

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Beechwood House
Centre ID:	OSV-0000409
Centre address:	Newcastle West, Limerick.
Telephone number:	069 624 08
Email address:	john@beechwoodhouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Beechwood House Nursing Home Limited
Provider Nominee:	John Raleigh
Lead inspector:	Caroline Connelly
Support inspector(s):	Noel Sheehan
Type of inspection	Unannounced
Number of residents on the date of inspection:	42
Number of vacancies on the date of inspection:	25

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 March 2017 20:55	01 March 2017 22:30
02 March 2017 08:50	02 March 2017 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection of Beechwood House Nursing Home. This was a follow-up inspection that was carried out to monitor compliance with the regulations and to inform a registration renewal decision. The provider applied to renew the registration of the centre which expired on 22 February 2017. As part of the inspection, inspectors met with residents, relatives, the provider nominee, the person in charge, the person participating in management, two Clinical Nurse Managers (CNM)'s, the physiotherapist, nurses and staff members. Inspectors observed practices and reviewed all governance, clinical and operational documentation to inform this registration renewal application. Inspectors also followed up on the actions required from the previous inspection.

Since the previous inspection in October 2016 there have been a number of positive changes to the governance and management structure which included changes to

the provider nominee and to the person in charge. The provider nominee at the time of the previous inspection had resigned from the centre and a new provider nominee is now in post. Another director of the company is working in the centre as a person participating in management and two new CNM's had been appointed since the previous inspection. An interview was conducted with the new CNM's during this inspection.

The inspectors met with the provider nominated who had actively engaged with HIQA since he had taken up his role. He demonstrated a willingness and capability to address the areas of non-compliance identified and to ensure compliance with standards and regulations. He stated he had made financial resources available to ensure the management team can effectively manage the centre and address the environmental, training, safeguarding and other non-compliances identified on previous inspections. Staffing levels had increased and the staff that spoke to the inspectors all highlighted how beneficial this has been for all staff and residents and enabled them to have time to provide person centred care to the residents. Overall inspectors saw significant improvements in the overall governance and management of the centre. This was through the addition of quality management systems and a management team with the knowledge to ensure compliance with the regulations. This had a demonstrable effect on improving residents' safety and quality of life within the centre.

Inspectors saw that a number of the actions required from the previous inspection had been addressed. Fire doors now had hold back mechanisms attached to the fire alarm that released if the alarm went off. A viewing panel, fire blankets and smoking aprons were provided in the smoking room. However the location of the smoking room continued to be of concern and the providers were looking into alternatives. A comprehensive annual review of the quality and safety of the service had been completed. The complaints policy had been amended and updated as had the risk management policy. There was comprehensive documentation of fire drills which had taken place on a very regular basis. The inspectors saw and residents and relatives confirmed that they were involved in the care planning process. The levels of non-compliance seen were significantly reduced.

The inspectors spoke to numerous residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Overall, inspectors found that there was evidence of good care practices in meeting the day-to-day needs of residents. Staff were kind and respectful to residents and demonstrated good knowledge of residents and intervention necessary for those with divergent needs. Inspectors were satisfied that residents had access to the services of a general practitioner (GP) and other healthcare professionals on a regular basis. The centre employed a physiotherapist who worked full time in the centre. Her role had been significantly developed and extended since previous inspections and was providing a vital service to residents. There was evidence of choice for residents in their day-to-day living with personal preferences accommodated as requested. A regular routine of daily supervised activities was in place and undertaken by the activity co-ordinator and the physiotherapist. Independence of residents was promoted and many were observed mobilising freely throughout the centre. An easily accessible enclosed garden area

was available for residents enjoyment.

During a previous inspection in May 2016 inspectors had identified that the governance and management of the centre was ineffective, there were ineffective systems in place to adequately supervise staff and residents. Following that inspection HIQA applied three restrictive conditions to the registration of the centre, one of which stated that no new residents were to be admitted to the centre. A registration renewal inspection was undertaken in October 2016 where the inspectors saw that there had been a number of changes to the management team including the appointment of a new person in charge who commenced employment in the centre at the end of August 2016. On the inspection in October 2016 Inspectors saw that a number of the actions required had been addressed and the level of non-compliances identified had been significantly reduced. However, on the 18 October 2016, following the inspection, HIQA was informed and the registered provider confirmed that the condition which directed the registered provider to not accept any further admissions to the designated centre had been breached by the registered provider. HIQA subsequently applied to the district court for an enforcement order of the conditions which was granted on the 07 February 2017.

On this inspection inspectors found that a small number of the actions required from the previous inspection were not completed but progress was evident towards their completion. Inspectors had identified the need for improvement in the management of residents' finances and this remained ongoing. Inspectors also identified on this inspection that an allegation of misconduct by a staff member had not been notified to HIQA. Additions were required to the statement of purpose and as already outlined a review of the smoking room. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose and function was viewed by the inspectors. It had been updated since the last inspection to reflect the new management structure and it clearly described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date and expiry date. However, the conditions attached by the Chief Inspector to the designated centre's registration, under Section 50 of the Health Act 2007, were not included and there was also a requirement to include the person participating in management to the organisational structure to ensure it met the requirements of legislation.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Since the previous inspection in October 2016 there have been a number of changes to the governance and management structure which included changes to the provider nominee and to the person in charge. The provider nominee at the time of the previous inspection had resigned from the centre and a new provider nominee is now in post. The person in charge at the time of the last inspection had resigned her post but had subsequently returned to the centre at the end of January 2017 as person in charge. An interview was undertaken with her in the HIQA offices in February 2017. Another director of the company is working in the centre as a person participating in management and two new CNM's had been appointed since the previous inspection. An interview was conducted with the new CNM's during the inspection. Inspectors found that there was now a clearly defined management structure in the centre that outlined the lines of authority and accountability. The management team displayed good knowledge of the regulatory requirements and they were found to be committed to providing person-centred evidence-based care for the residents. They were proactive in response to the actions required from previous inspections and inspectors viewed a number of improvements throughout the centre. Inspectors saw that a number of the actions required from the previous inspection had been addressed

On the previous inspection the person in charge had commenced the implementation of a quality assurance programme to continuously review and monitor the quality and safety of care. There had been some progress made in relation to the daily recording of KPI's and a number of audits in relation to medication management, care planning, incidents and complaints were on-going. On this inspection this had been further developed by regular management meetings, audits, data collection, regular staff meetings. Inspectors saw evidence of the collection of key clinical quality indicators including pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk and health and safety. Inspectors also saw that monthly audits had commenced on key areas of care including medication management, residents' choices, residents' privacy and dignity, incidents and accidents among other areas of clinical care.

There was evidence of consultation with residents and relatives through residents meetings and a comprehensive survey had been undertaken in 2016. Inspectors saw detailed minutes of resident's committee meetings and evidence that individual residents were consulted. There was evidence of follow up on issues raised and further updates which were fed back to the residents. The results of the resident and relative satisfaction surveys were correlated and a report on the findings was seen by the inspectors. Residents and relatives gave feedback on staff, nutrition, activities, care standards, laundry, physical environment, complaints, the relative, communication and management of finances. Overall there was a positive response and evidence that any areas where residents or relatives were not satisfied were followed up.

On the previous two inspections there was a requirement for an annual review which was not in place. On this inspection the inspectors saw that a very comprehensive annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards. This review was made available to the inspectors and there were a number of

recommendations and actions from this review that are currently being actioned.

Overall inspectors saw significant improvements in the overall governance and management of the centre. This was through the addition of quality management systems and a management team with the knowledge to ensure compliance with the regulations. This had a demonstrable effect on improving residents' safety and quality of life within the centre.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge displayed a very good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The inspectors interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She had extensive managerial experience and had been a person in charge of a number of nursing homes in the past. She demonstrated a commitment to her own professional development and had completed post registration training in gerontology.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and were confident that all issues raised would be managed effectively.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Records were kept securely, were accessible and were kept for the required period of time. Residents' records were kept in a secure place.

On the previous inspection, inspectors found that there were some gaps in employment in a staff file which was rectified. On this inspection, the inspector reviewed a sample of staff files and found that they contained the required information in relation to matters identified in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The provider confirmed that no staff was employed without completed vetting.

On the previous inspection although fire drills took place regularly in the centre, records kept of same were found to be inadequate. On this inspection the inspector saw that comprehensive records of fire drills were completed identifying actions taken and further actions required.

The designated centre had all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and these are reviewed and updated at intervals not exceeding three years as required by Regulation 4. The complaints policy and risk management policy had been updated since the last inspection and were found to be compliant with legislation.

Judgment:

Compliant

Outcome 06: Absence of the Person in charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There had been a number of changes to person in charge over the last number of months and the provider had notified HIQA in relation to same. This demonstrated their awareness of the responsibility to notify HIQA of any absence or proposed absence for 28 days or more.

Deputising arrangements were in place to cover for the person in charge when she was on leave. There are two new CNM's in post since the last inspection. One of the CNM's had worked in the centre as a staff nurse prior to her promotion and will act as person in charge when the person in charge is on leave. The inspectors met and interviewed the CNM during the inspection and she demonstrated an awareness of the legislative requirements and her responsibilities. She was found to be suitably qualified and experienced in residential care of the older adult. The other CNM and senior staff nurses also took responsibility for the centre at weekends, evenings and night time with the backup of the person in charge and provider on call.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

There were policies in place in the centre in relation to the management of responsive behaviour and the use of restraint dated September 2016. Inspectors viewed the use of restraint in the centre and saw that staff continued to promote a reduction in the use of bedrails, there were 14 residents using bed rails at the time of inspection and this had been reduced from 17 in use at the previous inspection. However there also had been a reduction in residents. Inspectors saw that some alternatives such as low profiling beds, crash mats and bed alarms were in use for some residents. Inspectors reviewed a sample of files of residents using bedrails and found that risk assessments detailing alternatives tried and considered as well as care plans guiding care were documented. Regular checks of all residents were being completed and documented. The inspectors recommended a further review of bed rail usage be undertaken to ensure the least

restrictive alternative was always in use.

Inspectors reviewed a sample of files of residents presenting with responsive behaviours and noted that comprehensive care plans were in place to guide staff in addition to behavioural support plans. There was evidence that residents who presented with responsive behaviour were reviewed by their GP and referred to psychiatry of old age or other professionals for full review and follow up as required. Inspectors saw evidence of positive behavioural strategies and practices implemented to prevent responsive behaviours. Staff reported due to increased staffing levels they have more time to supervise residents and to implement positive behavioural programmes. All episodes of peer to peer abuse were fully investigated reported to HIQA and relevant bodies and appropriate actions taken to prevent reoccurrence including greater supervision of residents and supervision of day rooms.

On the previous inspection inspectors viewed the system in place to safeguard residents' finances and saw that the system was not sufficiently robust. The administrator was a pension agent for a number of residents in the centre. Many of these residents did not have their own bank accounts so money was lodged to the nursing home account. Since the last inspection, the provider had contacted all residents and relatives of residents who the centre acted as pension agents for to see if they wished to put an alternative arrangement in place. This was a total of 15 residents and only one of these took back responsibility for the pension following two letters of communication. The provider had now taken over as pension agent and was in the process of setting up a nursing home pension account and pensions were now being paid directly into this account. The arrangements in place to collect pensions for these residents required review to ensure that residents had access to and retained control over their finances. It was noted that residents' pensions were paid into a central account and not into an individual interest earning account in their own name. The provider was working towards compliance with the Department of Social Protection guidelines but further work was required. Since the last inspection inspectors saw that improvements in the day to day management of residents money handed in for safe keeping were in place. Money was kept in a locked safe in the administration area, each resident now had an individual plastic pouch which contained their monies and an individual notebook where all lodgements and withdrawals were documented and two signatures were present. There was also a corresponding entry on the computer system which recorded all transactions and balances. However this system did not extend to other items handed in for safekeeping such as jewellery, medals, bank books and no records were maintained of these. There continued to be no system in place of internal or external auditing of residents accounts and although inspectors had no reason to question the accounts, this current system is not sufficiently robust to safeguard the residents or the staff and required immediate review. The provider assured the inspectors that he was working to ensure the new system would be sufficiently robust and implemented as soon as possible.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

On the previous inspection the risk management policy in place in the centre did not meet the requirements of regulation as it did not include the measures and actions in place to control the risks specified in regulation 26. There was also a risk register in place in the centre which inspectors noted was not centre specific. On this inspection inspectors saw the risk management policy had been updated to meet the requirements of legislation and the risk register was now more centre specific. The centre had policies and procedures in place relating to health and safety which were found to be in date. Inspectors also noted that there was a health and safety committee in the centre and reviewed the minutes of these meetings.

On the previous inspection the inspectors saw that a number of doors in the older part of the centre were held open by wedges. This would inhibit the mechanism on the door from closing in the event of a fire. On this inspection inspectors saw that suitable mechanisms to hold these doors open were in place. The hold back mechanisms were attached to the fire alarm and released if the fire alarm activated.

There were two smoking areas in the centre. One area was an outside courtyard and the other was the designated smoking room in the centre. On the previous inspection it was noted that there were no fire blankets available for these areas and no smoking aprons available for residents. On this inspection they were all in place as was a viewing panel in the smoking room required from the previous inspection. There were fire extinguishers located near these areas. Inspectors reviewed both the smoking policy and the risk register in relation to smoking and both of these documents identified that 'residents are visible and adequately supervised when smoking. However, although the viewing panel is now in place in the designated smoking room the inspectors continued to express concern about the visibility of residents when smoking in this room due to the location of the room. The smoking room was in the older part of the nursing home down a corridor and away from the main activity areas. The residents currently using the smoking room were assessed as competent to smoke unaided but newer residents coming in may not be so. The provider was asked to review these arrangements to ensure there is adequate supervision provided for residents while smoking.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

HIQA had received a number of notifications from the centre and notifications received were reviewed upon submission and prior to the inspection. The follow up to these notifications and actions taken were reviewed on inspection and inspectors were satisfied that all appropriate action was taken in response to all notifiable events.

All notifiable incidents and quarterly returns submitted to HIQA were generally timely. A record was maintained of incidents occurring in the centre and these correlated with relevant notifications submitted to HIQA. However, during the inspection the inspectors saw that an incident of misconduct by a staff member had not been notified to HIQA. There was evidence that the incident had been investigated and handled appropriately leading to disciplinary action and further supervision of the staff member. However there is a requirement to notify to HIQA any allegations of misconduct within three working days.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The inspectors were satisfied that residents' healthcare needs were maintained to a good standard. Residents received a comprehensive assessment on admission and at regular intervals thereafter. Residents had access to the services of a general practitioner (GP), including out-of-hours, and there was evidence of regular review.

Residents' medical records were seen and these were current with regular reviews including medication reviews, referrals, blood and swab results, and therapy notes. Residents' additional healthcare needs were met. Physiotherapy services were available in house by a full time physiotherapist and all residents were assessed for mobility and falls prevention. The role of the physiotherapist had been greatly extended and enhanced since previous inspections and she was now fully involved in moving and handling assessments and prescribing mobility plans. She also ran a falls prevention programme, shoulder rehabilitation and group circuit training. Residents spoken to were very complimentary about the physiotherapy provided. Dietitian and speech and language services were provided by professionals from a nutritional company, who were also contactable by telephone for advice as required. All supplements were appropriately prescribed by a doctor. Optical assessments were undertaken on residents in house by an optician from an optical company.

Residents in the centre also had access to the specialist mental health of later life services. Community mental health nurses attended the centre weekly to review and follow up with residents who have mental health needs and who display behavioural symptoms of dementia. Treatment plans were put in place which were followed through by the staff in the centre. Follow up to consultations was completed by psychiatrists as required. Residents and relatives expressed satisfaction with the medical care provided.

The inspectors saw continued improvements in resident assessment and care planning. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Care plans were developed for residents based on issues identified on assessment and records indicated they were reviewed and updated on an on-going basis. New care plans were seen to be very personalised, user friendly and provided adequate guidance on the care to be delivered. On the previous inspections there was no evidence that residents and relatives were involved in their assessment and care planning, on this inspection there was documentary evidence of resident relative involvement and residents and relatives also confirmed their involvement to inspectors.

Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were well met. On this inspection inspectors noted that improvements in wound care practices had also continued and wound care specialists had been involved leading to better outcomes for residents. Inspectors were satisfied that wounds were being assessed using a scientific measurement tool to establish if the wound was improving or deteriorating. Appropriate dressings and plan of care was in place to ensure staff were providing care in accordance with evidenced based practice.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals

procedure.

Theme:

Person-centred care and support

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

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

Findings:

On the previous inspection a new system of complaints management had been implemented which distinguished between formal and informal complaints and included two separate methods of complaint recording. Some complaints were logged in the complaints book and other complaints in an incident log which was also to be used to log accidents, incidents, allegations of abuse and other incidents. Inspectors found this system could lead to confusion and errors as staff were unclear where they should record certain complaints. On this inspection the inspectors saw that complaints were not being recorded on the computer system and there was no distinction between formal and informal complaints. Inspectors viewed the complaints log and found that since the last inspection complaints had been logged, details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied was recorded as required by regulations.

On the previous inspection the complaints policy also required review, in that it did not set out who the independent nominated person was to oversee that all complaints were appropriately responded to and records maintained. The policy was also not on display as required by regulations. On this inspection the inspectors saw that the complaints procedure was prominently displayed in the centre and outline the independent appeals process. There was a nominated person separate to the centre's complaints officer to ensure that all complaints were appropriately responded to and records kept. The independent appeals process was included and also contact details for the office of the ombudsman

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

There was evidence available that indicated residents were consulted with and participated in the organisation of the centre. A residents' meeting takes place in the centre on a regular basis. On the previous inspection the inspectors saw that although the issues raised by individual residents were documented, there was no documentary evidence available addressing how these issues were followed up and resolved. On average, between 20 to 25 residents would attend the meetings. It was not clear how the views of residents who did not attend the residents' council meeting were elicited. On this inspection inspectors saw detailed minutes of residents' committee meetings and evidence that individual residents were consulted. There was evidence of follow up on issues raised and further updates which are fed back to the residents. Resident and relative satisfaction surveys were also undertaken and a report was correlated on the findings which were seen by the inspectors. Residents and relatives gave feedback on staff, nutrition, activities, care standards, laundry, physical environment, complaints, the relative, communication and management of finances. Overall there was a positive response and evidence that any areas where residents or relatives were not satisfied were followed up.

On the previous inspection there was no access to independent advocacy services available for residents. On this inspection inspectors saw that the provider had engaged the services of an external advocate and posters advertising the advocate name and details were displayed throughout the centre. The advocate had visited the centre and was available if required. The provider was also in the process of vetting a volunteer who was well know to the residents who will be involved in the residents committee and available to support residents once all the requirements of vetting are in place.

Residents were facilitated to exercise their political and religious rights. The provider confirmed that residents can vote in the centre if they wish and residents' religious preferences were ascertained and facilitated. A Catholic priest comes to the centre weekly to say mass and the provider confirmed that residents from other religious denominations would be facilitated as required. The inspectors met the priest during the inspection and he was happy to attend the centre and he told the inspector that he felt the residents were well cared for and happy in the centre.

There was an open visiting policy and families with whom inspectors spoke confirmed that there were no restrictions on visits. There were a number of areas throughout the centre where residents could receive visitors in private and inspectors saw numerous visitors in and out of the centre during the inspection.

There was an activities coordinator working in the centre 30 hours per week with a schedule of activities including arts and crafts, knitting and sewing sessions and reminiscence therapy. Inspectors saw residents participating in and enjoying the various activities throughout the inspection. There is a full-time physiotherapist on site in the centre also who provides group and individual exercise sessions for residents and residents told inspectors how important these were to them to maintain their mobility and fitness levels. Staff were observed treating residents and speaking about residents

in a courteous and respectful manner.

Judgment:
Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

Findings:

Inspectors were satisfied that there were adequate staffing levels in the centre for the number of residents during the inspection. On the first night of the inspection, inspectors saw that at 21.00hrs there were seven staff in the centre to care for 42 residents. Many residents were up watching television or chatting and enjoying the company of staff and fellow residents. Staff who spoke to the inspectors confirmed that there was always staff allocated to supervising the day rooms to ensure the safety of the residents. Staffing reduced to five staff for the night when the medication rounds were completed and most residents were in bed. Staff told inspectors about the improvements in the centre, describing a much better atmosphere and the increase in staffing levels. They expressed confidence in the new management team and said they were approachable and very supportive to the staff. Night staff confirmed they are no longer tasked with extensive cleaning duties and have adequate time to attend to residents' needs.

Inspectors saw that recruitment of staff was ongoing with the recent appointment of two CNM's and a staff nurse. Two further nurses are to join the service in the next number of months. Care staff and a chef had also been appointed. As discussed in outcome 5 staff files met the requirements of legislation and no staff were commenced in employment without appropriate vetting for the centre having first been obtained.

The training matrix was made available and inspectors found that there was a good level of appropriate training provided to staff and staff were supported to deliver care that reflected contemporary evidence based practice. Training provided was confirmed by staff. Staff had completed mandatory fire and evacuation training, manual handling training, responsive behaviour training, elder abuse training and were due to attend

training in infection control in the week following the inspection.

Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their roles and responsibilities. They were aware of the regulations and standards and had access to copies of these if required.

The provider was required to keep staffing levels under review as the centre increases resident numbers to ensure that there is adequate staff to meet the needs of the residents taking into account the size and layout of the centre.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Beechwood House
Centre ID:	OSV-0000409
Date of inspection:	01/03/2017
Date of response:	07/03/2017

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The statement of purpose included the registration date and expiry date. However, the conditions attached by the Chief Inspector to the designated centre's registration, under Section 50 of the Health Act 2007, were not included and there was also a requirement to include the person participating in management to the organisational structure to ensure it met the requirements of legislation.

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

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

- i) The organogram set out in page 12 of the SOP has been amended to show the position of the PPIM.
- ii) A photo image of the current certificate of registration has now been inserted into the SOP at page 30, which clearly shows all conditions.

Proposed Timescale: 03/03/2017

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

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

The system in place to protect residents finances and personal property handed in for safekeeping was not sufficiently robust.

2. Action Required:

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

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

- A dedicated bank account is now open and all pension monies received on behalf of residents, whom the provider acts as a pension agent for, is deposited directly into this account – no cash is collected or transacted in any way. COMPLETE
- A ledger has now been set up to record all movements (deposits & withdrawals). This will show amounts carried forward each week, weekly deposits and any weekly withdrawals on behalf of the residents. COMPLETE
- All movements in the ledger will be traceable to the bank account by resident.
- This ledger will be reviewed monthly by the provider, a hard copy printed off and signed and filed securely in the providers' office.
- The ledger and bank account will be audited by an external independent accountant annually and records maintained on file.
- Where interest is received on account, it will be allocated on a pro-rata basis of value on account to each resident's balance.

Personal Items:

- All personal items handed into the provider are to be kept secure in the safe located in reception.
- A log book is to be introduced and kept securely with the items in the safe.
- When residents wish to remove, or return any items, it will now be recorded in the log book to show – DATE, TIME, ITEM REMOVED / RETURNED, and SIGNATURES of the resident and the staff member who is facilitating the requests.

Proposed Timescale: Personal Finance: 30 April 2017 for full implementation.
Each Month End for Internal Sign Off
Year End for Accountant Audit & Sign Off
Personal Belongings: 10 March for Log Book Introduction for personal items.

Proposed Timescale: 30/04/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Although there is a viewing panel in place in the designated smoking room the inspectors continued to express concern about the visibility of residents when smoking in this room due to the location of the room. The smoking room was in the older part of the nursing home down a corridor and away from the main activity areas. The residents currently using the smoking room were assessed as competent to smoke unaided but newer residents coming in may not be so. The provider was asked to review these arrangements to ensure there is adequate supervision provided for residents while smoking.

3. Action Required:

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

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

- The centre is promoting where possible and in agreement with residents the possible use of e-cigarettes as an alternative to the tobacco option.
- Beechwood House is committed to making the experience a positive one for all residents, and that all applicable stakeholders are involved in deciding the best solution for residents who smoke.
- The longer term objective will be to close the smoke room facility at its current location, but a short and medium term way of working needs to be agreed and be safe for users.
- Management will ensure that a decision is taken that takes all stakeholder views in to consideration and in keeping with ethos of collaborative inclusion in decision making, management will meet with the stakeholders to include i) residents who smoke, ii) relatives where required, iii) staff at Beechwood House.
- The Provider & DON will meet with the users of the smoke room facility, and outline the short, medium and long term objectives for the smoke room facility. The short and medium term objectives will be to phase out the usage of the internal smoke room, and for a more sheltered area to be provided in the external courtyard for the longer term.
- Residents admitted going forward who smoke will be advised of the smoking controls / plans pre-admission to ensure they are satisfied for themselves

Current Position:

Staff will continue to supervise and record all checks of the smoking room hourly. Residents who smoke unsupervised are assessed as competent to do so and risks are minimal. Fire aprons, fire blankets and extinguishers are also at hand outside and inside of the smoking room.

Proposal:

The timescale required to make an informed decision which includes all stakeholders will be 31 May 2017.

Once the decision is taken a further four weeks (30 June 2017) will be required to introduce any changes agreed with the stakeholders.

Proposed Timescale: 30/06/2017

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

The inspectors saw that an incident of misconduct by a staff member had not been notified to HIQA. There was evidence that the incident had been investigated and handled appropriately leading to disciplinary action and further supervision. However there is a requirement to notify any allegations of misconduct to HIQA within three working days.

4. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

- The Provider acknowledges the oversight of not reporting the allegation of misconduct by a staff member and misunderstood the requirement on disciplinary matters with staff.
- The Provider is totally committed to ensuring full compliance with all HIQA notifications in relation to all matters at the centre with immediate effect, and has familiarised himself with the HIQA Notifications List.
- A late notification of the NF07 was submitted via the portal and via email on 6th March 2017.
- The matter was dealt with at the time of the incident in relation to consequence for the staff member. This is detailed in the NF07 and investigation report.

Proposed Timescale: Immediate / COMPLETE

Proposed Timescale: 07/03/2017

