

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Beechfield Manor Nursing Home
Centre ID:	OSV-0000013
Centre address:	Shanganagh Road, Shankill, Co. Dublin.
Telephone number:	01 282 4874
Email address:	sreeja@beechfieldmanor.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Beechfield Nursing Homes Limited
Provider Nominee:	Ciaran Larmer
Lead inspector:	Leone Ewings
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	64
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
24 January 2017 11:30	24 January 2017 18:00
25 January 2017 10:00	25 January 2017 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an unannounced inspection of the centre for the purpose of monitoring compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. All notifications submitted by the provider and person in charge, and unsolicited information received by HIQA since the time of the last inspection on 19 and 20 April 2016, were reviewed, and followed up by the inspector. The person in charge had changed since the time of the last inspection.

The 13 action plans from the previous inspection related to premises, care plans, annual review of quality and safety, directory of residents, risk management procedures, follow-up on medicines errors, and complaints.

During the course of the inspection, the inspector met with residents, relatives, staff,

the person in charge and the provider. The views of staff, residents and relatives were listened to, practices were observed and documentation was reviewed.

Overall, the inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. All actions required since the last inspection had been addressed by the provider and person in charge. Evidence of good practice and improvements were found throughout the inspection.

Nonetheless, staff recruitment practices were found to be unsafe in terms of safeguarding residents. Five recently recruited staff did not have evidence of Garda Vetting disclosures prior to commencing work at the centre. Schedule 2 information did not consistently include references from the staff members' last employers, and as such this judgment was a major non-compliance. An immediate action was issued and the provider gave written assurances to HIQA on 3 February 2017 that all staff employed in the centre had Garda Clearance that is required in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was received.

The three action plans at the end of this report identify areas where improvements by the provider are required in order to fully comply with the regulations. These include staff and residents' records, health and safety and risk management and premises.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A written statement of purpose dated 12 October 2016 was in place, and this detailed the aims, objectives and ethos of the service. This information was fully compliant with legislative requirements.

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):

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

Findings:

The provider had addressed in full the non-compliances identified during the last inspection which took place on 19 and 20 April 2016. Some of the management team had changed since this time. Further to the last inspection the inspector reviewed the annual quality and safety report, which was informed by a resident survey and feedback obtained. Detailed analysis of the resident feedback collated in July 2016 had taken

place and informed an action plan for the remaining months of 2016 and into 2017. For example, staff turnover had been identified as an issue in 2016, but this had now resolved.

Management meetings took place between the provider and the person in charge on a weekly basis, and minutes of these meetings were reviewed by the inspector. The person in charge is supported by the head of clinical services and a training manager. Evidence of learning from complaints and serious incidents was recorded. Improved clinical supervision was in place and oversight of care practices.

The inspector confirmed that the person in charge recorded and monitored key performance indicators. This included the monitoring of a number of different areas including dependency levels, pressure ulcers, wounds, restraint, falls, weight loss and infections in the centre. Residents' dependency was closely monitored using a validated tool to inform and guide staffing decisions.

Overall, the provider and person in charge demonstrated that they were working towards full compliance with the regulations. Nonetheless, robust records of Garda Vetting disclosures were not in place for two newly-recruited staff and a further three staff members. The provider and person in charge were advised of this major non-compliance and took appropriate action on the day of the inspection. An immediate action was given to the provider and he responded in a timely way and updated HIQA as requested with measures put in place to mitigate risks to residents.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge had changed since the time of the last inspection. The required information to support this change was submitted by the provider and reviewed by the inspector.

The person in charge is a registered general nurse and works full time within the centre. The new person in charge was deemed to have the required skills, knowledge and experience to hold the post of person in charge.

She was knowledgeable about each resident's nursing and social care needs. Evidence of her continuous professional development was up to date. She has also successfully completed a management course.

Residents and relatives confirmed to the inspector that they recognised her role as a key manager, and someone who they can discuss and feedback to on any issues, or complaints at the centre.

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 as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall, a good standard of record keeping could be evidenced throughout the inspection. An electronic record-keeping system was in operation and all staff were familiar with its use. Some residents' records were also maintained on paper as separate files.

A sample of staff files were reviewed and found to contain many of the requirements of schedule 2 of the Regulations. Some improvements were required in this area as some of the records examined were found not to be in line with the recruitment policy. Five recently recruited staff did not have evidence of Garda Vetting disclosures, although evidence of an application for vetting was evidenced. Staff references from previous employment were also not found on the files of newly-recruited staff members. The provider was given an immediate action at the time of the inspection to address this, and subsequently submitted confirmation of disclosures in place. Interim measures to mitigate any risks associated with this non-compliance were implemented in a timely manner.

The centre was adequately insured against accidents or injury to residents, staff and visitors, as well as loss or damage to a resident's property.

A directory of residents was maintained which now contained all of the matters as set out under regulation 19.

The designated centre had all of the written operational policies required by schedule 5 of the Regulations and they had been recently reviewed. Key policies had been updated since the last inspection including the safeguarding policy.

Nursing and medication records were found to be maintained to a good standard. However, some improvements in how records of mobility were maintained were required, as some clinical records reviewed by the inspector lacked detail and key content about how residents could mobilise using steps, mobility aids and use of the stair-lift.

Judgment:
Non Compliant - Major

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The assistant director of nursing post was vacant at the time of this inspection as she had been promoted to the role of person in charge. However, two newly-appointed clinical nurse managers were in post and are also available to support the absence of the person in charge for any reason.

The provider has submitted the required information on the relevant people who are participating in the management of the centre. One clinical nurse manager completed an interview on the second day of the inspection to establish fitness to undertake this role and confirmed information submitted to HIQA by the provider.

Deputising arrangements were found to be clearly outlined in the statement of purpose and confirmed on inspection.

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

Overall the inspector found that there were adequate systems in place for safeguarding residents. The provider confirmed that he was not involved with supporting residents with their finances, or acting as a pension agent for any resident at the centre.

The inspector reviewed all measures in place to protect residents from being harmed or suffering abuse. The centre was guided by policies on the protection of vulnerable adults and policies read were updated in October 2016 to reflect best practice.

The person in charge took the lead for safeguarding at the centre, and was a key person when a response was necessary. Staff confirmed to the inspector that they would report any concerns to the person in charge, or her deputy.

Care and communication was observed to be mostly person-centred and in an environment which promoted residents' rights. Staff spoken with were knowledgeable of the different types of abuse and the reporting arrangements in place. The inspector spoke with a number of residents who said that they felt safe and secure in the centre.

The person in charge was aware of the legislative requirement to notify any allegation of abuse to HIQA. A number of notifications had been received since the date of the last inspection which were examined by the inspector. These had been notified within the required three day time frame. Some of the notifications submitted related to concerns relating to residents' rights to privacy and dignity. The inspector reviewed records and was informed that an investigation had been completed by an external third party. The report was requested from the provider and the inspector was informed that this was now nearing completion. On completion, this report would be submitted to HIQA. The inspector saw evidence that all residents had been safeguarded throughout the process and had access to independent external supports and advocacy services.

The inspector saw that additional staff training in the protection of vulnerable adults and privacy and dignity had taken place for all staff and this was up to date. All staff had received appropriate training and refresher training since the time of the last inspection. Additionally, the provider had put in place systems to review of the effectiveness and impact of this training.

A policy on the management of responsive behaviours that guided practice was in place. A sample of resident records for residents who had presented with responsive behaviours was reviewed by the inspector with the person in charge. Supportive care plans were developed and in place to inform staff and guide practice. All care plans were updated following specialist input and review from the community mental health team. Inspectors found evidenced-based tools were utilised to monitor behaviours where required. Staff were familiar with the residents and understood their behaviours, what triggered them and implemented the least restrictive interventions as outlined in the written care plan. Staff documented the rationale for use of any psychotropic medication, and audited and reviewed any use. The most recent audits confirmed a reduction in the use of psychotropic medication.

The policy, practice and assessment forms reviewed reflected practice in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011) The person in charge ensured that a detailed risk assessment took place and the least restrictive intervention was in use. Alternatives had been trialled prior to the use of any bed rails. For example, use of low-low beds and crash mats. The quarterly reports submitted by the person in charge could demonstrate a reduction in the use of bed rails and the risk register was kept up to date.

Judgment:

Compliant

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):

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

Findings:

The centre had the required policies in place relating to risk management. An up-to-date safety statement was also in place. There was a comprehensive risk register in place, which identified the risks and put controls in place either to minimise or fully control the risk. Improvements were noted since the time of the last inspection. Mobile radiators were not found to be in use in the dining room. Risks identified on the previous inspection relating to residents undertaking activity outside the centre were well managed and documented. Planning for this activity took place with the resident or residents and also took into account an overall risk assessment. Any additional supports or staff requirements were considered in the overall assessment, and a record held of this review.

The provider and person in charge had completed additional risk management theory

training and risk was fully documented on the electronic record-keeping system. The provider had a plan in place for responding to major incidents and satisfactory procedures were in place to prevent accidents.

There were systems and procedures in place for the event of an emergency and staff were familiar with the safe evacuation methods for residents. Documentation was available to ensure that all safety equipment was well maintained. Fire doors were fitted with electronic or magnetic hold open devices which would close in the event of an emergency situation. Emergency exits and fire assembly points were clearly indicated.

Infection control precautions within the centre were satisfactory. Staff were observed undertaking hand hygiene at the appropriate times. The centre was clean and household staff were able to describe the infection-control procedures in place.

As outlined in Outcome 12 of this report, there were some deficits found in terms of storage of moving and handling equipment on corridors and the storage of oxygen cylinders in the clinical room on the garden level. The provider took some immediate action in terms of the issues found in the clinical room. However, the storage of the free-standing oxygen cylinders on the floor of this room remained a hazard to staff and visitors which requires further review and risk assessment.

Judgment:
Substantially Compliant

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

Findings:
Overall, medicines were found to be managed well and safe practice was observed. Medicines management audits were conducted within the centre as part of the quality and clinical governance system in place. The inspector confirmed that improvements had taken place since the time of the last inspection. Clear systems were in place to identify and review any medication errors, omissions and variances. Records were audited by the person in charge, and error-reporting record forms were maintained by staff to a good standard.

Staff confirmed that pharmacists from the pharmacy who supplied medicines to the centre were facilitated to visit the centre and meet their obligations to residents as required by the Pharmaceutical Society of Ireland. Nursing staff were familiar with the procedure for storing, and disposing of unused or out-of-date medicines. The medication

prescription sheet contained details for prescribing crushed medications. The pharmacist had also delivered training sessions for staff involved in medicines management.

Residents were protected by the centre's policies and procedures for medication management. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system which was appropriate. Medicines were stored securely in the centre in a medication trolley or within locked storage cupboards. A secure temperature-controlled fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration. Fridge temperatures were checked and recorded on a daily basis.

Medicines requiring additional storage arrangement (controlled drugs) were stored securely within a locked cabinet, and balances were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of each shift.

The inspector observed nursing staff safely administering medicines to residents. The nurses on duty knew all the residents well, and were familiar with the residents' individual medication requirements. Medication administration practices were found to adhere to current professional guidelines.

The inspector reviewed a number of the prescription and administration sheets and identified that practices conformed to appropriate medication management practice. The inspector reviewed records which confirmed that all nursing staff had completed mandatory training in relation to medication management.

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

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care.

The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

Improvements were evidenced in residents' care plans and the inspector was satisfied that each resident's wellbeing and welfare was maintained to a high standard of nursing care and appropriate medical care. Admissions, transfers and discharges were well managed in line with policy. Any temporary absences of residents were carefully planned and supports in place to maintain residents' wellbeing.

The inspector saw that the arrangements to meet each resident's assessed needs were set out in individual care plans with evidence of resident or relative involvement at development and review.

Admissions policy and processes were reviewed with the person in charge and found to be comprehensive and detailed involving a pre-admission assessment. Family and residents confirmed their close involvement with the care planning and review process. Relatives confirmed that communication was very good standard between staff and residents.

The inspector reviewed the management of clinical issues such as wound care, nutrition, falls management, and dementia care including the management of behaviours that challenge and nutritional assessments found they were well managed and guided by policies. Care practices were found to be well managed and organised. Inspectors reviewed a sample of assessment and care plans. The person in charge and nursing staff could demonstrate improvement in record-keeping and care plans, since the time of the last inspection. Training in care planning had taken place and was now of a good standard.

Residents had access to general practitioner (GP) services and out-of-hours medical cover was in place. A full range of other services was available on referral to the local health office or privately including speech and language therapy (SALT), occupational therapy (OT) and dietetic services. Residents were enabled to make healthy living choices and enjoyed opportunities to engage in physical activity and pastimes. A physiotherapist attended the centre to provide individual and group sessions for the residents. Chiropody, dental and optical services were also provided both on a public and private basis. The inspector reviewed residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes, both in the electronic record-keeping system and on paper records.

Each resident has opportunities to participate in meaningful activities. The activity programme was based on residents' assessed interests and capabilities. The inspector spoke with several residents who confirmed they enjoyed various activities and pastimes. For example, music, prayers and physical exercises. The inspector was informed that the residents' had chosen to play bingo on the day of the inspection. Each resident's individual preferences were documented in their care plan and this information was also used to plan the activity programme. Information about religious services and activities was updated regularly with plans for the week. Some residents also chose to spend some time alone in private, and a residents' right to refuse to take part in any group activity was fully respected by staff.

Judgment:
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):

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

Findings:

At the time of the last inspection, a small number of rooms on the ground and first floor were identified as requiring an assessment for potential residents to safely use the steps to and from this area of the house. On admission, these residents would require ongoing assessment and review, and a four-monthly assessment (or more frequently if their condition changes) would take place.

Alternative rooms are made available to residents of these rooms if their mobility needs change significantly to the point that they cannot use the steps. The findings of this inspection were that a number of the rooms were not occupied, and others were used for respite stays only. The residents who occupied these rooms were fully independent with mobility or required the assistance of a mobility aid to mobilise. Overall, the governance and use of these rooms was found to be satisfactory and in line with the statement of purpose. However, records of mobility need improvement as outlined in Outcome 5 of this report.

Storage of equipment had also been identified previously as an area for improvement, relating to storage in residents' en-suites. The provider and person in charge could

evidence that this had been fully addressed and any storage in these rooms was personal storage of residents' own property. This aspect of storage had been addressed.

The findings on this inspection were that the clinical room on the garden level did not have adequate storage space. This area was frequently accessed by nursing staff and contained medicines which require additional storage precautions. This area was found to have large seated mobile weighing scales, medical equipment stored under shelves on the floor, and a equipment used for chiropody services. The storage of five oxygen cylinders both free-standing and in a stand was not safe or in line with legislative requirements. Staff working in this area could not comfortably access hand-washing facilities in this room.

The dirty utility on the ground floor did not have suitable racking to allow for drying of equipment after coming out of the bed pan washer/sterilizer.

Overall, the centre appeared well-maintained. However, the carpeting in the main entrance hall and on the main staircase appeared worn and loose in some areas. The person in charge informed the inspector that this flooring was due for replacement shortly. Some communal circulation areas did not have suitable hand-rails in place to facilitate independence.

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):

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

Findings:

The inspector spoke with residents and staff who were fully aware of how to make a complaint about any aspect of service provision. The outcome and record of satisfaction with the response to the provider with any complaints is recorded by the person in charge.

Complaints were now well managed by the person in charge, and local resolution was considered as first response. There was a detailed policy and procedure in place to ensure complaints were monitored and could be appealed. The complaints procedure was clearly displayed and outlined the name of the complaints officer. Details of the appeals process was clearly outlined. All complaints to date had now been addressed. The complaints policy was summarised in the statement of purpose.

Both residents and staff confirmed that they were encouraged and supported to express concerns whether verbally or in writing through the complaints process. The person in charge told the inspector that she encouraged a culture of openness and transparency and welcomed feedback. She also said she welcomed suggestions or complaints as they were a valuable source of information and would be used to make improvements in the service provided. Complaints were also discussed and recorded at weekly meetings held with the person in charge and the provider to inform improvements in the service.

A detailed complaints record was maintained and inspectors saw that it contained details of the complaints, and compliments and the outcome of any complaint and the complainants' level of satisfaction with the outcome.

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:

There were appropriate staff numbers and skill mix to meet the needs of residents on the days of the inspection. The inspector reviewed the actual and planned rota and found that there was enough staff on duty seven days per week to meet the specific needs and dependency of residents outlined in the statement of purpose while taking into account the size and layout of the centre. Staff were appropriately supervised and two clinical nurse managers were in post in the centre.

Staffing levels and staff turnover were identified by the provider and person in charge to the inspector as an issue during 2016. However, staffing levels had now improved.

Additional staff on duty included the activities staff, human resources manager, household, and catering and reception staff. Night staff comprised of two registered nurses and five care staff. The person in charge confirmed that there was some use of agency staff but staff turnover had decreased in recent months. Recruitment was

ongoing at the time of the inspection with some vacancies for care staff.

The inspector found that staff had up-to-date mandatory training. The training plan for 2017 was part of the plans included in the annual review of 2016. Staff had access to education and training to meet the needs of residents as outlined the statement of purpose. Staff had received a broad range of training suitable to meet the assessed needs of residents. For example, medication management, privacy and dignity, end-of-life-care and dementia care.

The human resources manager provided an overview of how staff will be supervised appropriately and how staff are recruited, selected and vetted in accordance with best recruitment practice. Nonetheless, as outlined in outcome 5 of this report some staff files did not contain all requirements schedule 2 of the regulations. Staff recruitment was not in line with policy and was found not to be fully implemented to as a measure to safeguard residents.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Leone Ewings
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:	Beechfield Manor Nursing Home
Centre ID:	OSV-0000013
Date of inspection:	24/01/2017
Date of response:	24/02/2017

Requirements

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

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

Outcome 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:

Evidence of Garda Vetting disclosure was not in place for all staff.

Staff references from their previous employers were not available in staff files.

Schedule 3 clinical records of mobility, lacked detail and key content about residents' abilities using mobility aids, stairs and the use of the stair-lift.

1. Action Required:

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

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 received Garda Vetting disclosures for all our staff working in Beechfield Manor. We checked all staff files since last inspection in April 2016. All staff have references from their previous employers and their files are up to date. We will not employ any new staff without Garda vetting disclosure being in place first. Schedule 2 requirements will be maintained.

All residents moving and handling assessment have been updated which includes detailed assessment of their ability to use mobility aids, stairs and stair lift. Also, we will continue to assess resident's Barthel score which explains resident's ability to use stairs. Moving and handling assessment and Barthel assessment will be updated on a four-monthly basis or more if they have had any changes in their condition. Schedule 3 information will be maintained.

Proposed Timescale: 24/02/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The control measures in place for the correct storage of portable oxygen cylinders in the clinical room were not satisfactory.

2. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

Two portable oxygen cylinders were returned (Two oxygen cylinders were used by residents who had passed away). The rest of the oxygen cylinders are chained to the wall. Hazard signage was and is in place – Complete.

We are improving the storage space for our Oxygen Cylinders so that it is more appropriate and as required – time scale – 03/03/17.

A secure storage unit has been ordered - it will be in place by the 31st March.

A Risk Assessment was carried out on the Oxygen Cylinders and on the Clinical Room. A Risk Assessment was carried out on Hoist Storage.

In the Clinical room, there is clear access for staff to wash their hands at the hand basin, medical equipment is now stored on shelves off the floor. Chiropody equipment is no longer stored in the Clinical room.

Proposed Timescale: 31/03/2017

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:

All the requirements of schedule 6 including storage in the clinical room and flooring in one part of the centre required review.

3. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

A secure storage unit has been ordered - it will be in place by the 31/03/17.

Carpet for the front corridor & stairs has been ordered and will be done by 10/03/2017.

Racking for sluice room has been ordered – will be in place by 16/03/17.

An assessment of the need for some additional handrail has been done, supplier was in on 24/03/17 to measure – will be completed by 31/03/17.

Proposed Timescale: 31/03/2017