

**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 62408
Email address:	beechwoodhouse@live.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	Unannounced
Number of residents on the date of inspection:	61
Number of vacancies on the date of inspection:	8

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.

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 Quality 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 following receipt of unsolicited information. 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:
18 May 2016 20:15	18 May 2016 23:15
19 May 2016 09:15	19 May 2016 18:15

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This report sets out the findings of an unannounced two day, follow up triggered inspection of Beechwood House Nursing Home which is registered to deliver care to 69 residents. Since the previous inspection the Health Information and Quality Authority (HIQA) had received a number of concerns in relation to poor safeguarding practices, inadequate staffing levels and ineffective recruitment, induction and retention of staff in the centre. Provider led information was requested from the centre for a number of issues raised and inadequate information was received by HIQA in response. A further concern in relation to staffing was received by HIQA in May 2016. This inspection also followed up on actions required from the previous dementia thematic inspection which took place in September 2015 where the centre was found to be non-compliant in all six outcomes inspected against. Inspectors were not reassured by the response to the action plan from the provider and the provider and person in charge attended a meeting at the HIQA office.

On this inspection inspectors arrived unannounced to the centre at 20:15hrs. The

centre was warm and comfortable and residents were up and around enjoying evening drinks. A number of residents were being assisted to bed by staff. Inspectors met with residents, relatives, staff members, the person in charge, deputy person in charge and administration staff over the course of the two days of inspection. The provider nominee was on leave and therefore was not available during the inspection.

On this inspection there were 61 residents living in the centre. Inspectors found that the premises, fittings and equipment were generally of a high standard and very clean and well-maintained. There was a good standard of décor throughout and well-kept gardens and grounds with plenty of seating available for residents' and relatives' use. Residents and relatives were spoken to throughout the inspection. The feedback received from them was generally positive and indicated that they were satisfied with the staff and care provided but all identified a shortage of staff as their main concern.

Inspectors saw that some improvements had taken place since the last inspection as required in the action plan. These included improvements in the décor, there were more pictures up throughout the centre and some rooms were more personalised. Murals were seen in the day room and dining room of the high dependency unit. Access to the garden area was now more easily available and there was a full time activities coordinator employed in the centre providing a wide range of activities. Independent advocacy services are now being provided. These issues will be outlined further under the relevant outcomes in the body of the report. However, many of the actions required in relation to staffing levels, institutional practices, assessment, care planning, staff training and complaints procedure remained non-compliant.

Significant issues were also identified by inspectors during this inspection regarding aspects of protection of residents, lack of staffing levels and complaints management. Inspectors found the system in place to deal with complaints was not sufficiently robust. Inspectors saw that a number of complaints and issues raised by residents were not investigated and acted on and residents did not receive information on the outcomes of same. Inspectors were not satisfied that the provider had taken all reasonable measures to protect residents from abuse or to put the necessary systems in place for the protection of residents. A number of allegations of abuse were documented as complaints and not as allegations of abuse and were not investigated fully. In a number of cases there was no evidence that any action was taken and that any measures were put in place to prevent reoccurrence. These allegations were also not notified to HIQA as required by regulations. This will all be outlined in further detail in the main report. An immediate action plan was issued to the provider and person in charge following the inspection for action on the above issues and also for the failure to ensure that the number and skill mix of staff was appropriate to the assessed needs of the residents and taking into account the diverse layout of the centre over three floors.

Overall inspectors found the current governance and management of the centre was ineffective. Although the provider nominee was generally in the centre on a daily basis 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. The person in charge was counted as the second nurse on duty during the day to care for the 61 residents present at the time of inspection, and did not have the supernumerary time to undertake her managerial and regulatory duties. All these issues and other failings are addressed under the relevant outcomes in the body of the report. On this inspection the centre was found to be non-compliant in nine out of the 10 outcomes inspected against with one outcome being substantially compliant. Seven outcomes were found to have major non-compliance and two outcomes moderate non-compliance.

The provider was requested to attend a meeting at HIQA head office following the inspection to discuss these issues of concern.

A number of other improvements were required to comply with the requirements of 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. These are dealt with in detail in the Action Plan at the end of this report.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

On the previous dementia thematic inspection which took place in September 2015 the centre was found to be non-compliant in all six outcomes inspected against. Of the six outcomes four were found to have major non-compliance and two outcomes were found to have moderate non-compliance. Inspectors were not reassured by the response to the action plan from the provider and the provider and person in charge attended a meeting at HIQA's office. On this inspection, inspectors saw that some improvements had taken place since the last inspection in relation to the premises, access to the garden area and provision of activities and independent advocacy services which will all be discussed under the relevant outcomes. However, many of the actions required in relation to the significant areas of staffing levels, institutional practices, assessment, care planning, staff training and complaints procedure remained non-compliant.

Overall inspectors found the current governance and management of the centre was ineffective; although the provider nominee was generally in the centre on a daily basis, 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.

Inspectors found the management systems in place were not sufficiently robust to ensure that the service provided was consistent and effectively monitored. This was evidenced by gaps in: mandatory training for staff; ineffective systems for management of complaints; inappropriate recording and handling of allegations of abuse; inadequate supervision of residents and staff; no system in place for identifying new or changing

hazards; inadequate or missing risk assessments; inadequate audits that failed to contribute to the quality and safety of care in a meaningful way; gaps in relation to the notification of incidents; lack of assessments and meaningful care plans; inconsistent documentation; limited documentation in place in relation to environmental restrictions; out of date policies and procedures that did not always direct the care to be given to residents. 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) not being made available to residents and the chief inspector.

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. Staffing levels throughout the day and night were inadequate to meet the needs of the residents and institutional type practices had continued in the centre. Staffing levels are discussed further in outcome 18.

Following the inspection the provider was requested to attend a meeting at HIQA head office.

Judgment:
Non Compliant - Major

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

Theme:
Governance, Leadership and Management

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

Findings:
This outcome was not fully inspected on this inspection with the exception of contracts of care. Inspectors noted from a small sample of contracts of care seen that contracts of care were not signed and dated for two residents that had resided in the centre for some time.

Judgment:
Substantially Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

On the previous inspection, 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 Regulations in Designated Centres for Older People) Regulations 2013. This was discussed with the provider nominee on the inspection and an action was given in the report. On this inspection, the inspector found that of the sample viewed, two staff files did not contain full employment histories and one staff file did not contain evidence of application for Garda vetting. One staff file did not contain a reference from the staff member's most recent employer, there was no evidence that other references had been verified and one reference for a staff member was not received until five weeks after they had started employment. This was also not in line with the centre's own policy on staff recruitment, selection and appointment which outlined that references, including a reference from the last place of employment would be required prior to confirming the offer of employment.

Inspectors found that the records reviewed were maintained in a manner that did not facilitate ease of retrieval. It was difficult to determine if the 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 as, although requested by inspectors, staff did not have access to the policy on staff training and development. Inspectors found that policies and procedures in place did not always accurately reflect practices in the centre. For example, it stated in the Schedule 5 policies for Staff Recruitment, Selection and Appointment, Protection of the Resident from Abuse and Responding to Complaints that 'an annual audit shall be undertaken to determine compliance to this policy and procedure'. However, inspectors found no evidence of these audits.

It was also evident that not all policies as required by Schedule 5 had been reviewed and updated as necessary, for example, the policy on protection of the resident from abuse was effective from 25 October 2012 and required updating to reference the current national policy on safeguarding vulnerable adults.

Judgment:

Non Compliant - Major

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:

During the 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. Inspectors were not assured that management were fully aware of their responsibilities in the prevention, detection and reporting of abuse.

There was a policy in place that covered prevention, detection, reporting and investigating allegations or suspicion of abuse. However this policy was not updated since 2012. Staff with whom inspectors spoke with had knowledge of the indicators to look out for and staff stated that if they had concerns about adult protection they would be dealt with by the provider. However inspectors saw that although allegations of abuse were reported, they were documented in the complaints log and not being logged and investigated as allegations of abuse. Also these incidents were not being notified to HIQA as allegations of abuse or allegations of misconduct as required by the regulations. The action in relation to this is under outcome 10 notifications. There was evidence that disciplinary action had been taken for a number of allegations of abuse/misconduct but there was no evidence of actions taken in other instances and there was no evidence that these allegations were all investigated appropriately. Inspectors also found that there were gaps in the measures in place to protect residents from suffering abuse in that not all staff had been provided with appropriate mandatory training. This was also a finding at the previous inspection.

There was a policy on challenging behaviour and the inspectors saw that some staff had received training on dealing with behaviours that challenge. However there were a number of staff who did not have this training. From a selection of care plans viewed by the inspector it was noted 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. Residents who were assessed as requiring one to one

supervision and who the provider had applied for one to one funding from the HSE for. These residents were admitted without full consideration if the centre would be able to meet their needs. In one instance the admitting GP questioned the suitability of centre to meet the needs of the resident. 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, this is discussed further under outcome 18 staffing.

On the previous inspection it was not possible for inspectors to establish how many residents used bed rails as a form of restraint. All beds which inspectors saw had bed rails attached and different staff reported different numbers and these numbers varied significantly. On this inspection the person in charge stated she had carried out a restraint review which resulted in the reduction in the use of bedrails from 31 on the previous inspection to 27 in use on this inspection. Bed rails had been removed from beds where they were not being used and inspectors saw a large number of bed rails in a storage room. Inspectors saw that a restraint file index was now maintained identifying what type of restraint used for residents. Although inspectors saw that restraint assessments were being completed there was limited documentation to show that where restraint was used, it was checked on a regular basis. The centre's policy on restraint referenced the use of alternative nursing measures. However, there was no evidence that alternatives were given due consideration. This was also identified on the previous inspection.

Judgment:
Non Compliant - Major

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:
The person in charge had notified HIQA of accidents/incidents and quarterly returns as required by regulations. Inspectors saw there had been allegations of misconduct resulting in disciplinary action and a number of allegations of abuse. However 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.

Judgment:
Non Compliant - Major

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):

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

Findings:

Residents' healthcare needs were generally 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.

Residents assessed needs were generally 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. The electronic system was updated and signed by the nurses and care assistants responsible for the records. However, it was unclear as to the extent the pre-admission assessment considered if the centre would be able to meet residents' needs and in the case of a number of residents inspectors found that residents were accepted and admitted then retrospective funding for one to one care was applied for. However at the time of the inspection one to one care was assessed as required but it was not being provided. This was discussed further in outcome 7 safeguarding.

Referrals had been made to other services, for example to speech and language therapy and dietician. A physiotherapist worked in the centre on a full time basis and there was a physiotherapy room available. 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 a mobility plan for all residents. On the previous inspection, inspectors noted there was limited adherence to the physiotherapist's mobility plans. For example, staff did not always provide or support residents to stand or move. On this inspection inspectors saw that the physiotherapist provided excellent one to one sessions with residents and group exercise sessions which promoted residents mobility and respiratory function. However 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. Mobility care plans seen by inspectors were inadequate to direct care examples were see of a resident who is confined to a wheelchair having a care plan saying he required snug fitting shoe wear and his mobility frame to be kept beside him. There was nothing to inform staff whether he could transfer independently from the wheelchair or if he required the assistance of

one or two staff or a hoist. Another resident who walked with a walking frame but did not have a mobility assessment or falls assessment in place. In the case of manual handling as identified on the previous inspection it was difficult to establish if all staff had this training. Staff reported that because of staff shortages and time pressures they tended to manually handle residents instead of using the hoist. Inspectors concluded a more comprehensive moving and handling training programme needed to be provided and as outlined above comprehensive assessments and moving and handling plans.

Overall 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. These care plans were generic in format and the content did not identify individual needs and choices. It was difficult to find information on the electronic system and in many cases vital information was found to be missing. Residents with significant responsive behaviours did not have assessments or care plans in place to direct the care required for the resident and to ensure a consistent approach by all staff. This was particularly relevant in light of the high turnover of staff as will be discussed in outcome 18 Staffing. 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. Inspector formed an opinion that the care plans were not a live document used to direct care, they were not personalised and staff were not always familiar with their content. This was discussed in detail with the person in charge and deputy person in charge and they acknowledged the requirement to ensure the care plans were live documents directing care for all residents.

Documentation and practices around wound care was also found to be inconsistent. One resident had a significant long standing pressure sore which they had on admission to the centre. The wound was being assessed using a scientific measurement tool however this was happening infrequently and not after each dressing and there was no photographic monitoring of the wound. It was difficult to establish if the wound was improving or deteriorating. The nursing staff said they had received advice from a tissue viability nurse over the phone some time ago but there was no evidence of the documentation of that advice. A further review of the wound is required by a wound care specialist to ensure staff are providing care in accordance with evidenced based practice.

Judgment:
Non Compliant - Major

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:

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

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

Findings:

Beechwood house nursing home was extended to provide residential accommodation for up to 69 residents. The older part of the building was originally a private home. 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. There were several interesting seating areas throughout the centre. A phone was available in a quiet room for residents to take private calls. All bedrooms had full en-suite facilities. The full 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. Inspectors found that the location, layout and design of the centre was of a high standard and generally comfortable and homely.

On the previous inspection inspectors identified that parts of the premises required redecoration and upkeep. For example, some upholstery was stained, some bedspreads were torn, a picture frame was broken and many bedrooms were not personalised. A section of the ground floor was designated a high dependency unit. The seating areas in the high dependency unit had scope to be decorated in such a manner to provide a greater level of stimulating décor for residents to look at. For example, there was little use of contrasting colour on walls or doors. A number of residents in this area experienced dementia. Access to the garden from this unit was restricted. Most of the residents in this unit could only access the garden/outdoors on request. On this inspection inspectors saw that most of these issues had been rectified, torn and worn equipment and soft furnishing had been replaced and repaired. Residents now had easy access to the outdoor space as the door was open. Gates had been placed on stairs to mitigate risks in the areas leading to the outdoor space, which was seen to be picturesque with numerous pot plants and trailing plants. Plenty of tables and chairs were available for resident use. Mural's had been put on the walls in the high dependency unit dining and day room adding colour, reminiscence and discussion points as one was of a countryside/farm scene and one was off an old kitchen scene. Other pictures were seen throughout the building and bedrooms seen were more personalised. Inspectors recommended further attention to appropriate signage in the centre.

On the previous inspection it was identified that access to a call bell was not available in of a small sitting room in the high dependency unit. On this inspection that was now in place. Also on the previous inspection wheelchairs were regularly operated without footplates. In one instance where a resident was being transferred from the bedroom to the sitting room, the wheelchair (which was missing the footplates) was tilted on its two back wheels and pushed along in this manner. On this inspection inspectors saw wheelchairs all had footplates and they did not see any inappropriate transfer practices using the wheelchairs.

The inspectors observed lunch being served throughout the centre and although the

food was seen to be of a high standard with choice provided at all meals 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.

Judgment:

Non Compliant - Moderate

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:

Inspectors reviewed the complaints log book and found that details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied was not always recorded as required by regulations. It was also not clear if measures required for improvement in response to a complaint were put in place. Inspectors were also concerned that allegations of abuse were inappropriately logged by the provider, as complaints in the complaints log book and in some cases there was no evidence available of any investigation into these allegations or the outcome of the investigation. This was outlined further in Outcome 7 Safeguarding and Safety. These allegations of abuse were also not notified to HIQA as required by regulations. This was outlined previously in Outcome 10 Notification of Incidents.

A summary of the complaints procedure was displayed in a prominent position in the centre. The inspector reviewed the complaints policy and found that it was effective from August 2012 and so required review. The regulations require that all policies require review and updating to reflect best practise at intervals not exceeding three years. This action was also an outstanding action from the previous inspection.

Further updates were also required to ensure the policy complied with regulations. The policy did not reflect practice in the centre. In some parts of the policy it stated that the complaint was to be reviewed by the nurse in charge; however, in other parts this was crossed out and the person representing the provider was written in. On the previous inspection, the person representing the provider informed inspectors that she was the nominated complaints officer in the centre. Also, the policy stated that complaints data was analysed twice a year and that an annual audit was undertaken to determine compliance with the policy and procedure; however, this was not evident in practice. It was not set out in the complaints policy who the independent nominated person was to oversee that all complaints were appropriately responded to and records maintained.

These required updates were also outlined to the provider on the previous inspection but had not been addressed.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Since the last inspection, an activities coordinator had been employed in the centre who worked in the centre five days per week. Inspectors observed and residents confirmed that they enjoyed partaking in the activities available in the centre. Home visits were also facilitated as requested. The new activities coordinator met with the inspectors and outlined her role of facilitating group and one to one activities. This appointment was seen to be a great addition to the team and provided social stimulation for the residents which was well received by all.

Staff were observed treating residents and speaking about residents in a courteous and respectful manner. However, some residents stated that they would like to go for a walk but that the care staff just didn't have enough time to bring them as they were all so busy. Although residents stated that staff were very kind, they also stated that there were not enough staff, especially at night. Some residents stated that staff don't answer the call bell for quite a while as they are rushing all the time.

Breakfast was served in the centre from 06:30hrs and most residents stated they had their breakfast between 07:00hrs and 07:30hrs. However, there was no evidence to support that this breakfast time was determined by residents' expressed preference or if it was based on routine practices in the centre. Some residents the inspector spoke with stated that they would prefer to stay asleep in the morning but are woken up for breakfast.

Inspectors saw evidence that residents were asked about their preferences and if they were happy with the services being provided in the centre. This was done on a monthly basis with residents being asked individually if they were happy or had suggestions for improvements. However, it was not evident from the last three monthly meetings that

suggestions for improvements from residents were always acted on, responded to and recorded by staff.

On the previous inspection it was identified that residents did not have access to independent advocacy services. On this inspection there were posters on display advertising the number to call should you wish to avail of these services. The person in charge informed inspectors that the advocate will visit the centre on request and had visited the centre recently.

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 each resident could receive visitors in private.

The centre was suitably resourced with adequate daily entertainment and leisure facilities such TV, radio, newspapers and magazines.

Judgment:
Non Compliant - Major

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

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

Findings:

As identified on the previous inspection residents and relatives indicated that staff generally treated them with respect and dignity and residents were generally very complimentary about staff. However some residents informed inspectors that they might be waiting quite a while for drinks or for staff to answer bells. Relatives and staff also reported the lack of staff as the most difficult issue for them. They said they would not like to bother staff as they appeared to be "rushed off their feet". During the inspection, residents were seen to receive attention from staff. There were examples of good interaction where staff and residents chatted with each other and staff engaged well with residents when assisting at meal times. However inspectors were concerned in relation to staffing numbers throughout the day and night taking into account the layout

of the building over three floors and the complex needs of residents.

Inspectors reviewed staffing rotas, staffing levels and skill mix and found that generally there was only one nurse on duty in addition to the person in charge and six care staff to meet residents' care needs during the day. The staffing level at night had increased to two nurses since the last inspection, when there was one nurse and three care staff. However there has been no increase in staff numbers as care staff had been reduced to two staff. There were four staff to provide care to up to 69 residents over three floors. Staff reported that they also have to undertake cleaning duties at night in addition to preparing the breakfast and ensuring everyone has had breakfast before the day staff start work at 08.00 hrs. These staffing arrangements, supports and working conditions, did not take adequate cognisance of the complex cognitive, physical, psychological and social needs of residents living in the centre.

At the last inspection the inspectors found that the majority of residents were awoken early for their medication and their breakfast. The inspectors considered this to be an institutionalised practice. In addition, the observations that inspectors noted during formal observation, indicated task based care. There was a sense that the routine dictated the way the centre was run. Since the last inspection staff told the inspector they had brought the breakfast time later and had brought staff in at 07:00am to assist with breakfast however this had stopped about two weeks before the inspection and staff were back to commencing breakfasts before 06.30am. Staffing levels were dictating staffing rituals and practices.

As identified on the previous inspection inspectors viewed staff training records. However, it could not be discerned from the records whether all staff had completed mandatory fire and evacuation training, manual handling training and training in relation to the detection and prevention of and response to abuse. An overview sheet or a staff training matrix was not available. This was found to be the same on this inspection there were five new staff who had not received mandatory training.

Inspectors noted that there has been a continuous high turnover of staff, Staff retention rates were very poor and new staff were being recruited on a very regular basis. Inspectors were not satisfied that there was a robust system in place for recruitment and retention of staff. The person in charge told the inspectors that she was not involved in the recruitment of new staff that this was done by the provider. Even when clinical staff were being recruited and interviewed this was conducted by the provider and did not involve staff with a clinical background. The new staff are then allocated to the person in charge to induct. There is no formal induction process in place. Staff reported it is just an observation of staff undertaking their day to day work practices. New staff received two supernumerary induction days without pay following which they commenced work and were counted in the staffing compliment. HIQA received information in relation to concerns over poor induction practices in the centre and inspectors saw that there was evidence to support these concerns.

The issue of inadequate staffing had arisen in a number of previous reports and continued to be a very serious concern on this inspection. HIQA has continued to receive numerous pieces of information expressing concern with regards to staffing levels at this centre. The inspectors saw on the evening of the first inspection that a resident who

was assessed as requiring a one to one staffing allocation, had a member of staff allocated to check on him on an half hourly basis only. This staff member was responsible for all residents on the ground floor and half the residents on the first floor, along with his cleaning and breakfast duties and providing continence and full care to many residents. There was no evidence to show that the staff member did or could provide half hourly checks when one to one care was the assessed criteria for the resident.

Shift handover meetings took place at the beginning of each shift. Another meeting took place at 12noon. Staff reported the 12 noon meeting to be particularly beneficial as it was an opportunity for staff to report on the findings from the morning's work. Staff meetings took place approximately twice yearly. Minutes were maintained of these meetings which were seen by the inspectors. It was identified in the last meeting that they were having a problem with red groins for numerous residents; this would be seen as a quality indicator of staff rushing and not providing full care.

Overall inspectors concluded that the number and skill mix of staff was not appropriate to meet the needs of the residents and the size and layout of the centre and an immediate action plan was given to the provider in relation to staffing levels before the inspectors left the centre.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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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:	18/05/2016
Date of response:	03/06/2016

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 not effective management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

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

monitored.

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

Immediate actions shall be carried out as follows:

1. A full review of the governance and management systems will be carried out with urgency within Beechwood House Nursing Home. An external company who specialise in quality and safety and governance systems have been recruited to carry out this review with Beechwood House Nursing Home, in June 2016. (Timescale for completion: 30th June 2016).
2. Clear Roles and Responsibilities for all staff will be identified in job descriptions and communicated to staff. (Timescale: 30th June 2016). The roles and responsibilities of the person in charge and the provider nominee shall be clearly identified in job descriptions, for example auditing, monitoring, supervision of staff and oversight of training needs.
3. A new person in charge will be appointed to the nursing home. This will be a fully supernumerary position. Recruitment is commencing immediately. (Timescale: 30th June 2016).

In addition, a full review of all processes within the nursing home will be carried out over the next 12 months to ensure that the service provided is safe, appropriate, consistent and effectively monitored. This shall include a review of staff levels and skill mix, introduction of formal systems for supervision of staff, addressing any training needs for staff, implementing an audit schedule and oversight of quality and safety in the nursing home (including incidents).

Proposed Timescale: 30/06/2016

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 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 HIQA under section 8 of the Health Act 2007.

2. Action Required:

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

1. The Registered Provider has arranged a full Gap Analysis against the HIQA standards to take place in the next 4 weeks.
2. This shall be undertaken on an annual basis.

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

There was not a clearly defined management structure that identified the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

3. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

1. As per Action 1, A full review of the governance and management systems and structure will take place in June. (Timescale: 30th June 2016).
2. A reviewed and updated Organisational Structure will be put in place that identifies the lines of authority and accountability within the nursing home. Staff will be educated on the new structure to ensure they are aware of the lines of accountability and authority. (Timescale: 30th June 2016).
3. A Management Team shall be established consisting of senior management within the nursing home. This shall meet on a monthly basis and shall oversee all operational and management processes and outcomes within the nursing home.
4. Multidisciplinary teams shall be established to oversee the provision of both care services and support services within the organisation. These shall involve all relevant staff, and shall facilitate communication with and from staff regarding key activities and resident priorities within the nursing home.
5. As per action 1, a person in charge will be in place with clearly defined roles and responsibilities, in a fully supernumerary position.
6. The management structure shall be strengthened over the following 1 year as part of the full review of all process in the Nursing Home.

Proposed Timescale: 30/06/2016

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

Inspectors noted from a small sample of contracts of care seen that contracts of care were not signed and dated for two residents that had resided in the centre for some time.

4. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

1. The gap in the two resident contracts were immediately actioned and addressed following the HIQA inspection. Both residents were supported to review the contracts and both residents have now signed them. (Completed May 2016)
2. A full review of all resident contracts was carried out in May 2016 following the HIQA inspection to identify any further gaps. (Completed May 2016)

Resident contracts shall be audited at on a quarterly basis going forward, as part of the full development of the quality and safety management system.

Proposed Timescale: Completed – May 2016

Proposed Timescale: 31/05/2016

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:

Staff did not have access to all of the policies required by Schedule 5.

5. Action Required:

Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

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

1. To ensure staff have access to policies and procedures, additional folders are being developed to ensure that controlled copies of the policies and procedures are available in each unit of the Nursing Home. (Timescale: 30th June 2016)
2. The redevelopment and update of schedule 5 policies and procedures to incorporate best practice updates shall be prioritised and addressed immediately. To ensure the documents are reflective of the processes in the nursing home staff shall be involved in the redevelopment and update. (Timescale: 31st August 2016).
3. Staff will be educated on all schedule 5 policies and procedures as they are updated and activated. (Timescale: 31st August 2016).

Proposed Timescale: 31st August 2016 (Immediate Actions required)

Proposed Timescale: 31/08/2016

Theme:

Governance, Leadership and Management

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

It was evident that not all policies as required by Schedule 5 had been reviewed and updated in accordance with best practice at intervals not exceeding three years.

6. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

1. As per action 5, as part of the full development of the quality and safety management system all policies and procedures shall be reviewed and updated over the coming 1 year based on best practice, regulatory and standards updates (schedule 5 policies and procedures shall be prioritised to be completed by end of August 2016).
2. Staff education shall be rolled out for each policy. Oversight by the management team shall take place in relation to the implementation of the policies within the nursing home on an ongoing basis.
3. A scheduled workplan shall be developed and put in place to set out the policies which will be reviewed each month over the coming year. This shall allow for a thorough and effective review and update process. The workplan shall be implemented for the year and adherence to the workplan shall be overseen by the registered provider (Timescale: 30th June 2016).

Proposed Timescale: 31/08/2016

Theme:

Governance, Leadership and Management

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

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 Regulations in Designated Centres for Older People) Regulations 2013.

7. 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:

1. An audit is being undertaken to identify any gaps in staff files.
2. A dedicated staff member has been assigned to oversee the review and update of staff files and to address any gaps in relation to Schedule 2 of the Health Act 2007

(Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013.

3. A staff file checklist in line with the regulatory requirements has been developed to allow for effective auditing of all the staff files. (Completed – May 2016)

4. All identified gaps in the required documentation shall be obtained. The provider nominee shall monitor this on a weekly basis (31st July 2016)

5. When the audit is completed, this shall be repeated at defined intervals going forward. This shall be defined as part of the overall review of the quality and safety management system over the coming year.

Proposed Timescale: 31st July 2016 (Immediate Actions required)

Proposed Timescale: 31/07/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Not all staff had up-to-date training in the management of responsive behaviours.

8. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

1. A review of training records and staff training requirements took place in May in relation to responsive behaviours. (Completed -May 2016).

2. Certified Training in the management of responsive behaviours has been arranged for the staff who did not have up to date training in this area. This shall be completed for all outstanding staff by 30th June 2016.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

Responsive behaviours exhibited by residents that is challenging or poses a risk to the resident concerned or to other persons, was not managed and responded to appropriately.

9. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

1. As per Action 8, Certified Training in the management of responsive behaviours has been arranged for the staff who did not have up to date training in this area. This shall be completed for all outstanding staff (30th June 2016).
2. The policy and procedure shall be review and updated with prioritisation over the next 4 weeks. (30th June 2016)
3. All care plans in relation to behaviour that challenges shall be reviewed and redeveloped by the multidisciplinary team. All care plans shall clearly identify the behaviours exhibited by the residents, and shall give clear direction to staff on how to prevent or appropriately respond to behaviours that challenge. (Timescale: 15th July 2016).
4. Key information from the care plans shall be communicated to all relevant care staff.

Proposed Timescale: 15th July 2016 (Immediate Actions required)

Proposed Timescale: 15/07/2016

Theme:

Safe care and support

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

Not all staff were trained in the detection and prevention of and responses to abuse.

10. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

1. Training has been arranged for the staff who have not received formal training in elder abuse. (30th June 2016)
2. All staff shall attend the training even if the training was not out of date, as a refresher following HIQA observations. (31st August 2016)
3. Ongoing policy refresher sessions shall be held with staff in relation to types and nature of abuse, detection and prevention of abuse, and response to abuse allegations. These shall take place on a quarterly basis.
4. The policy on detection and prevention of and responses to abuse shall be prioritised for immediate update to ensure it reflects all changes in standards, regulation, best practice and publications. This shall be communicated to all staff and all staff shall be required to acknowledge same. (30th June 2016).

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

The provider had not taken all reasonable measures to protect residents, staff and visitors from abuse.

11. 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:

1. As per action 10, Training has been arranged for the staff who have not received formal training in elder abuse. (30th June 2016).
2. All staff shall attend training even if the training was not out of date, as a refresher following HIQA observations. (31st August 2016)
3. All residents shall be admitted to the centre with full consideration of their needs. The preassessment and assessment policies and procedures shall be the prioritised for review and development. (31st August 2016)
4. For the resident who was identified as requiring one to one support arrangements have been made with him and his family, and he is to be transferred to a different facility next Wednesday 8th June 2016.

Proposed Timescale: 31/08/2016

Theme:

Safe care and support

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

A number of allegations of abuse were documented as complaints and were not being investigated appropriately.

12. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

1. The provider nominee shall complete a full review of all the complaints logged to ensure that any inappropriate documentation of an episode or allegation of abuse is highlighted, reported, investigated as per policy and procedure. (30th June 2016)
2. As per action 10, the policy and procedure on detection and prevention of and responses to abuse shall be updated and all staff shall receive training on prevention, detection and manage of incidents and allegations of abuse. (30th June 2016)
3. Staff shall be provided with feedback and lessons learned regarding the inappropriate logging of abuse incidents in the complaint log. This shall ensure all staff are aware to report incidents or allegations of abuse as per policy and procedure. (30th June 2016)

Proposed Timescale: 30/06/2016

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:

Inspectors saw there had been allegations of misconduct resulting in disciplinary action and a number of allegations of abuse. However 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.

13. 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:

1. Lessons learned have been noted by the Provider Nominee and Person in Charge. The Registered Provider are fully aware of the requirement to give notice to the chief inspector in writing of the occurrence of any incident set out in the regulations, Schedule 4, within 3 working days of its occurrence. The new Person in Charge, when the post is commenced, will be made aware of this requirement immediately.
2. The Provider Nominee is now aware of all their requirements under the Regulation 415 of 2013.

Proposed Timescale: Completed (May 2016)

Proposed Timescale: 31/05/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Residents care plans were found not to be person centred to the residents and did not direct the care for the residents

Mobility assessments and plans of care were not in place for residents

14. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each

resident when these have been assessed in accordance with Regulation 5(2).

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

1. An audit of all resident care plans shall be initiated immediately. This shall include review the appropriateness of interventions and directions for staff to guide care, identification of the issues and risks relevant to the resident and ensuring the care plans are person centred. All findings shall be communicated to key working and multidisciplinary team, and the resident shall be involved in the development of the updated care plans. (immediate commencement – to be completed by 30th June 2016).
2. As part of the Multidisciplinary team, the physiotherapist works full time (1 WTE) and links closely with the nursing staff on a daily basis to ensure effective communication of the resident risks and needs.
3. A review of the communication processes between the physiotherapist and the nursing/health care assistant staff shall be carried out to ensure the results of physiotherapy assessment are incorporated into the care plans.
4. The person in charge shall audit care plans for completeness and to ensure they are person centred on a monthly basis.
5. The policy and procedure for assessment and care planning shall be updated. (Timescale: 31st August 2016)

Proposed Timescale: 31/08/2016

Theme:

Effective care and support

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

Residents needs were not being comprehensively assessed as there was a lack of appropriate evidenced based assessments undertaken for a number of residents.

15. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

1. An audit of all resident assessments on Epiccare shall be undertaken. This shall include review the appropriateness of assessments completed, and shall identify where any assessments were inappropriately excluded. (immediate commencement – to be completed by 31st August 2016)
2. All findings shall be communicated to relevant care staff.
3. The preassessment and assessment policies and procedures shall be the prioritised for review and development. (31st August 2016).
4. As part of the redevelopment of the PIC role the PIC shall have responsibility for all preassessments of residents. (30th June 2015).

Proposed Timescale: 31/08/2016

Theme:

Effective care and support

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

Documentation and practices around wound care was also found to be inconsistent. A further review of the wound is required by a wound care specialist to ensure staff are providing care in accordance with evidenced based practice.

16. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

1. The issues highlighted by HIQA were immediately actioned. There is now a wound assessment which takes place after each dressing change. Photographs were taken and are being taken weekly to document the progression of the wound. (Completed and ongoing)
2. The nursing home is linking with the TVN in limerick hospital for resident wounds.
3. The nursing staff liaise closely with the residents GP with regard to the progression and improvements of the wound. (Completed and ongoing)
4. A full review of wound management practices will take place as part of the overall review of all process in the nursing home over the next 1 year. Auditing of wound management care plans shall be undertaken by the person in charge on a monthly basis, to ensure adherence to the policy and procedure. (31st May 2017)

Proposed Timescale: 17th June 2016 (Immediate required actions)

Proposed Timescale: 17/06/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Dining space was limited particularly in the high dependency unit where many residents were seen to have their meals in the day room.

17. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

1. The availability of space in HDU been under review by the provider nominee for some time. Planning permission was received on 1st June 2016 to initiate the building of an extended, large size, dining room for residents. The currently used space will be turned into an additional day room to provide further space for residents. Building works will commence next Monday 6th June 2016. This will significantly increase the dining space for residents. (Timescale: 15th July 2016)
2. A review of the dining practices will be commenced immediately to ensure no inappropriate practices are taking place. Where any resident is not seated and dining at a dining table, this will be investigated and actioned. (Timescale: 15th July 2016)

Proposed Timescale: 15/07/2016

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:

Inspectors reviewed the complaints log book and found that details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied was not always recorded as required by regulations.

18. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

1. The complaints policy and procedure shall be reviewed and updated immediately. (30th June 2016).
2. Training for staff on the updated nursing home complaints process, including reporting and management of complaints, shall be carried out immediately following the update (15th July 2016)
3. As per action 13, a review of the complaint log will be carried out in full. This shall include ensuring that details of any investigation into complaints are clearly documented, the outcome of the complaints are documented and whether or not the resident was satisfied was documented. Issues identified shall be actioned, and lessons learned shall be provided to staff.
4. Monthly audit of complaints shall be undertaken by the person in charge to ensure the complaints are managed as per the policy and procedure. (31st May 2017)

Proposed Timescale: 15/07/2016

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 in the complaints policy who the independent nominated person was to oversee that all complaints were appropriately responded to and records maintained.

19. 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 Person in Charge is the nominated person for complaints under Regulation

1. As per action 19, the complaints policy and procedure shall be reviewed and updated as a priority. (30th June 2016). This shall include links to the ombudsman where an individual is not satisfied with a complaint.
2. The provider nominee shall be the Nominated person who shall 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. The person in charge shall be the nominated complaints officer.
3. Compliance with the policy implementation shall be audited and documented by the person in charge.
4. Trending on incidents and complaints will be prepared and analysed monthly by the management team.

Proposed Timescale: 30/06/2016

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:

Some residents the inspector spoke with stated that they would prefer to stay asleep in the morning but are woken up for breakfast. Some residents stated that staff don't answer the call bell for quite a while as they are rushing all the time.

20. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

1. The PIC shall review the allocation of tasks undertaken by night staff and by staff in the morning to ensure that the need to complete tasks is not affecting the timeframe in which breakfast is served.
2. Following the HIQA inspection, immediate actions were put in place. Breakfast is

served from 7am to 10am and not before this. Residents can have their breakfast at any time they wish within that time. The provider nominee shall ensure if a resident wishes to have a later breakfast and mealtimes that this will be accommodated insofar as possible. The provider nominee has provided lessons learned and feedback to all staff in relation to the promotion of choice in this regard (Completed and ongoing)
3. The PIC shall ensure Meals and Mealtimes are discussed at all resident meetings 3 monthly and shall ensure the actions are followed through. (Completed and ongoing)

Proposed Timescale: 15/07/2016

Theme:

Person-centred care and support

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

It was not evident from the last three monthly meetings that suggestions for improvements from residents were always acted on, responded to and recorded by staff.

21. 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:

1. The provider nominee shall conduct a review of the meetings from the last three months (minutes, staff and resident interview as required) to review the suggestions for improvements from residents, and how they were responded to, recorded by staff and actioned. (Timescale: 31st July 2016)
2. Any suggestions which were not addressed shall be actioned immediately. The resident shall be communicated with regarding any suggestion they have not received updates on. (Timescale: 31st July 2016)
3. Feedback and lessons learned will be provided to staff. (Timescale: 31st July 2016)
4. The policy and procedure shall be reviewed and updated in relation to consultation and participation of residents. (31st May 2017)

Proposed Timescale: 31st July 2016 (Immediate Actions required)

Proposed Timescale: 31/07/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Inspectors found that the number and skill mix of staff was inappropriate to meet the

needs of the residents and the size and layout of the centre

22. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. A fifth staff member has been recruited for the night shift in the nursing home (Health Care Assistant). The staff member is to start duty on the night of Tuesday 7th June. Any night there shall be 5 staff on duty in the nursing home. (Completed)
2. A PIC is being recruited who will be supernumerary and not included in the number of nursing staff on the floor. A full review of the staffing level and skill mix shall be undertaken as a matter of urgency.

Proposed Timescale: 30th June 2016 (Immediate Actions required)

Proposed Timescale: 30/06/2016

Theme:
Workforce

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

Not all staff had received mandatory training

23. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

1. As per actions 9 and 11 training is being scheduled for outstanding staff members.
2. A staff training matrix shall be developed. This shall identify mandatory training needs for all staff, the most recent training received and when staff are due to receive their next training. this shall include a traffic light system to ensure any due training is clearly highlighted.
3. A full review of any outstanding training needs shall be carried out.
4. All mandatory training shall be arranged for staff immediately.

Proposed Timescale: 31/07/2016

Theme:
Workforce

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

Due to poor staffing levels staff were not been adequately supervised.

24. Action Required:

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

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

1. A PIC is being recruited who will operate in a supernumerary basis.
2. The PIC shall be responsible for oversight and supervision of all staff. this shall be clearly outlined in their job description.
3. The PIC shall allocate appropriate time to ensure the formal and informal supervision occurs.
4. Formal supervision schedules shall be set out for staff and each will be required to attend one to one to allow for formal supervision with the person in charge. (Timescale: 31st August 2016)
5. The PIC shall ensure annual performance appraisals are carried out for all staff.

Proposed Timescale: 31st August 2016

Proposed Timescale: