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:	Beechfield Manor Nursing Home
Name of provider:	Beechfield Manor Nursing Home Limited
Address of centre:	Shanganagh Road, Shankill, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	19 February 2025
Centre ID:	OSV-0000013
Fieldwork ID:	MON-0045850

About the designated centre

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

Beechfield Manor Nursing Home is a purpose built nursing home located in Shanganagh Road, Shankill Co. Dublin. It is registered to provide accommodation for 69 residents in 67 single and one double bedrooms. Each room is fully decorated and furnished. Residents are encouraged to bring personal belongings and small items of furniture where appropriate. The majority of the rooms have en suite facilities. Professional nursing care is provided to residents 24 hours a day by our dedicated team of qualified registered nurses, headed by our Director of Nursing and supported by Assistant Director of Nursing, two Clinical Nurse Managers, qualified staff nurses and experienced carers, with additional input from catering, housekeeping and laundry staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	62

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
Wednesday 19 February 2025	08:20hrs to 17:15hrs	Lisa Walsh	Lead
Wednesday 19 February 2025	08:20hrs to 17:15hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were content living in Beechfield Manor Nursing Home. Residents were complimentary of the staff, with one saying "staff are nice". Even with the expressed praise for staff members individually, some residents and their visitors reported that on occasions residents had to wait a prolonged period of time for staff to attend to their care needs when they used the call-bell. Some residents' also expressed their view, that delays to care being provided also impacted their ability to get up, dressed, showered and have their breakfast at their preferred time. In addition, some residents and visitors gave feedback on staffing arrangements, reporting that the centre did not have a sufficient number of staff, especially on the weekends. Another visitor expressed their concern that there had been several changes in senior management within the centre over a short period of time and felt that this had impacted on the care provided to residents, leading to supervision issues.

This unannounced inspection involved speaking with residents, staff, and visitors to gain insight into the residents' lived experience in the centre. The inspectors also observed the environment, interactions between residents and staff, and a range of documentation.

On arrival to the centre, following an introductory meeting, the person in charge guided inspectors on a tour of the premises. It was clear that the person in charge was very well known to the centre's residents and visitors and was aware of residents' needs.

The centre is comprised of a Georgian style house with a purpose-built extension with resident accommodation on each floor, located in Shankill, Co. Dublin. The centre is spread out over three floors and can accommodate a maximum of 69 residents in 67 single occupancy bedrooms and one twin bedroom. The twin room continued to be operated as a single bedroom to meet the needs of a resident, which was detailed in previous reports. Many residents had personalised their rooms with personal possessions and photographs.

Residents have access to a range of communal areas, including a choice of sitting rooms, located on each floor. Some residents were also observed to sit in smaller seating areas near the nurses station on some floors. On the day of inspection the sitting room on the lower ground floor was not accessible to residents as there was equipment being stored in the room for repair works that were occurring with the lift. The sitting rooms were seen to be clean and each had a television, however, they lacked in decoration to provide a homely atmosphere. There was a large dining room on the lower ground floor which was used for all residents' in the centre. There was also a smaller dining/activity room off the large dining room, however, inspectors did not observe any residents use this area.

Outdoors, the centre had a large patio terrace on the ground floor with potted

plants and some seating. Residents' could also access some smaller patio areas on the lower ground floor through the dining room, this was also where the residents' smoking shelter was located.

The inspectors observed the lunchtime experience. Staff began bringing residents to the dining room at 11.35am where they waited for the first of two meal sittings, which started at 12pm to 1pm. The second meal sitting was 1pm to 2pm. At 11.35am, inspectors observed staff plating up residents' meals for lunch and placing them on trays, which were then served after 12pm. Some residents choose to eat their meals in their bedroom, which was aligned with their will and preference. Inspectors observed that staff sat with residents and provided discreet, resident centred care and support where required. Residents' could choose between two meal options on the day of inspection. Residents' were also offered refreshments throughout the day. There was mixed feedback received about the food, some residents' were complementary of the food, with one resident saying the food was "excellent". However, some residents reported that food can be cold on occasions and one resident said they did not like the food. A small number of residents also reported that their food was already sauced before they received it and they were not given a choice to have sauce or not.

There was an activity schedule available for residents. On the day of inspection there was one activity staff in the morning and two activity staff in the afternoon. Residents were observed watching Mass or news on the television in the morning. A small number of residents had one-to-one sessions of "forever therapy", which included a massage. In the afternoon, some residents took part in a pottery class, which they said they thoroughly enjoyed. Following this, some residents took part in chair yoga. Some residents spoken with expressed their wish to have more outings. In addition, some residents said they would like to participate in activities more however, staff are sometimes delayed in bringing them to attend the activities or sometimes do not bring them at all so they miss the activity.

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. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, inspectors found that improvements were required in a number of areas of the service to ensure the service was safe, consistent and of a good quality, which is detailed under each regulation. In particular, some of the systems in place with regard to oversight of training and staff development, individual assessment and care planning and fire precautions. Other improvements were also required in relation to managing behaviour that is challenging, residents rights, infection control

and premises. There were also some gaps in the management structure and changes in the operational management team. On the day of inspection, recruitment had been completed with start dates scheduled for new members of management. With the recent changes, there was a need for enhanced focus on the development of a new management team.

This was an unannounced inspection to monitor compliance with the regulations and follow up on the compliance plan from the previous inspection, with a focus on fire safety and premises. This inspection also followed up on solicited and unsolicited information received since the last inspection. The inspection was carried out over one day with two inspectors. Beechfield Manor Nursing Home Limited is the registered provider for Beechfield Manor Nursing Home and is involved in the operation of a number of designated centres in Ireland.

There had been recent changes to the senior management team which impacted the management structures in the centre. The assistant director of nursing was the person in charge and had been in the role as person in charge for the past five months. During this period and on the day of inspection, the director of nursing role was vacant. In addition, the group quality and clinical practice lead role, who the person in charge reported to, was vacant on the day of inspection and had been vacant since the beginning of January 2025. Inspectors were informed that both roles were filled and awaiting staff to start in the roles.

The person in charge facilitated this inspection and was observed to be well-known to the residents. They are responsible for the centre's day-to-day operations. They worked full time in the centre and was supported in their management of the centre by two clinical nurse managers. The person in charge was also supported by a team of staff nurses, health care assistants, activity staff, catering and domestic staff.

Regular meetings were scheduled to take place, however, due to the recent changes in senior management some gaps were observed in meetings that were due to take place to ensure oversight of the centre. For example, clinical governance and operations meetings were due to take place each quarter, however, records available evidenced that no meeting had taken place since October 2024. Weekly reports were also due to be completed by the person in charge and sent to the registered provider. However, no weekly report had been completed since November 2024.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not fully effective and sufficiently robust as it had failed to identify key areas for improvement in areas such as assessment of residents needs and care plans. In addition, a residents survey had been completed to get residents feedback. However, the action plan developed did not address all concerns raised by residents in relation to their reported prolonged waiting time for staff assistance.

Staff had access to appropriate mandatory training and all staff had up-to-date safeguarding and fire safety training completed. However, inspectors identified that further training and supervision was required to ensure good quality care was

provided to residents. A review was also required to ensure the registered provider had allocated sufficient resources to ensure effective delivery of care, was meeting the needs of residents and that staff were appropriately supervised. Inspectors were informed that there was a lot of new staff in the centre which impacted the supervision issues observed during the inspection.

Regulation 16: Training and staff development

Action was required in the area of staff supervision and staff knowledge. Inspectors observed incidents where enhanced staff supervision was required. For example:

- On one occasion inspectors observed that where a resident had used their call-bell for assistance, and staff were aware of the resident calling for support. However, they did not respond in a timely manner to meet the needs of the resident. Inspectors observed the resident waiting over eight minutes for staff to respond to their request for assistance.
- Another example observed by inspectors, while a resident was calling staff for help, a staff walked past their room and did not respond to their calls for help. Another staff responded to the residents calls for help three minutes later.
- In the morning, staff were asked to facilitate activities in one sitting room. However, staff did not provide any activation for residents' and was observed to read a newspaper while the residents sat in silence. Only after being prompted by a resident, staff turned the television on for them.
- Some examples were observed where there were sufficient staff available to attend to residents' who required the toilet, however, there were not timely responses to support residents' needs, as residents' were asked to wait for assistance to go to the toilet.
- The oversight and management of staff responses to residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) also required further training and supervision. This is detailed under Regulation 7: Managing behaviour that is challenging.

Judgment: Not compliant

Regulation 23: Governance and management

While there were a number of comprehensive management systems established in respect of premises and fire precautions, further oversight and action was required to ensure all systems in place, were robust enough to be assured of the quality and

safety of the service. For example:

- The oversight systems of staff supervision and training were not sufficiently robust to support staff in appropriately assessing and responding to residents' needs, promoting residents' rights and managing responsive behaviour. These are further discussed under Regulation 16: Training and staff development, Regulation 9: Residents' rights and Regulation 7: Managing behaviour that is challenging.
- The management oversight of residents' individual care needs, assessments and care plans was not fully effective. This is further detailed under Regulation 5: Individual assessment and care plan. For example, replacing of some floors.
- Inspectors found that some of the actions identified from the previous inspections' compliance plan had not been addressed.
- While there were management arrangements in place to provide oversight of premises and fire safety issues, a number of concerns were highlighted on this inspection as detailed under Regulation: 17 Premises and Regulation 28: Fire Precautions.
- Current arrangements for the auditing and oversight of infection control processes did not adequately identify areas that did not comply with the requirements of the regulations. This is detailed in Regulation 27: Infection control.

While there was an established organisational structure in place, it was found that the lines of authority and accountability for the person in charge was unclear due to gaps in management structure. The registered provider had not ensured the designated centre was operated at all times in line with its statement of purpose and its conditions of the registration. For example, the management structure in place was not reflective of that outlined in the statement of purpose.

A review was also required to ensure the registered provider had allocated sufficient staffing resources to ensure effective delivery of care and was meeting the needs of residents.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing and implemented policies and procedures set out in Schedule 5. These were available to staff and reviewed at intervals not exceeding three years.

Judgment: Compliant

Quality and safety

While efforts were made by the nursing and care staff to provide a good standard of care to the residents, inspectors found that further improvements were required. As described above, the current management systems in place to ensure the service was safe and appropriate impacted on the quality of care being delivered to residents. The impact of this is described under the relevant regulations below, including individual assessment and care plan, managing behaviour that is challenging, residents' rights, fire precautions, premises and infection control.

Residents' social and health care needs were assessed using validated tools. Comprehensive assessments were completed on or before the residents' admission to the centre. However, inspectors found that some assessments were not completed appropriately and did not correlate with care planning information. As a result the care plans did not effectively guide appropriate care to some residents.

The centre had a policy to guide the use of restraint and restrictive practices and maintained a register of restrictive practices in use in the centre. The practice in the use of restrictions in the centre required action, as they were not always managed in accordance with the national restraint policy and guidelines. At times, this impacted residents' rights and was restrictive when staff were observed managing responsive behaviour.

An up-to-date safeguarding policy was in place to guide staff in the event of a concern of abuse arising. Inspectors found that safeguarding training was provided to staff in person and all staff had completed this training. Residents told the inspectors that they were happy living there and they felt safe. On the day of inspection, the registered provider was not a pension agent for any residents, however, they had applied to become a pension agent for a small number of residents'. There was a policy in place to ensure the management and oversight of residents' accounts.

There was an activities programme in place, and activity staff were available in the centre. Information was available on independent advocacy services and residents were supported to access these services, if required. Residents' also had access to newspapers, internet, radio and television and could undertake personal activities in private. Residents' were consulted about the organisation and had the opportunity to feedback through residents meetings and residents surveys. While some residents were observed to enjoy activities available and spoke about particular activities they enjoy, inspectors observed that there was insufficient opportunities for meaningful activation for some residents at the time of inspection.

Inspectors reviewed the building and facilities available to residents at the centre on this inspection. Generally, the centre was well presented and was maintained in a good state of repair. Audits were in place to ensure that maintenance issues and repairs were logged and actioned. However, a smoking area outside the lower ground floor dining room did not appear to be regularly cleaned as an extensive

amount of cigarette butts were noted on the ground in this area. A store room on the lower ground floor required attention from maintenance and cleaning also as it was found to be dusty, and used for storage of a vacuum cleaner and some cardboard items. The provider had identified areas for upgrade and plans were in place to improve floor coverings, and damaged doors. A major upgrade project was underway at the centre to upgrade a passenger lift. This works had been ongoing before the inspection day, and was having an impact on the space available to residents such as a sitting room used as temporary storage. A separate lift was still in operation for the residents which ensured that they had access to all other areas of the centre. Further upgrades were required such as a bedroom which did not have an en-suite facility available to it did not have a sink as required by the regulations. These and other premises issues are discussed under Regulation 17: Premises.

While the centre was generally clean on the day of inspection, a number of areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018), and this will be discussed under Regulation 27.

Fire safety practice was reviewed on this inspection. The registered provider had systems and oversight in place to manage the risk of fire. A fire safety risk assessment (FSRA) had been completed in the centre in October 2024. This FSRA had identified some areas requiring improvement and indicated a timeline for action based on the level of risk associated with that item. A separate fire door audit was also carried out to identify remedial works to fire doors. A plan was put in place for the remediation of the fire doors, however, on the day of inspection, a number of issues were identified relating to fire doors and the containment of fire.

Residents living at the centre were accommodated on all three floors. However, a concern was raised with residents living in a section of the first floor, where an alternative means of escape required evacuees to go outside onto a balcony area, with no clear indication of where to go from there. The provider had personal emergency evacuation plans (PEEPs) in place for each resident which provided a reference for staff during an evacuation to guide them on the evacuation plan. These PEEPs were updated regularly to take account of the changing needs of the residents and were used in staff training in fire evacuation drills. However, the use of evacuation aids such as evacuation sheets was not reflected in the fire drill record. Evacuation aids were in use and formed part of the evacuation policy at the centre. Annual fire safety training was delivered to all staff at the centre, however, inspectors were not clear on the content of the training as this was not available. The evacuation policy at the centre reflected progressive horizontal evacuation, which requires staff to assist residents to move to an adjoining compartment, to a place of relative safety within the centre. This system of evacuation is dependant on compartmentation being complete. On reviewing compartmentation at the centre, a number of areas of concern were highlighted, such as concerns relating to fire doors, and compartmentation measures in floors walls and ceilings within the centre. The lift that had been removed from the central nurses station area, resulted in a lack of effective compartmentation being in place between the floors. There were no measures in place to mitigate the loss of compartmentation during the

replacement of the lift. Following the inspection, the provider submitted a timeline of when the new lift would be in place so that compartmentation could be restored. These and further fire safety issues are discussed under Regulation 28: Fire Precautions.

Regulation 17: Premises

Overall, improvement was required by the provider to ensure that the premises were appropriate to the number and needs of the residents of the designated centre and in accordance with the statement of purpose prepared under Regulation 3. For example;

- An area set aside as a sitting room 3 for residents on the lower ground floor was not available to residents within the centre, as it was in use as a storage space. This was a temporary situation as the storage was related to the replacement of the lift.

While overall, the premises at Beechfield Nursing Home was kept in a good state of repair, a number of areas required further strengthening from the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Areas of the centre required maintenance attention including radiators and radiator covers which were damaged and some of which were showing signs of rusting. This would also impact effect cleaning of the equipment.
- The floor covering on the stairs at the entrance was in a poor state of repair as it was heavily worn. The carpet was presenting a trip hazard to residents that may traverse the stairs.
- A bedroom on the ground floor did not have a resident sink available within the residents rooms, as required by regulations. This room did not have an en-suite.
- The area provided for resident smoking was directly outside of an exit from the dining room. This area had an excessive amount of waste cigarette butts on the ground in the area.

Judgment: Substantially compliant

Regulation 27: Infection control

While there were some areas of good practice observed on the day of the inspection, some areas of the management oversight of the environment requires review to ensure the risk of transmitting a healthcare-associated infection. For

example:

- A number of chairs in a communal room were stained and ripped. This would impact effect cleaning of the equipment.
- Inspectors observed a used urine bottle left on a resident's food tray table next to the resident's drinking water.
- Some store rooms had clinical equipment stored together with non-clinical equipment in one area, this may pose a risk of cross-contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, some areas of fire safety required significant attention to align with the requirements of the regulations and to provide residents with appropriate protection from the risk of fire.

The registered provider did not provide adequate means of escape including emergency lighting for example:

- The secondary escape route from a part of the first floor, required evacuees to exit onto a balcony area. The route to safety was by re-entering the building from the balcony. There were two other doors off this balcony, however they were both locked, and while one of the locks was an electronic keypad lock, staff were not able to unlock it because they did not know the code. One of the doors opened into the protected stairwell but the other door did not open into a protected area. This could lead to delays to evacuation, and a risk to evacuees if they re-entered the building at a point which may be affected by a fire.
- The external route from the lower ground floor area to the assembly point was unclear. While there was routes to adjacent areas at the same level, these areas were not designated as assembly points. One of these areas was into a private residential housing area. The available route to the assembly point on the ground floor level was upwards over steps for which there were not adequate methods of evacuation of residents that required assistance.
- The lower ground floor external evacuation route was partially obstructed by plant pots in one area where the route narrowed. This left little remaining space for safe evacuation, and could cause delays or convergence at these points during an evacuation.
- There did not appear to be appropriate emergency lighting available outside the exit door at the ground floor near the visitors room.

The registered provider did not make adequate arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout, and escape routes.

For example:

- Inspectors could not be assured that some site specific conditions present at the centre were being discussed with staff during fire safety training. Details of procedures which reflected the situation on the ground at the centre were not available, for example:
    - The use of evacuation aids to assist residents in the event of a fire. The aids available included ski sheets and wheelchairs, however, there use was not being indicated on the fire drill records.
    - The situation surrounding the re-entry requirement on a section of the first floor where the secondary exit was onto a balcony.
    - Procedures relating to the movement through compartment lines that reflected the policy of progressive horizontal evacuation which was in place at the centre.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- The fire detection and alarm system was in the process of being upgraded at the time of inspection, as the management had identified areas where the existing system required improvement. However, on the day of inspection, there were areas that required detection including:
    - The service shafts at the rear of the lift at all levels did not have a fire detection device in place. These areas were also used for storage and were a high fire-risk area.
    - Measures for detection of fires required review in the large dining room, as a single detector was in place within this room which inspectors could not be assured was adequate to cover the size and shape of the room.
    - A storage space beside the sitting room on the lower ground floor.
- Measures in place to contain fires smoke and fumes required attention including:
    - A hot press storage area on the first floor was not provided with appropriate containment measures to ensure that fire smoke and fumes would be contained within this cupboard in the event of a fire. There was no adequate containment measures in place from the room to the attic space. This could result in fire smoke and fumes spreading from this room, to the attic, and onwards over the bedroom areas. This room was in close proximity to a number of bedrooms.
    - The removal of the lift near the nurses station had resulted in a lack of containment between the floors. The provider committed to a two week timeframe for the re-instatement of the lift and subsequent effective containment.
    - A service shaft room to the rear of the lift did not have appropriate measures in place to restrict the spread of fire smoke or fumes from this room to the adjoining escape corridor. There were unsealed service penetrations over the door to the ceiling above the escape corridor, and large gaps in the floors walls and ceilings of these rooms. There were electrical and mechanical services within the rooms

including water services and pumps.
    - Inspectors could not be assured that attic hatches on the first floor were fire rated. The attic hatches would provide a route for fire smoke and fumes to travel into the attic space above resident bedrooms and if not fire rated, would increase the risk of fire spread in the event of a fire.
    - Assurances were required that fire compartments were in place within the attic space above the resident bedrooms. Compartments in the attic would inhibit the spread of fire smoke and fumes in the attic space above resident bedrooms in the event of a fire. In the absence of the fire certificate documents the inspector could not be assured that these containment measures were in place and appropriate.
    - Electrical switch boards were positioned on escape corridors in various locations at the centre. The switch boards were not protected with fire rated surrounds. This posed a risk of fire spread to the escape corridor routes.
- A number of issues were noted with fire doors around various areas of the centre. While it was noted that the provider had completed a fire door assessment, it was not clear when the remedial work would be completed. The issues identified included:
    - Many bedroom doors did not appear to have appropriate fire rated hinges and handles. Some hinges were painted over. Bedroom doors were not labelled as fire doors, and in many cases, inspectors could not be assured that they would perform as fire doors in the event of a fire.
    - Large gapping was noted around some doors including some cross-corridor compartment doors. Gapping allows a route for fire smoke and fumes to travel across compartment lines.
    - Some of the doors were missing sections of smoke seals. These smoke seals act to impede the travel of smoke across compartment lines or into the escape route in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that assessments and care plans were reviewed and updated as required when there was a change in the resident's condition and that these correlated with each other to ensure that residents needs were met. For example:

- A resident who had a pressure ulcer had a care plan in place. However, there had been significant changes to their needs and this had not been reassessed. While their care plan had been updated, this did not incorporate the changing needs of the resident. In addition, the resident was due to be repositioned every two hours, however, there was no record available of this

occurring. For another resident with a pressure ulcer, their assessment had been completed, however, the information was incorrect. This resulted in a care plan that did not meet their needs.
- Some residents care plans had not been completed within 48 hours after the residents admission and following their assessment.
- Not all assessments were completed correctly. For example, a resident with responsive behaviours had been assessed, however, the assessment contained incorrect information and this resulted in a resident being overly restricted to manage their responsive behaviours.
- The person in charge informed inspectors that they could not meet the needs of a small number of residents who required support to communicate freely with staff in the centre. For example, they could not access an interpreter for a resident who needed this to communicate their needs to staff.

Judgment: Not compliant

Regulation 9: Residents' rights

Staff interactions were observed to be kind and respectful towards residents, however, inspectors observed lengthy periods of time where some residents were in various sitting rooms without meaningful activation. While an activity schedule was displayed it was limited in the activities offered. For example, inspectors observed that the activity available on the morning of the inspection could only be offered to a small group of residents at a time and there was no alternative activities offered to the other residents. In addition, in one sitting room, staff were asked to facilitate an activity for residents. However, staff did not provide any activation for residents'. Only after being prompted by a resident, staff turned the television on for them. From inspector observations, there was an over reliance on passive activities like watching television to provide activation for residents. Some residents expressed their wish to have more outings. In addition, some residents said they would like to participate in activities more however, staff are sometimes delayed in bringing them to attend the activities or sometimes do not bring them at all so they miss the activity.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Inspectors were not assured that episodes where a resident displays responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) was managed and responded to in a manner that is not restrictive. For example, inspectors observed some residents' wanting to leave the

area they were sitting in. Some had chair sensor alarms and others did not. They were observed standing up and beginning to walk out of the room they were in, trying to leave on multiple occasions. Each time they tried to leave the room, staff redirected them to sit back down.

Another example observed by inspectors where a resident required additional supervision from staff to meet their needs, which was in place. However, they also had a wander guard in place which was overly restrictive and did not meet their needs.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had assurances in place to safeguard residents and protect them from abuse. Staff had access to safeguarding training with all staff having completed this. Records reviewed had the required Garda (police) vetting disclosures in place for staff prior to commencing employment in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Beechfield Manor Nursing Home OSV-0000013

Inspection ID: MON-0045850

Date of inspection: 19/02/2025

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• We remain committed to ensuring that a high standard of quality care provision within the centre remains paramount, with specific emphasis placed on person centred care delivery.

• A Quality of Interaction Schedule (QUIS) has been commissioned by the PIC to assess the quality of interactions between staff and residents, thus enabling determination of the nature and scope of training required to be provided within the centre.

• The PIC in collaboration with the Senior Clinical Management Team now monitors call bell activity as part of their daily walkarounds – as a component of this review live call bell data is also examined.

• The PIC in collaboration with the Clinical Management Team has increased the frequency of call bell audits, with any deficiencies identified actioned and resolved in a timely manner

• The PIC has undertaken a review of the activity schedule to ensure that there is evidence that the same is devised in consultation with residents. Resident choice is now reflected on activity schedules to reflect ongoing catering for individual preference.

• The PIC and the Clinical Management Team have reiterated the fundamental importance of reactive, responsive, and appropriate care interventions to staff during unit meetings - specific reference and significance has been placed on the necessity for prompt tending to elimination requirements, resident requests and call bell responses

• Since the previous inspection, clinical staff working within the centre have been tasked with completing further training in understanding dementia and responsive behaviours

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A new PIC has been appointed to the centre since the last inspection and is currently in post.

• A new Group Quality and Care Manager has also subsequently been appointed to enhance governance of the centre and support the PIC in the provision and delivery of enhanced care outcomes.

• The PIC has assumed ongoing responsibility to produce and maintain a staff roster which is reflective of appropriate number and skill mix of staff, ensuring at all times staffing is in accordance with the Statement of Purpose.

• The Clinical Management Team will continue to ensure that the duties of staff are allocated appropriately and that a suitable ratio of staff to residents is maintained to promote optimal outcomes for our residents.

• Since the previous inspection a training needs analysis has been conducted by the Groups Quality Manager in collaboration with the PIC. All clinical staff working in the centre have been tasked with completing responsive behaviour and resident rights training. The PIC has also completed a review of the induction process to ensure coverage of key training requirements.

• The PIC has implemented a key staff allocation list for care plans. All nurses have received care plan training and further care plan workshops are planned to supplement existing knowledge in this regard.

• The PIC maintains oversight of care plan audits, the same of which are completed at regular intervals with any deficiencies identified promptly addressed through the initiation of robust action plans overseen by the PIC and the Clinical Management Team.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• Since the previous inspection the lift in the centre has been fixed. All items have

subsequently been removed from the communal sitting room on the lower ground floor.

• The smoking area has since been included on a cleaning schedule. Daily oversight pertaining to the cleanliness in this area is overseen by the PIC and Clinical Management Team

• A Full deep clean was carried out in the centre. All radiators and covers were reviewed by an outside contractor. The process of replacement and cleaning of same has commenced.

• The damaged carpet on the stairs is scheduled for repair by outside contractors.

• A bathroom sink has been scheduled to be installed in the bedroom by outside contractors.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• After the previous inspection, the PIC has commissioned a review of all chairs in circulation in communal areas to assess feasibility of cleaning and/or repair(s) as appropriate. Any chairs subsequently deemed unsuitable or unfit for purpose have been condemned accordingly and replaced.

• On the date of the inspection that the urine bottle was removed from beside the resident's food tray. The Clinical Management Team identified the resident involved in this instance so that additional control measures be implemented to mitigate potential risk going forward. The Clinical Management Team continue to conduct daily walkarounds at regular intervals to maintain supervision & oversight.

• The Clinical Management Team has initiated a review of the current storage facilities to ensure appropriate segregation of clinical and non-clinical equipment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The secondary escape route from the first floor has been reviewed. Staff have been

given access to the electronic keypad lock and same displayed via 'Butterfly Display'.
• A full review of external routes from the lower ground floor has been conducted. The home is awaiting delivery of appropriate evacuation aid to assist with 'evacuation of individuals' up steps.
• All plant pots were removed from the route, this is checked daily by maintenance to ensure it is kept clear.
• The emergency lightening outside the exit door has been upgraded. The service shaft at the rear of the lift has a fire detection in place. The dining room was reviewed and additional detector was installed.
• All firestopping works are currently ongoing by a professional fire contractor in the home to include measures to contain fire smoke and fumes:
o Hot press storage.
o Lift works (near nurses station) completed and now working.
o Service Shaft room, gaps in floors and ceilings.
o Attic Hatches
o Electrical Switchboards
• All new fire doors have been ordered and the home is awaiting for same to be installed
• Arrangements have been made by the PIC to ensure that the use of supplementary assistive devices such as wheelchairs and ski sheets are covered as a component of fire training, and their use reflected within the narrative of fire drill documentation.
• The fire detection and alarm system has now been upgraded.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Since the previous inspection a training needs analysis has been conducted to ensure that all nursing staff have completed care plan training.

• Supplementary care plan training workshops have also been conducted inhouse to further support staff nurses to compile care plans within the scope and remit of their roles. Emphasis has been placed on the relevance of assessments and their role in guiding care plan content.

• The Clinical Management Team has initiated a robust review of all resident care plans to ensure they are reflective of the current status of the individual resident and sufficiently address identified care requirements.
• The Clinical Management Team will ensure that care plans are initiated within regulatory timeframes in consultation with the resident and/or their nominated representative as appropriate.

• The Clinical Management Team will ensure that care plans are updated within regulatory timeframes or more frequently as dictated by an alteration in the clinical

status of a resident.

• The Clinical Management Team now signs and reviews the contents of repositioning charts on a daily basis to ensure they remain clinically appropriate and are filled in their entirety.

• The PIC has followed up with the HSE with respect to a costing proposal update for interpreter services for the resident requiring input from the same, in an attempt to further enhance care outcomes.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Quality and Group Manager and PIC has met with the activities team and tasked them with ensuring that there is evidence that activity schedules are devised in consultation with residents.

• Choice of activities are now reflected on activity schedules. An external activity schedule has been implemented. The activity schedule is offered in an accessible format for all residents. Documentation is maintained for all residents reflecting resident input and engagement.

• The Clinical Management Team oversees that staff are tasked on a daily basis with ensuring that residents in so far as they wish are supported with attending activities in a timely manner. Information pertaining to this is evidenced on daily allocation sheets.

• The PIC has tasked staff with completing training with respect to Resident's Rights

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• A Quality of Interaction Schedule (QUIS) has been completed to assess the quality of interactions between staff and residents, thus enabling determination of the nature and scope of training required to be provided within the centre.

• The PIC of Beechfield Manor remains committed to promoting a restraint free

environment so far as is reasonably practicable. The Group Quality and Care Manager in collaboration with the PIC has initiated a review of all restrictive practices utilised in the centre to ensure that the least restrictive practice is used only as a last resort where trialled alternatives are deemed unsuitable or inappropriate. All restrictive practices within the centre are used for the shortest duration possible and their use subject to continuous and ongoing review in consultation with the resident and/or their nominated representative and the multidisciplinary team.

• Since the previous inspection, the PIC has discussed what constitutes a restrictive practice and appropriate management at unit meetings with staff. A restrictive practice committee has also been established

• The PIC has tasked staff with completing training with respect to restrictive practices and responsive behaviours

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/03/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	18/04/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Substantially Compliant	Yellow	18/04/2025

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	03/03/2025
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.	Not Compliant	Orange	03/03/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Substantially Compliant	Yellow	31/03/2025

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/05/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	31/08/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Not Compliant	Orange	31/08/2025

	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.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/08/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/06/2025
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	30/06/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Not Compliant	Orange	30/06/2025

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/03/2025
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/03/2025
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	31/03/2025