<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Beaumont Residential Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre I D:</td>
<td>OSV-0000198</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Woodvale Road, Beaumont, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 429 2195</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:admin@brccork.com">admin@brccork.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Beaumont Residential Care</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Kieran O'Brien</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>73</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
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.
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 2 day(s).

**The inspection took place over the following dates and times**

From: 25 August 2016 08:30  
To: 25 August 2016 18:30  
26 August 2016 08:15  
To: 26 August 2016 16:50

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

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

**Summary of findings from this inspection**

Beaumont Residential Care is a purpose-built residential centre, with accommodation for 73 residents. The centre is located in the suburbs of Cork city and is situated on large, well maintained, landscaped grounds with adequate parking facilities. It is a two storey premises with bedroom accommodation on both floors.
This inspection was announced and took place two days. The purpose of the inspection was to inform a registration renewal decision and to monitor ongoing compliance with regulations and standards. As part of the inspection, the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident/incident logs, policies and procedures, complaints log and staff files.

The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable and homely way. The centre was clean, spacious and decorated to a high standard throughout. All areas were bright and well lit, with lots of natural light.

Residents' care was provided to a good standard and staff were seen to interact with residents in a respectful manner. Residents received a comprehensive assessment on admission and at regular intervals thereafter.

Prior to the inspection, questionnaires were forwarded to the centre for distribution to residents and relatives. Twelve completed questionnaires were returned from relatives and fourteen were returned by or on behalf of residents. These were reviewed by the inspector and feedback was predominantly positive from both residents and relatives. Residents and relatives spoken with by the inspector were complimentary of the care provided.

Some improvements were required. These included the recording and investigation of allegations of abuse under the complaints process. A review of the complaints log identified that a number of complaints were made by residents and relatives in relation to the attitude and performance of staff. Based on a review of these complaints, it would be more appropriate that they were investigated under the safeguarding policy rather than through the complaints process. Improvements were also required in relation to the management of smoking. There was an inadequate assessment of the risks associated with smoking and there were inadequate arrangements for the supervision of residents while they smoked.

Other required improvements included:
- fire drills were not carried out at suitable intervals
- there was an inadequate process for consultation with residents
- there was no access to independent advocacy services
- notifications were not always submitted as required
- the complaints process did not contain an appeals process
- there was not always a verified reference from the most recent employer.

The action plan at the end of this report identifies where improvements are needed to meet 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.
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 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:
There was a written statement of purpose that contained all the information required by Schedule 1 of the regulations.

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):
No actions were required from the previous inspection.

Findings:
There was a clearly defined management structure. The person in charge was present in the centre for four days each week, which usually included one day each weekend. The person in charge reported to the managing director, who was present in the centre daily, including weekends. The person in charge was supported by a clinical nurse manager 2 and by two clinical nurse managers 1. Formal management meetings were held approximately every three months, however, informal consultation took place on a daily basis due to the constant presence of the managing director in the centre.
There was a comprehensive programme of audits that included audits of nursing care involving an analysis of the prevalence of wounds, the nutritional status of residents, prevalence of infections, transfers to acute care facilities and the number of falls. There was a detailed analysis of the results of the audit and actions taken in response to issues identified. There were also audits of accidents and incidents, hand hygiene practices, medication management, the dining room experience, privacy and dignity, call bell response times and manual handling practices. All audits involved detailed analysis of the results to identify learning as an opportunity for improvement.

There was an annual review of the quality and safety of care. However, the inspector was not satisfied that the review included adequate consultation with residents. This is discussed in more detail under Outcome 16.

Judgment: Substantially Compliant

**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:
The inspector reviewed a sample of the residents’ contracts of care and found that each resident had an agreed written contract. Each contract outlined fees payable and also included the fees for additional services.

There was a residents’ guide that included a summary of the services and facilities available, the terms and conditions of residency, the procedure respecting complaints and the arrangements for visits.

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:  
There was a suitably qualified and experienced person in charge, who worked full time in the centre. The person in charge was supported in her role by a clinical nurse manager 2 and two clinical nurse managers 1.

There was evidence that the person in charge demonstrated a commitment to her own continued professional development as evidenced by training records showing attendance at a number of recent training programmes.

Residents, relatives and staff spoken with by the inspector stated that the person in charge had a daily presence in the centre and was available to answer any queries or concerns. Staff spoken to by the inspector were aware of the reporting relationships and there was evidence that the person in charge held regular staff meetings.

Throughout the inspection the person in charge demonstrated an adequate knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The inspector was satisfied that the person in charge was a suitably experienced nurse with authority, accountability and responsibility for the provision of the service.

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:  
The records listed in Schedules 2, 3, and 4 of the Health Act 2007 (Care and Welfare of
Residents in Designated Centres for Older People) Regulations 2013 were kept secure, readily available and easily retrievable. An up-to-date insurance certificate was available demonstrating insurance against accidents or injury to residents, staff and visitors. The policies listed in Schedule 5 of the regulations were available and up-to-date.

The inspector reviewed a sample of staff files and found that most of the information required by the regulations was readily available and accessible. However, a number of staff did not have references from their most recent employer and some references were not verified. A record of current registration with the relevant professional body was available for all nursing staff.

**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:**
There had been no period when the person in charge was absent from the designated centre for 28 days or more. There were adequate procedures in place should the person in charge be absent for a prolonged period.

**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):**
No actions were required from the previous inspection.
Findings:
There was a policy in place that addressed prevention, detection, reporting and investigating allegations or suspicion of abuse. Training records viewed by the inspector indicated that all staff had attended up-to-date training in recognising and responding to abuse. All staff spoken with by the inspector knew what action to take if they witnessed, suspected or had abuse disclosed to them. Some improvements, however, were required. A review of the complaints log identified that a number of complaints were made by residents and relatives in relation to the attitude and performance of staff. Some of these complaints could be perceived as a manifestation of responsive behaviour, however, this was not the case for all. Based on a review of these complaints, it would be more appropriate that they were investigated under the safeguarding policy rather than through the complaints process. A number of these complaints related to night duty and the inspector was not satisfied that there was an adequate investigation to determine whether or not there was a basis for these allegations and to reassure management that residents were at all times safe.

Residents spoken with by the inspector said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. While staff members spoken with by the inspector were knowledgeable of individual resident's behaviour, including how to avoid the situation escalating, training records indicated that a significant number of staff had not attended training in responsive behaviour.

The only restraint in use in the centre were bedrails. Based on a sample of records viewed by the inspector, risk assessments had been completed for all of these residents. The alternatives to bed rails had been considered, for example low beds. Improvements, however, were required in relation to the management of restraint as contemporaneous records were not maintained demonstrating the time or frequency of safety checks while bedrails were in place.

The centre was not managing the finances of residents, however, petty cash was held on behalf of residents to cover day-to-day expenses, such as hairdressing. Records of all transactions were available that included signatures of a member of staff and the resident/relative, where appropriate or by two members of staff.

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:**
There was an up-to-date safety statement. There was a risk management policy and associated risk register. The risk management policy, however, required review as it did not address the measures and actions in place to control the risks specified in the regulations. The inspector viewed the accident and incident log and there was evidence of learning from accidents and incidents and feedback to staff at meetings. There was an emergency plan in place outlining what to do in the event of an emergency.

There were adequate procedures in place for the prevention and control of infection. Wash hand basins, hand gels, and disposable gloves and aprons were appropriately placed throughout the centre. There were adequate facilities for the secure storage and disposal of clinical waste.

There were reasonable measures in place to prevent accidents including safe floor covering, handrails on all corridors and grab rails in toilets and bathrooms and window restrictors on all windows. All staff members had received up-to-date training in moving and handling.

Suitable fire equipment was provided and there was adequate signage indicating what to do in the event of a fire. Records indicated that fire safety equipment was serviced annually and the fire alarm was serviced quarterly. Emergency lighting was most recently serviced in August 2016, and while it had not been previously serviced quarterly, measures have been put in place to ensure this occurs in the future.

There were records of the daily inspection of the means of escape, weekly sounding of the fire alarm, and weekly checks of fire doors. All exits were seen to be unobstructed on the day of the inspection. Training records indicated that not all staff had received up-to-date training in fire safety and evacuation procedures. Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire. There were frequent reviews and updates of fire safety practices with staff, however, records of fire drills at regular intervals were not available demonstrating the simulation of evacuation for the purpose of learning.

A number of residents smoked. While each resident that smoked had a risk assessment, this was generic in nature and did not take into account the psychological and physical capacity of the resident to be responsible for cigarettes and lighters or the level of supervision required when smoking. Additionally the assessment did not take into account any sensory impairment that a resident may have. There was a designated smoking room containing a fire blanket that was ventilated to the external air by natural and mechanical means. There was a suitable ashtray attached to the wall with an integrated flameless lighter suitable for cigarettes. The smoking room, however, was located at the end of a corridor on the first floor and was remote from the rest of the centre. There was no viewing panel to support the observation of residents while in the
room. The inspector was not satisfied that adequate supervision arrangements were in place for residents that smoked.

**Judgment:**
Non Compliant - Moderate

---

**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:**
There was a medication management policy for ordering, prescribing, storing and administration of medicines. The inspector viewed a sample of residents’ prescriptions and all contained appropriate information including a recent photograph of the resident; the name, dosage and route of administration for all medicines; and the maximum dosage for prn (as required) medications.

The inspector found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices.

There were regular medication audits carried out by a pharmacist and improvements as a result of issues identified. There was evidence of attendance at medication management training by nursing staff.

Medications requiring special control measures were managed appropriately. Records indicated that these were counted by two nurses at the end of each shift. Medications requiring refrigeration were stored appropriately and the temperature of the fridge was monitored and recorded. There was an adequate system in place for the return of unused and out-of-date medicines to the pharmacy.

**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):
No actions were required from the previous inspection.

Findings:
The inspector reviewed the incident log and complaints log and while most notifications were submitted within the required timeframe, allegations of abuse were not always submitted as required.

Judgment:
Non Compliant - Moderate

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The inspector reviewed a sample of residents' records, which included comprehensive biographical details, medical history, nursing assessments and life histories.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare services including dietetics, speech and language, physiotherapy, occupational therapy, psychiatry, chiropody and palliative care. GPs visited the centre regularly and there was evidence that residents were reviewed regularly. Out-of-hours GP services were also available. A physiotherapist organisation visited the centre for one afternoon each week to carry out individual assessments, where required, and also facilitated group classes.

Dietetic, speech and language therapy, and occupation therapy services from a nutritional supply company visited the centre every three months or more frequently if required. Residents also had access to mental health of later life services. Based on a sample of care plans reviewed residents were reviewed by allied health services, however, one resident was in receipt of a modified diet but there was no record of an assessment by a speech and language therapist. Additionally, a recent assessment by a dietician did not make reference to a modified diet.
Residents and families were also invited to visit the centre prior to admission to determine if the centre was suitable to their needs. Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores and for the risk of malnutrition. Records indicated that these were reviewed at a minimum of every four months and more frequently, if required.

Care plans were developed for issues identified on assessment. These were seen to be comprehensive, person-centred and provided detailed guidance on the care to be delivered on an individual basis to residents.

There were opportunities for residents to participate in activities that were meaningful and purposeful to them and that suited their needs, interests and capacities. There was an activities coordinator present in the centre for a number of hours on three days each week. Activities were also facilitated by an external organisation that specialised in the provision of activities and visited the centre on two days each week. A physiotherapy group visited the centre one day each way and provided physical exercise related activities. The programme of activities included activities such as Sonas (a therapeutic communication activity), arts and crafts, music, physiotherapy led exercises, quizzes, and board games. Most activities were done in groups, however, one-to-one activities were carried out with residents that either did not wish to partake in group activities or for which group activities were unsuitable.

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):
No actions were required from the previous inspection.

Findings:
Beaumont Residential Care is a purpose-built residential centre, with accommodation for 73 residents. The centre is located in the suburbs of Cork city and is situated on large, well maintained, landscaped grounds with adequate parking facilities. It is a two storey premises with bedroom accommodation on both floors. The first floor is accessible by two sets of stairs and two lifts.
On the days of inspection, the centre was bright, clean, spacious and decorated to a high standard throughout. Resident accommodation comprises 73 single bedrooms, all of which are en suite with shower, toilet and wash-hand basin. The centre is divided into three sections; the main ground floor wing has bedroom accommodates for 19 residents; the East Wing is the designated dementia unit and accommodates 10 residents; and the first floor, which has bedroom accommodation for 44 residents.

All bedrooms were spacious and were seen to be personalised with residents' individual property and possessions. There was adequate space in the bedrooms for furniture such as a bed, a chair and bedside locker. The rooms also had enough space for equipment such as hoists to be used, with sufficient space to access the beds from either side.

The East Wing, the designated dementia unit, was painted in bright colours with floral murals on the walls. The doors to the bedrooms were all different colours to support residents identify their own bedrooms. Communal space in the East Wing comprised a sitting room, a kitchen/dining room and there was also seated areas along the corridor. There were rummage boxes along the corridors and there were various memorabilia, such as a record player, a typewriter and an old style telephone. There was free access to secure outdoor space from this unit, which contained garden furniture, seating with brightly coloured cushions, and various shrubbery.

Communal areas in the main wing on the ground floor included a reception area, a day room, a television lounge, a dining room, a reading room and a visitors' room. There was a secure garden with shrubs and flower beds that was maintained with assistance of one of the residents. Communal space on the first floor comprises one small sitting room. Residents on the first floor were seen to use the lift and many of these residents spent daytime hours in the communal rooms downstairs. The use of contrasting colour that was evident in the East Wing, had not yet extended to the main part of the centre.

There were adequate sanitary, laundry and sluicing facilities. Access to rooms such as the treatment room, sluice rooms, laundry, cleaners' room were all secure on the day of inspection. Windows have restrictors applied to prevent them from opening fully.

There was a large well-equipped kitchen with adequate hand hygiene and changing facilities for staff. The most recent inspection report from environmental health was available and demonstrated an adequate level of compliance. There was evidence of good practice in relation to the management of clinical and domestic waste.

There were up-to-date records of the maintenance of equipment such as beds, lifts, clinical equipment, and hoists.

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
<table>
<thead>
<tr>
<th><strong>Theme:</strong></th>
<th>Person-centred care and support</th>
</tr>
</thead>
</table>

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

**Findings:**
The centre had an up-to-date policy and procedure on the management of complaints. The policy had recently been reviewed based on guidance issued by the Ombudsman. The policy specified that the person in charge was the nominated person for managing complaints. The policy did not, however, identify an effective independent appeals process or identify the person responsible for ensuring that all complaints are adequately responded to or that appropriate records were maintained. The complaints process was on prominent display in the centre.

The inspector viewed the complaints log containing records of complaints, the results of any investigations, any actions taken and whether or not the complainant was satisfied with the outcome of the complaint.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 14: End of Life Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were written policies and procedures in place for end-of-life care. Staff were supported in the provision of end of life care by the residents’ GPs and the community palliative care team, to which there was good access.

Religious preferences were documented and there was evidence that they were facilitated. Records indicated that end-of-life preferences were discussed with residents and/or their relatives and these were documented in residents’ records.

All residents were accommodated in single rooms, so the option of a single room was always available. Family and friends were facilitated to remain with the resident including overnight, should they wish to do so.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were policies and procedures to supporting the management of nutrition. There were adequate systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were weighed and assessed for the risk of malnutrition on admission and at regular intervals thereafter.

Most residents had breakfasts in their bedrooms but had their lunch and supper in the dining rooms. Breakfast was served for most residents from 08:00hrs, lunch was served from 12:00hrs, and supper was served from 17:00hrs. There was an adequate system of communication between nursing and catering staff to support residents with special dietary requirements. Residents were offered a choice of food at mealtimes, including residents that were prescribed modified diets. Alternatives to what was on the menu were also provided to residents that requested this. The inspector noted that residents prescribed specific diets received the correct diet and modified meals were well presented. Food appeared to be nutritious, was attractively presented and available in sufficient quantities. Fluids were available throughout the day and tea/coffee and snacks were served between meals.

On the day of the inspection there were adequate numbers of staff on duty to support residents with their meals. Residents requiring assistance were assisted by staff in a respectful and dignified manner.

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):
No actions were required from the previous inspection.

Findings:
A number of questionnaires were given to residents and relatives in advance of this inspection. 12 completed questionnaires were returned by relatives and 14 completed questionnaires were returned by or on behalf of residents. Overall, the feedback was overwhelmingly positive with only a small number of issues identified for improvement.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Residents’ privacy was respected and the inspector observed staff knock on doors before entering residents’ bedrooms. There were no restrictions on visiting times and there was adequate space for residents to meet with relatives in private, separate from their bedrooms. Visitors were seen to come and go throughout the day and it was evident that they were familiar with staff and staff were familiar with them.

A range of activities were available each day such as physical activity exercises, arts and crafts, quizzes, SONAS, and music. Thursday night was usually movie night and a large projector screen was available. Residents were given snacks and drinks, including wine, during the movie. Residents had access to television, newspapers, and telephone facilities. Residents were facilitated to vote in local and national elections.

The preferences of all religious denominations were respected and facilitated. Religious ceremonies were celebrated in the centre that included weekly mass for catholic residents. Each resident had a section in their care plan that set out their religious or spiritual preferences.

The provider and person in charge were in the process of obtaining the services of an independent external advocate, however, this service was not yet available to the residents.

Residents were consulted through residents' meetings however, the frequency of these meetings was not adequate to ensure to support on-going consultation. For example, records available indicated the most recent meeting was held in July 2016 and the meeting prior to that was held in August 2015.

Judgment:
Non Compliant - Moderate

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:**
There was an up-to-date policy on the management of residents’ personal property and possessions. There were adequate facilities for laundering residents’ clothes. All clothes were labelled and there were no concerns in relation to clothes not being returned following laundering.

There was adequate storage for residents’ personal belongings, including lockable storage. There were adequate arrangements in place for the regular laundering of linen and clothing, and the safe return of clothes.

**Judgment:**
Compliant

**Outcome 18: Suitable Staffing**

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

**Theme:**
Workforce

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

**Findings:**
An actual and planned roster was maintained in the centre with any changes clearly indicated. Residents, relatives and staff spoken with felt there was adequate levels of staff on duty. This was supported by observations of the inspector who was satisfied that there were satisfactory numbers of staff and skill mix to meet the needs of residents and to the size and layout of the designated centre. Staff members were seen to interact with residents in a caring and respectful manner.
Where support to eat and drink was being provided, it was done in a discreet way.

Records viewed by the inspector confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse; manual handling; however not all staff had received fire safety and evacuation training. Staff also had access to a range of education on areas such as medication management, falls prevention, dementia, end of life care and responsive behaviour. However, a record of attendance at each of these training sessions was not always maintained.

**Judgment:**
Substantially 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:**

John Greaney
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 report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Beaumont Residential Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000198</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>25/08/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>16/09/2016</td>
</tr>
</tbody>
</table>

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 an annual review of the quality and safety of care. However, the inspector was not satisfied that the review included adequate consultation with residents.

1. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Whilst residents and their families are routinely consulted in relation to all aspects of their care we accept that greater formal consultation is required, including making available the findings of our annual review of the quality and safety of care to residents and their representatives. In addition, formal meetings with the residents’ committee will now be scheduled every four months commencing in October 2016.

Proposed Timescale: 30/09/2016

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:
The inspector reviewed a sample of staff files and found that most of the information required by the regulations was readily available and accessible. However, a number of staff did not have references from their most recent employer and some references were not verified.

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:
We have commenced a review of our recruitment procedures to identify any shortcomings in the processing of staff documentation in advance of employees’ commencing work. This includes the required format of references, whether professional or character, reference checking, and Garda Vetting. Guidelines will be prepared and circulated to relevant management and admin staff.

Proposed Timescale: 30/09/2016

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:
Contemporaneous records were not maintained demonstrating the time or frequency of safety checks while bedrails were in place.

3. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
A record of safety checks being carried out will be recorded contemporaneously. To facilitate this, a record keeping mechanism will be implemented and staff will be trained in its use.

**Proposed Timescale:** 30/09/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvements were required in relation to safeguarding, including:
- a number of complaints were recorded in relation to the attitude and performance of staff and a number of these related to night duty. Based on a review of these complaints, it would be more appropriate that they were investigated under the safeguarding policy rather than through the complaints process
- the inspector was not satisfied that there was an adequate investigation to determine whether or not there was a basis for these allegations and to reassure management that residents were at all times safe.

4. **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:**
All complaints are initially recorded as such in our electronic records management system and a complaints-handling workflow has been developed to clarify which policies to investigate under. An investigation will be carried out under the Prevention of Abuse to Residents Policy (SOP 32) if this is then deemed appropriate. A plan has been put in place and commenced to rotate HCAs between day and night duty to facilitate on-going training.

In addition senior nursing management have carried out night time supervision and training and this will continue on a quarterly rotation. These measures commenced on 26/08/2016 and will be reviewed at monthly meetings.

A thorough investigation of all complaints is carried out, with the results of these investigations recorded and documented in line with company policy.

**Proposed Timescale:** 26/08/2016
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 required review as it did not address the measures and actions in place to control the risks specified in the regulations.

5. **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:**
Our risk management policy (SOP36) is currently being revised to detail the measurements and actions we have in place to control the five risks specified in Regulation 26 (1) (C).

**Proposed Timescale:** 30/09/2016

---

Theme:
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were frequent reviews and updates of fire safety practices with staff, however, records of fire drills at regular intervals were not available demonstrating the simulation of evacuation for the purpose of learning.

6. **Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
Employees routinely receive detailed documented training in fire safety practices (compartmentation, how to respond to fire alarms, how to use portable fire-fighting equipment, how to evacuate residents using ski-sheets etc), during day time as well as night time shifts. In addition, we will now schedule simulated evacuation drills at regular intervals where staff will be “walked through” the evacuation process in the event of a fire.

**Proposed Timescale:** 30/09/2016
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector was not satisfied that adequate assessment and supervision arrangements were in place for residents that smoked:
• the smoking risk assessment was generic in nature and did not take into account the psychological and physical capacity of the resident to be responsible for cigarettes and lighters or the level of supervision required when smoking. Additionally the assessment did not take into account any sensory impairment that a resident may have
• smoking care plans did not identify in adequate detail the level of supervision required while residents smoked
• the designated smoking room was located at the end of a corridor on the first floor and was remote from the rest of the centre. There was no viewing panel to support the observation of residents while in the room.

7. 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 nursing home has had a no smoking policy in operation for a number of years and, of our 73 residents, just five are now considered “smokers”. We will revise our risk assessment template to provide a more comprehensive risk profile of these five residents, including taking into account any relevant psychological factors and sensory impairments, and level of supervision required. For health & safety reasons only limited supervision can be undertaken while residents are in the smoking room, i.e., intermittent checks. We will continue to closely monitor these residents and if, in the opinion of senior management (Provider, PIC, CNM2), a particular resident is no longer “safe” to smoke or whose smoking habit cannot be managed/controlled within our current infrastructure, we shall request that the resident stops smoking altogether (with supports) or, as a last resort issue notice to terminate the Contract for Care.

Proposed Timescale: 30/09/2016

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:
The inspector reviewed the incident log and complaints log and while most notifications were submitted within the required timeframe, allegations of abuse were not always submitted as required.

8. 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:
Notice to the chief inspector will be furnished 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.

Proposed Timescale: 26/09/2016

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:
One resident was in receipt of a modified diet but there was no record of an assessment by a speech and language therapist. Additionally, a recent assessment by a dietician did not make reference to a modified diet.

9. 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:
All residents who are identified as needing the support of allied health services have access via a specialist nutrition company. This includes speech and language therapy, dietician and occupational therapy. In relation to the resident referred to by the inspector, a modified diet was discussed with the dietician and nursing staff based on the resident’s health status. A clinical decision was made to trial a modified diet to reverse weight loss and this has proven successful.

Proposed Timescale: Ongoing

Proposed Timescale: 16/09/2016

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:
The complaints policy did not identify an effective independent appeals process.
10. **Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
We have amended our Complaints Policy (SOP 11) to include a clear and effective appeals process in line with requirements.

**Proposed Timescale:** 30/09/2016

**Theme:**
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not identify the person responsible for ensuring that all complaints are adequately responded to or that appropriate records were maintained.

11. **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:**
We have amended our Complaints Policy (SOP 11) to identify the person responsible for ensuring that all complaints are adequately responded to and that appropriate records are maintained.

**Proposed Timescale:** 30/09/2016

**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:
The provider and person in charge were in the process of obtaining the services of an independent external advocate, however, this service was not yet available to the residents.

12. **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 Sage Advocacy service is organising a presentation to residents and staff in late September 2016 outlining the supports and advocacy offered to nursing home residents, and how to access such services.

**Proposed Timescale:** 31/10/2016

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were consulted through residents' meetings however, the frequency of these meetings was not adequate to ensure to support on-going consultation. For example, records available indicated the most recent meeting was held in July 2016 and the meeting prior to that was held in August 2015.

**13. 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:**
As stated under Action 1, whilst residents and their families are routinely consulted in relation to all aspects of their care we accept that greater formal consultation is required. Of particular value in terms of feedback are residents' interactions with our Activity Coordinator (generally undocumented unless entered electronically). More regular formal meetings with the residents’ committee will now be scheduled every four months commencing in October 2016.

**Proposed Timescale:** 30/09/2016

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had access to a range of education on areas such as medication management, falls prevention, dementia, end of life care and responsive behaviour. However, a record of attendance at each of these training sessions was not always maintained.

**14. 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:**
We are committed to ensuring staff are well equipped with skills and knowledge to
provide the best quality care to our residents. We use a variety of training methods to achieve this: 5 key domains are timetabled for all staff and recorded; Fire, Infection Control, Elder Abuse, Manual Handling, and Dementia. These domains are supplemented by other formal and informal training. We prioritise staff who have most direct care giving contact with residents.

Training techniques, involving senior staff as coaches, incorporate:
- group discussions,
- PowerPoint presentations,
- storytelling,
- hands on training,
- and bedside training,
- multimedia training using specialist DVDs.
- and online training (examples of this type of training include Dr Sabina Brennan’s Freedem videos, and specific NHS videos). Several staff access future learn.com and hseland.ie for self-directed learning.

Dementia care and end of life care are priority topics in our training. Much of our informal training including our lunchtime sessions have not been routinely documented and this will now be done going forward.

Proposed Timescale: Ongoing

**Proposed Timescale: 16/09/2016**