

**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:	Nora Raleigh
Lead inspector:	Caroline Connelly
Support inspector(s):	Maria Scally
Type of inspection	Announced
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	19

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
11 October 2016 21:15	11 October 2016 23:30
12 October 2016 09:00	12 October 2016 19:15
13 October 2016 08:40	13 October 2016 17:30

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

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

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection which took place over three days. The provider applied to renew the registration of the centre which will expire on 22 February 2017. As part of the inspection Inspectors met with residents, relatives, the provider, the person in charge, 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.

The centre had a history of a high level of non-compliance identified during previous inspections in September 2015 and May 2016. During the inspection in May 2016 inspectors identified that the governance and management of the centre was ineffective, there were ineffective systems in place to adequately supervise staff and residents. There was evidence of a lack of understanding of the regulatory requirements by the provider and person in charge in relation to many aspects of the running of the centre which included protection of residents, supervision of residents and staff, provision of adequate staffing levels, assessment and care planning, notifications required to HIQA, the implementation of a quality management system and on-going monitoring of the quality and safety of care for residents. There were seven major non-compliances identified and two moderate non-compliances out of ten outcomes inspected against. Following the inspection the provider was requested to attend a meeting at HIQA head office and subsequently received three restrictive conditions on the registration of the centre one which outlined that no new residents were to be admitted to the centre.

Since the last inspection 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. The provider also engaged the services of a consultancy firm to assist them in the implementation of governance and management systems. The consultants were contracted for two days per week which included being on site one day per week. The new person in charge was supernumerary to the nursing complement which enabled her to have full clinical oversight of the centre. There was evidence that the person in charge was fully engaged in the governance, operational management and administration of the centre on a day-to-day basis.

The inspectors met with the person nominated to act on behalf of the provider entity, who at the time of the inspection demonstrated a willingness to engage with the authority to address the areas of non-compliance identified. She stated she 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. Inspectors saw that a number of the actions required had been addressed and the level of non-compliances identified had been reduced to one major and three moderate non-compliances on this inspection. Three further outcomes were also assessed as substantially compliant.

A number of completed questionnaires from residents and relatives were received and the inspector spoke with residents during the inspection. The collective feedback from residents and relatives was mostly 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. 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 and in the enclosed garden area.

Inspectors saw that four fire doors were wedged open during the inspection. This would inhibit the mechanism on the door from closing in the event of a fire. These were removed once highlighted by inspectors and the provider undertook to ensure suitable mechanisms will be put in place to hold these doors open if required. Evidence of the proposed instillation of hold back mechanisms attached to the fire alarm that released if the alarm went off was forwarded to the inspector following the inspection but they had not been installed to date as the provider was waiting parts for same and therefore the centre remained non-compliant. Inspectors also identified the need for improvement in the management of residents' finances, complaint handling, smoking areas, the involvement of residents and families in the care planning process, the requirement for an annual review and an effective quality management system. 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 Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 inspector, 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 not all of the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007 were included and the arrangements for the management of the centre in the absence of the person in charge was also not included. Changes were also required to the complaints procedure that was included in the Statement of purpose. These were identified to the management team by the inspectors during the inspection and they were rectified. Following these amendments the updated statement of purpose was found to meet the requirements of legislation.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

On the previous inspection inspectors identified that the governance and management of the centre was ineffective, there were ineffective systems in place to adequately supervise staff and residents. There was evidence of a lack of understanding of the regulatory requirements by the provider and person in charge in relation to many aspects of the running of the centre which included protection of residents, supervision of residents and staff, provision of adequate staffing levels, assessment and care planning, notifications required to HIQA, the implementation of a quality management system and ongoing monitoring of the quality and safety of care for residents. Following the inspection three restrictive conditions were attached to the registration of the centre, one which outlined that no new residents were to be admitted to the centre. On the previous inspection the person in charge was counted as the second nurse on duty during the day to care for up to 69 residents and did not have the supernumerary time to undertake her managerial and regulatory duties.

Since the last inspection 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. The provider also engaged the services of a consultancy firm to assist them in the implementation of governance and management systems. The consultants were contracted for two days per week which included being on site one day per week. The new person in charge was supernumerary to the nursing complement which enabled her to have full clinical oversight of the centre. There was evidence that the person in charge was fully engaged in the governance, operational management and administration of the centre on a day-to-day basis.

The inspectors met with the person nominated to act on behalf of the provider entity who at the time of the inspection demonstrated a willingness to engage with the authority to address the areas of non-compliance identified. She informed the inspectors that she had employed the services of the management consultants to provide the centre with advice and guidance to ensure delivery of effective governance and management to ensure effective compliance with the regulations and the standards. She stated that financial resources had been made 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. Inspectors saw that a number of the actions required had been addressed and the level of major non-compliances identified had been significantly reduced from seven major non-compliances and two moderate non-compliances at the last inspection to one major and three moderate non-compliances on this inspection. With three other outcomes substantially compliant.

On the previous inspection there was no evidence of a quality assurance programme in place to continuously review and monitor the quality and safety of care. There was no

comprehensive auditing programme established with key performance indicators (KPI's) recorded and no trending of falls, accidents and incidents. There was no system to ensure an annual review of the service took place, prepared in consultation with residents and their families and that resulted in a copy (of the review) being made available to residents and the chief inspector. On this inspection inspectors saw that 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. However these and other audits required further development to ensure the implementation of actions and recommendations from these. The management consultants had undertaken a gap analysis of the centre in June 2016. However there continued to be no annual review of the service, prepared in consultation with residents and their families and that resulted in a copy (of the review) not being made available to residents and the chief inspector and therefore the centre remained non-compliant in this area also.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a residents' guide available in the centre. This guide was compliant with regulations as it contained a summary of services and facilities in the centre, the terms and conditions related to residence, a summary of the complaints process and the arrangements for visits.

On the previous inspection, it was found by inspectors that some contracts were not signed and dated for residents. A random sample of resident contracts were examined on this inspection and they were seen to relate to the care and welfare of the resident in the centre and included details of services to be provided, the fees to be charged and details of any additional services that may incur an additional charge. They were also found to be dated and signed by the resident and/or their representative.

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 was new to her role since the last inspection and underwent an interview with the inspectors, 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 not all staff files were found to contain 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. On this inspection, the inspector reviewed a sample of staff files and found that they did contain all of the information required with the exception of one staff file reviewed which did not contain a full employment history together with a satisfactory history of any gaps in employment as required by legislation; however, this was rectified during the course of the inspection.

The Directory of Residents was reviewed by an inspector who found that it complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Residents' records as also required under Schedule 3 of the Regulations were also maintained.

The records listed in Schedule 4 to be kept in the centre were nearly all maintained and made available to inspectors with the exception of a record of fire drills. Although fire drills took place monthly in the centre, records kept of same were found to be inadequate.

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.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was new to the role since the last inspection and was aware 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. The ADON who is also relatively new to the post of ADON was in charge when the person in charge is on leave. The ADON was on leave during the inspection so the inspectors were unable to meet and interviewed her but they had met her on the previous inspection. 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):

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

Findings:

On the previous inspection there was evidence that all reasonable measures were not being taken to protect residents from abuse and inspectors were not satisfied that appropriate actions were being taken following an allegation of abuse to prevent similar incidents occurring in the future. Inspectors were not satisfied that staff understood the nature of abuse and were not assured that management were fully aware of their responsibilities in the prevention, detection and reporting of abuse. Since the last inspection substantial improvements have been undertaken to ensure residents are now being safeguarded. The safeguarding policy had been updated since the last inspection. All staff had received training in safeguarding and staff spoken to knew what constituted abuse and what to do in the event of an allegation, suspicion or disclosure of abuse. There was no evidence of any barriers to staff or residents disclosing concerns they had in relation to this matter. Residents stated they felt safe and attributed this to the kindness and attentiveness of staff. When there were suspicions of abuse they were appropriately investigated and responded to and notified to HIQA as required by regulations. Follow up reports were also received. Allegations of abuse were no longer being recorded in the complaints book as was seen on the last inspection but were recorded on an incident form and stored in the incident folder. Further consideration should be given to the storage of these separately to ensure confidentiality.

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 17 residents using bed rails at the time of inspection and this had been reduced from 27 in use at the previous inspection. 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.

On the previous inspection inspectors saw that behavioural interventions records did not give clear directions to staff on how best to prevent or appropriately respond to behaviours that challenge and in fact were found that in a number of cases they did not even identify the responsive behaviours exhibited by the residents. Inspectors found that safeguarding measures had not been put in place to ensure the safety of residents, visitors and staff in the centre. Inspectors saw that these residents were not receiving adequate supervision and there was no documentary evidence of half hourly checks as put forward by management. On this inspection staff spoken with confirmed and training records reviewed indicated that staff had attended training on dealing with responsive behaviours. Inspectors observed that residents generally appeared relaxed and content during the inspection. 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. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person-centred way by the staff using effective de-escalation methods as outlined in residents' care plans. Staff reported due to increased staffing levels they have more time to supervise residents and to implement positive behavioural programmes.

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 seven residents in the centre, many of these residents did not have their own bank accounts so money was lodged to the nursing home account. The administrator kept a book and a record of all financial transactions including any money given to residents for personal use and she had only recently commenced the process of signing it out and getting another staff member to countersign and the resident where possible. However there were not individual accounts kept and money given to residents was given out of petty cash and then subtracted from the residents own balance of money in the nursing home account. There was 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 she would implement a new system and ensure all residents had individualised accounts going forward.

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):

No actions were required from the previous inspection.

Findings:

A risk management policy was in place in the centre; however, inspectors found that it 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; however, inspectors noted it was not centre specific as the risk posed by a chairlift was included; however, the centre did not have a chairlift. Also, some of the controls outlined to mitigate risks identified were not specific to what was in place in the centre. 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.

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. It was noted that there were no fire blankets available for these areas and no smoking aprons available for residents. 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, as there was no viewing panel into the designated smoking room it was not possible that residents were visible to staff when smoking in this room. The smoking room was in the older part of the nursing home and away from the main activity areas. The provider was asked to review these arrangements to ensure there is adequate supervision provided for residents who have been assessed as requiring supervision while smoking.

Records were available to inspectors that showed the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. The inspector noted the last fire drill had taken place on 1 October 2016 and drills took place monthly in the centre. However, other than a list of staff, there was no other record kept of fire drills that took place or any learning that came about as a result of these drills. This is addressed further under Outcome 5 Documentation. It was also noted on the first day of inspection that a small number of fire doors were kept open using door wedges. This would inhibit the mechanism on the door from closing in the event of a fire. These were removed once highlighted by inspectors and the provider undertook to ensure suitable mechanisms will be put in place to hold these doors open if required. Evidence of the proposed installation of hold back mechanisms attached to the fire alarm that released if

the alarm went off was forwarded to the inspector following the inspection but they had not been installed to date as the provider was waiting parts for same and therefore the centre remained non-compliant. Personal emergency evacuation plans were also available for all residents and instructions in relation to what to do in the event of fire were displayed prominently throughout the building.

There was a plan in place for responding to emergencies which was also available at the nurses' station for easy access.

There were arrangements in place to monitor visitors to the centre, a visitors book was in place for guests to sign in and out and all visitors had to buzz for entry. A reception desk was in the main foyer where staff working at reception had full view of visitors coming and going to the centre.

There were handrails in the corridors and grabrails in place in toilet/bathroom areas. Floor coverings were found to be well maintained. Access to high risk areas such as the laundry room, sluice room and treatment room was restricted with an electronic system and cleaning staff had a lockable compartment on their cleaning trolleys for their supplies. There were policies in place on infection prevention and control and staff interviewed demonstrated knowledge of the correct procedures to be followed. There were cleaning schedules in place on the doors of the bathrooms and these areas were checked on a regular basis by staff. The environment was observed to be clean and personal protective equipment, such as gloves, aprons and hand sanitizers were made available as required for staff in the centre. The centre's training matrix indicated that all staff were due to receive training in infection control in the week following the inspection.

Staff were trained in moving and handling practices. There was evidence that the hoists had all been last serviced in May 2016.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the systems in place for medication management in the centre and saw that new systems had been implemented since the last inspection. Audits of medication management had taken place and as a result of same the person in charge had introduced and implemented new medication prescription and recording sheets which segregated the regular medications from the as required medications and short

term medications. Photographic identification was on all medication sheets along with all the required information and were seen to be comprehensively completed. The nurses were transcribing medications but this was all completed in accordance with best practice guidelines and all transcribed medications were checked and signed by two nurses and the prescribing GP. Changes to the medication system had been implemented with the involvement of the GP and pharmacist.

The medication trolley's were secured in the clinic room and the medication keys were held by the nurse in charge. The inspector observed a nurse administering the lunch time medications, and this was carried out in line with best practice. Medications were prescribed and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with one of the nursing staff which accorded with the documented records.

There was a system in place for reviewing medications on a three monthly basis by the GP and pharmacist and this was documented in residents' notes. Medications that required crushing were seen to be prescribed as such and signed by the GP. As required medications stated frequency of dose therefore ensuring there was a maximum dose in 24 hours that could not be exceeded.

There were centre specific written operational policies and records relating to the ordering, prescribing, storing and administration of medicines to residents which were reviewed and updated in September 2016.

Medication errors were recorded and evidence that appropriate action was taken as a result of same. The pharmacist was involved in the reviewing the residents' medications on a regular basis and provided advice and support to the GP and staff.

Judgment:
Compliant

Outcome 10: Notification of Incidents

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

Theme:
Safe care and support

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

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

Findings:

On the previous inspection inspectors saw that allegations of abuse and allegations of misconduct by staff had not been notified to the chief inspector as set out in paragraphs

7(1)(a) to (j) of Schedule 4. Since the last inspection these have now been notified.

On this inspection inspectors saw that there was a comprehensive log of all accidents and incidents that took place in the centre and that incidents, as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents as required.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs

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

Theme:
Effective care and support

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

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

Findings:

Since the previous inspection there have been substantial improvements in residents overall health care in the centre. Residents' healthcare needs were maintained to a good standard. For example, doctors visited regularly; residents were facilitated to attend specialist medical appointments. There was evidence in residents' medical notes of regular review by their General Practitioner (GP) and residents generally retained the services of their own GP. On call doctor services were available out of hours and inspectors met a doctor treating a resident on the first night of the inspection.

Residents assessed needs were set out in individual electronic care plans. A review of the written and the electronic records showed that an assessment was generally carried out within 48 hours of admission and reviewed at least four monthly thereafter. On the previous inspection inspectors identified that there had not been a comprehensive assessment of residents needs undertaken prior to them being admitted to the centre. On this inspection the new person in charge confirmed that all potential admissions will be fully assessed prior to an offer of a residential place in the centre to ensure the centre would be able to meet residents' needs.

Referrals had been made to other services, for example to speech and language therapy and dietician and there was evidence of their involvement in residents' records. The provider employed a physiotherapist who worked in the centre on a full time basis and

there was a well equipped physiotherapy room available for resident use. The physiotherapist met and spoke to the inspectors during the inspection. Her role involved providing physiotherapy to residents, on-going assessment and reviewing of residents' needs and providing mobility plans for all residents. On the previous inspection, inspectors noted there was no evidence of the physiotherapist being involved in moving and handling assessments nor in fact did inspectors see any evidence of these being completed at all. The physiotherapist was also not involved in drawing up or the prescribing of mobility care plans for residents. The physiotherapist confirmed this was the case to inspectors. On this inspection inspectors saw that the physiotherapist was now fully involved in the assessment and the prescribing of mobility care plans which were seen by inspectors to be comprehensive and did direct care. Inspectors saw that the physiotherapist provided excellent one to one sessions with residents and group exercise sessions which promoted residents mobility and respiratory function. She also ran a falls prevention programme, shoulder rehabilitation and group circuit training. Residents spoken to were very complimentary about the physiotherapy provided. Inspectors also saw care staff assisting in the group activity sessions and also providing one to one mobilising with residents as prescribed in the residents care plans. Staff reported that because there is now more staff it enables them to get more involved in all aspects of residents care and to provide residents with more time to mobilise.

On the previous inspection inspectors found inconsistencies in the assessment and care planning documentation of the residents they reviewed. Core care plans were being used for a number of residents and these were not being personalised to that resident. On this inspection inspectors saw improvements in the care plans viewed, comprehensive assessments had been undertaken using validated tools and the care plans were seem to be much more personalised to individual residents and their needs and choices. Residents with responsive behaviours did have assessments and care plans in place to direct the care required for the resident and to ensure a consistent approach by all staff. This was identified as requiring improvement on the previous inspection. On the previous inspection nursing staff told inspectors that although they are allocated responsibility for a number of residents' assessments and care plans to ensure they are comprehensive and up to date, they reported they did not have the time to do so and quoted poor staffing levels as the contributing fact. On this inspection staff reported that this had changed and they now had the required time. However inspectors noted there was no evidence of residents signing off on their care plans nor family involvement in the care planning process. This was confirmed by relatives who spoke to inspectors during the inspection. The person in charge acknowledged that although significant improvements had been made they had further work to do to ensure the care plans were live documents directing care for all residents and that residents and families were involved where possible.

Documentation and practices around wound care was also found to be inconsistent on the previous inspection. On this inspection inspectors noted that improvements in wound care practices had taken place and wound care specialists had been involved leading to better outcomes for residents. Inspectors were satisfied that 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:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

Beechwood House nursing home provides residential accommodation for up to 69 residents. The older part of the building was originally a private home and this part of the centre was now used primarily as sitting, dining and therapeutic areas and staff facilities. Bedrooms were located in the purpose-built extension and this extension was over three floors. A phone was available in a quiet room for residents to take private calls, a prayer room was available for residents' use as well as a number of day rooms and seating areas throughout the centre. All bedrooms had full en-suite facilities. The en-suite facilities were generous in size and helped to promote independence and dignity. There were also bathrooms and toilets along the corridors for residents to access with suitable grab-rails and call bells. There was suitable signage for these rooms and the doors were painted red to enable residents to locate these easily. Inspectors found that the location, layout and design of the centre was of a high standard, comfortable and homely.

Residents had easy access to enclosed outdoor space and tables and chairs were available outside for residents' use. On the previous inspection, it was identified that there was not enough dining space for all residents in the dining rooms available; however, on this inspection, it was noted that a further extension had just been added to one of the communal rooms which increased dining space for residents and so there was now suitable dining space available for residents when meals were served over two sittings. This extension had been very recently added and required further painting and skirting boards; however, it was a bright and comfortable room and inspectors observed residents enjoyed having council meetings, exercise sessions and other activities in this room. Suitable decoration and pictures were seen throughout the building and bedrooms seen were personalised.

Equipment for use by residents appeared to be in good working order; however there had been no regular servicing of air mattresses, beds and recliners to date. The provider confirmed a service agreement was now in place for regular servicing of all equipment

used by residents.

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):

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

Findings:

On the previous inspection inspectors identified a number of deficiencies in the way complaints were recorded and investigated in the centre. On this 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 new system could lead to confusion and errors as staff were unclear where they should record certain complaints.

On the previous inspection the complaints policy also required review and this had been updated since the last inspection. However it continued not to meet the requirements of legislation as it continued to distinguish between complaints being resolved locally and formal complaints and said complaints resolved locally could be just documented in the resident's record. This is contrary to the requirements of the regulations which state that "all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan". The complaints policy had been updated to include the required changes as identified above and was given to the inspectors on the last day of the inspection. However it continued to require review in that it did not set out clearly in the complaints policy who the independent nominated person was to oversee that all complaints were appropriately responded to and records maintained.

Inspectors viewed the complaints log and complaints book 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.

A summary of the complaints procedure was displayed in a prominent position in the

centre on the first day of the inspection but was removed as it was not the correct procedure and this required replacement with immediate effect. The system of complaints management required further review to ensure it was fully compliant with the requirements of legislation and that it was accessible and effective for all.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The policy on end of life was viewed by inspectors and found to be comprehensive and directed staff to give a high standard of evidence-based appropriate care to residents and their relatives at any stage of end-of-life care from a practical, emotional and spiritual perspective.

The inspector observed, and residents and relatives reported, that residents' religious and spiritual needs were well provided for. Mass took place in the centre weekly on a Thursday morning. Prayers and the rosary were held at different times of the day and residents confirmed their enjoyment of these. Residents from other religious denominations were visited by their minister as required.

Residents who spoke with the inspector relayed positive feedback with regard to their care, access to the staff and their freedom to speak with the person in charge and staff regarding any issue. End of life care plans seen by the inspector generally recorded residents' end of life wishes and whether they wished to be transferred to acute services or remain in the centre if they were unwell. Referrals to specialist services were evidenced and residents had access to palliative care services as required.

Inspectors were satisfied that care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and autonomy. Individual religious and cultural practices were facilitated and family and friends were facilitated to be with the resident when they were at end of life stage.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was robust evidence that each resident's dietary requirements as well as likes and dislikes were well known by catering staff. The inspector saw that in the kitchen the cooks had a folder which contained a dietary sheet for each resident identifying individual resident's preferences, dislikes, special diets and fluid requirements. This was seen to be very personalised to each individual resident. Inspectors observed that residents were provided with food and drink at times and in quantities adequate for their needs, they were offered choice and menus indicated there was variety. Residents that required specific diets and/or special consistencies of food were facilitated accordingly. Inspectors viewed the modified diets and liquidised diets which were presented in an appetising format.

Inspectors saw that referrals were made to the dietician services for nutritional review and advice, and speech and language therapy if a resident had swallowing difficulties (dysphagia). There was evidence available in residents' records that allied healthcare recommendations were in place. Residents were weighed monthly and weekly if there were changes to their weight. There was evidence that the documentation of a weight loss/gain prompted an intervention once a concern was identified.

On the previous inspection inspectors observed that there was not enough dining space for all residents in the dining rooms and many residents were seen to have their meals in their chairs particularly in the high dependency sitting room. Since the last inspection the provider had extended the dining room in the high dependency unit to provide a large sitting room and converted the sitting room to a dining room, providing ample space for the residents to sit, dine and walk around. Residents were very complimentary in relation to these changes and about the food and choice of food in general. Inspectors observed mealtimes in the both dining rooms and found that mealtimes were an inviting and enjoyable time for residents. Residents were offered a varied, nutritious diet with three choices of dinner, desert and three choices at tea-time. The variety, quality and presentation of meals was of a high standard. Tables were set in an attractive manner with appropriate place settings. Assistance was given to residents in a dignified manner by staff and mealtimes were seen to be a social occasion.

Plenty of drinks were available for residents throughout the day with tea/coffee rounds morning and afternoon and trays with drinks, fruit and snacks available in the day

rooms.

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

Findings:

Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities. On the previous inspection, it was noted that breakfast was served in the centre from 06:30hrs and there was no evidence to support that breakfast time was determined by residents' expressed preference; however, on this inspection residents spoken to stated that they had a choice in relation to breakfast times in the mornings and the person in charge confirmed that breakfast did not start before 07:00hrs. Inspectors observed residents having their breakfast at different times during the morning up to 10:30hrs.

There was evidence available that indicated residents were consulted with and participated in the organisation of the centre as residents had been provided with opportunities to join the residents' council meetings. A residents' meeting takes place in the centre approximately on a monthly basis. This is currently chaired mainly by the administrator. Items discussed included meals, structural changes in the centre, residents' care, activities, and issues that have arisen for residents. However, 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 don't attend the residents' council meeting were elicited.

There was no access to independent advocacy services available for residents; however, the provider undertook to ensure residents would have access to these services going forward.

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.

Residents have access to a portable telephone in the centre should they wish to make calls in private. 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.

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. The activities coordinator also confirmed she has recently completed activities assessments for residents to ensure that the activities available meet residents' needs. The activities coordinator confirmed that there have been no social outings in the past year for residents but this is being considered going forward. There were notice boards available in the premises providing information to residents and visitors.

Staff were observed treating residents and speaking about residents in a courteous and respectful manner.

Closed circuit TV (CCTV) was in the centre and signage was in place indicating its use. There was a CCTV policy in the centre which referred to the protection of the privacy and dignity of staff, residents and visitors.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Inspectors saw, and residents confirmed, that residents were encouraged to personalise their rooms. Residents' bedrooms were seen to be spacious and comfortable and many were personalised with residents' own cushions, ornaments, pictures and photos. Plenty

of storage space was provided to residents for storage of their clothing and belongings. Locked storage space was provided for residents to store valuables as required.

There was an up-to-date policy on residents' personal property and possessions.

Personal clothing were washed in-house in the laundry system and residents and relatives said they were happy with the laundry facilities. Clothes were discreetly marked and residents reported that clothes generally did not go missing and were always returned to residents laundered and in a timely fashion.

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):

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

Findings:

On the previous inspection, it had been identified that staff levels were inappropriate and inadequate to meet the needs of the residents and the size and layout of the centre and that poor staffing levels contributed to institutionalised practices such as waking the majority of residents early for their medications and breakfast. An immediate action plan was issued to the provider in relation to staffing levels. Staffing levels have increased since the last inspection, inspectors reviewed staffing rotas, staffing levels and skill mix on this inspection and found that there was sufficient staff on duty to meet the needs of residents. Based on interviews with staff and residents, inspectors confirmed that practices such as waking residents for medications and breakfast had ceased and generally residents confirmed they had choice in relation to waking times in the centre. Staff also confirmed that they had more time to perform their duties, spend time with residents and that they were more content in their work. Night staff spoken with confirmed they are no longer tasked with extensive cleaning duties and have adequate time to attend to residents' needs.

Since the last inspection a training matrix was now 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. All 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.

There were two nurses on duty at all times and the person in charge was extra to the staffing complement. Staff were supervised appropriate to their role. Following a review of staff files, it was noted by inspectors that although a performance appraisal system had been initiated, it had not yet been fully rolled out and completed for all staff. The provider confirmed that the recruitment and interview of clinical staff will now be conducted with the involvement of the person in charge and staff with a clinical background. Inspectors reviewed the staff file of a newly recruited staff member and found that an induction and training record is now kept for new staff which includes an induction checklist for the centres' policies and procedures which is signed off by the new staff member and their line manager upon completion. A record of supervision of evidence based practice is also kept in staff files; however, these forms, including information on what follow up and training support may be required for the staff member is not always completed.

The provider and person in charge confirmed there were no volunteers working in 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:	11/10/2016
Date of response:	31/01/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

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

There was no annual review of the service took place, prepared in consultation with residents and their families and that resulted in a copy (of the review) being made available to residents and the chief inspector.

1. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the

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

quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

- (i) A resident/relative satisfaction survey to be complete November 2016
- (ii) An annual review of the service will be undertaken

Proposed Timescale: (i) A resident/relative satisfaction survey - COMPLETE; (ii) Analysis of satisfaction survey – mid February 2017.

(iii) Annual Service Review to be complete by 31st January 2017.

Proposed Timescale: 14/02/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Although fire drills took place monthly in the centre, records kept of same were found to be inadequate.

2. Action Required:

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

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

The centre will put in place a more detailed record of the fire drills. The PIC / Provider Nominee will monitor to ensure that these are completed to show details of the effectiveness of the drill, the attendees, learnings from the drill etc.

Training in fire safety and record keeping to complete by end of February.

Proposed Timescale: 28/02/2017

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 manage residents' finances in the centre was not sufficiently

robust to safeguard residents or staff.

3. 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:

(i) The current system for the nursing home acting as pension agent will be reviewed. Where next of kin and relatives can become the pension agent for the Resident this process will be actioned asap. Letters have been written to next of kin / relative contact details for residents. Some have made contact at this stage (but not all) and some 1-2-1 meetings have taken place.

(ii) 4 residents will not be included in this process due to a risk assessment being carried out / no next of kin. To facilitate this there will be a Beechwood House Pension A/C set up and any residents for whom Beechwood House will remain an Agent for their pension contribution will go into this one account. All debits / credits will be controlled and tracked through any transfers with on-line banking records and commentary. The Dept. of Social Protection have been contacted to see if they could facilitate – at this stage, they can facilitate removing Beechwood House as a Pension Agent, but cannot then guarantee any payments to the Nursing Home thereafter.

All residents are issued with invoices.

Where a resident requires petty cash on site, this will be documented on the resident's invoice and a receipt kept of when money is exchanged. Where required, this money will kept in a secure safe in a wallet with all records for that resident.

Proposed Timescale: Pension Bank A/C set up by 10th February 2017.
Next of Kin / Relatives to be met by 17th February 2017, availability permitting.

Proposed Timescale: 17/02/2017

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:

The risk management policy did not meet requirements as it did not include the measures and actions in place to control the risks specified in regulation 26.

4. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

The risk management policy has been reviewed and amended to include the measures and actions in place to control the risks specified in regulation 26.

Furthermore the Risk Register has been reviewed and is currently being updated.

Proposed Timescale: Risk management policy – complete. Risk register to be complete by 10th February 2017

Proposed Timescale: 10/02/2017

Theme:

Safe care and support

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

On the first day of inspection inspectors saw that a number of fire doors were kept open using door wedges. This would inhibit the mechanism on the door from closing in the event of a fire. These were removed once highlighted by inspectors and the provider undertook to ensure suitable mechanisms will be put in place to hold these doors open if required. Evidence of the proposed instillation of hold back mechanisms attached to the fire alarm that released if the alarm went off was forwarded to the inspector following the inspection but they had not been installed to date as the provider was waiting parts for same and therefore the centre remained non-compliant.

5. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

The doors identified by the Inspectors have now been fitted with hard wired magnetic door openers/closers which are directly connected to the fire alarm system.

Proposed Timescale: 31/01/2017

Theme:

Safe care and support

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

It was noted that there were no fire blankets available near smoking areas and no smoking aprons were available for residents. 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, as there was no viewing panel into the designated smoking room it was not possible that residents were visible to staff when smoking in this room. The smoking room was in the older part of the nursing

home and away from the main activity areas. The smoking facilities required immediate review.

6. 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:

- (i) A glass panel has been installed in the smoking-room door;
- (ii) Smoking aprons and fire blankets are now available in the smoking room and in the external courtyards where smoking is permitted;
- (iii) A staff member is always allocated to the "older" part of the building. A part of their duties is to supervise the smoking room and a record of the checks is maintained.

Proposed Timescale: 31/01/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Inspectors noted there was no evidence of residents signing off on their care plans nor family involvement in the care planning process. This was confirmed by relatives who spoke to residents during the inspection.

7. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

All residents (family members if appropriate and with resident consent where possible) have been invited to meet with nursing staff to discuss residents' care plans and plans of care and following this an invite will be issued every four months or if there are changes to residents' care needs.

The current round of care plan reviews will be complete by 31st March 2017.

Proposed Timescale: 31/03/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

A summary of the complaints procedure was displayed in a prominent position in the centre on the first day of the inspection but was removed as it was not the correct procedure and this required replacement with immediate effect.

8. Action Required:

Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

The complaints procedure has been amended and is now displayed in the main reception and on the residents' noticeboard.

Proposed Timescale: Complete

Proposed Timescale: 31/03/2017

Theme:

Person-centred care and support

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

It was not set out clearly in the complaints policy who the independent nominated person was to oversee that all complaints were appropriately responded to and records maintained.

9. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The complaints policy and procedure have been reviewed and amended to ensure that there is a person nominated to oversee that all complaints are appropriately responded to and records maintained. This person will be the Provider Nominee for complaints addressed by the Person In Charge, and we are waiting for an external independent person to confirm that they will advocate when complaints are addressed by the Provider Nominee, of the Person In Charge.

Proposed Timescale: 31/01/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There was no access to independent advocacy services available for residents.

10. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

The Registered Provider will use the services of Sage Advocacy who provide the following:

Advocate is available from 23 January 2017.

Information and advice to nursing home managers on how residents can access independent support and advocacy services.

A Rapid Response Service where individuals urgently need support an experienced Sage Representative will call to a nursing home within 48 hours.

There has been no named advocate available recently (although the advocacy services have been used). A newly appointed named Sage advocate starts on 23rd January.

Independent facilitators for residents' groups who are trained, supported and accountable.

Support and advocacy for and on behalf of individual residents from Sage representatives who are trained, supported and accountable.

Individual residents have used the services of Sage in the nursing home prior to the inspection.

Sage notices will be displayed in prominent places which will include Rapid Response Service phone numbers and other relevant details.

Proposed Timescale: 31/01/2017

Theme:

Person-centred care and support

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

There was no documentary evidence available addressing how issues raised and recorded at the resident's council meetings were followed up and resolved. It was not clear how residents the views of residents who don't attend the residents' council meeting are elicited.

11. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

The residents council will be chaired by the Activities Coordinator and the Provider is currently seeking a person who is not an employee of the centre and who will represent those residents with dementia or cognitive impairment at these meetings. A relative had volunteered to sit on the committee but has recently declined.

Mr. Pat Ring has been nominated by the management team as the independent advocate.

All resident council meetings will be minuted and a copy provided to the PIC and Provider Nominee, who will develop action plans to address any identified issues. The minutes of the next council meeting will reflect this action plan and measures put in place.

The Activities Coordinator will visit each resident prior to the meeting to tell them about the meeting and ask if they would like to attend or have a matter raised on their behalf (a record of this will be maintained). A copy of the minutes will be provided to each resident after the meeting.

Meetings will be held quarterly.

Proposed Timescale: Last meeting 18th January 2017

Next meeting due in mid-April.

Proposed Timescale: 15/04/2017