activity coordinators in the center and as reported by the inspector on one of the inspection days the staff allocated specific to activities was required to cover healthcare assistant sick leave. The PIC assures the inspector that this is not a regular occurrence and every effort if made to ensure the allocated activity person is assigned solely to provide activity to residents.

• The PIC has reviewed the activity calendar with the activity team and communication to all staff has been completed to highlight that "activity" for residents is not solely for activity staff and can include residents involved in rearranging their personal possessions in their room, conversations, reading newspaper, and positive engaging communication. All staff are encouraged to sit, engage and provide social interaction with all residents throughout their working day.

• As part of monitoring the residents satisfaction with activities, the annual resident survey includes relevant questions

• In addition the PIC is arranging for members of the staff to avail of training in exercise class management in the coming months.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2022
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/07/2022
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	31/07/2022
Regulation 21(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/07/2022

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/07/2022
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	31/07/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of	Substantially Compliant	Yellow	31/12/2022

	healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/07/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/07/2022
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	11/06/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of	Not Compliant	Orange	11/07/2022

	its occurrence.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	11/07/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	11/07/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/08/2022
Regulation 8(1)	The registered	Not Compliant	Orange	11/07/2022

	provider shall take all reasonable measures to protect residents from abuse.			
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	11/07/2022
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	11/07/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/07/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2022