

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Beech Lodge Care Facility
<b>Centre ID:</b>	OSV-0000408
<b>Centre address:</b>	Bruree, Limerick.
<b>Telephone number:</b>	063 90522
<b>Email address:</b>	info@beechlodgcarefacility.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Beech Lodge Care Facility Limited
<b>Provider Nominee:</b>	Anne Maria Moore
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	Noel Sheehan
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	66
<b>Number of vacancies on the date of inspection:</b>	0

## **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 1 day(s).

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

From: 25 May 2017 10:30 To: 25 May 2017 17:45

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable 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 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This inspection of Beech Lodge Nursing Home by the Health Information and Quality Authority (HIQA) was unannounced and was the twelfth monitoring event in the centre. The status of actions generated from the most recent inspection of 20 July 2016 was reviewed. Inspectors found that actions were completed in a satisfactory manner. Sixty six residents were accommodated in the centre on the day of inspection. Inspectors spoke with the provider, the person in charge, residents and staff members. Inspectors observed practices and reviewed documentation such as residents' care plans including medical records, accident and complaint logs, records of residents' finances, policies, minutes of meetings and staff files. Documentation in relation to residents' files was maintained on an electronic system. Medical files, audit results, complaints and incidents were maintained in paper format.

Overall, inspectors noted that a warm, inclusive environment existed in the centre. Furnishings, décor and cleanliness in the centre were of a high standard. Residents stated that they were happy in the centre and spoke in a positive manner with regard to the care they received from staff. Residents were complimentary of the choice of food served in the centre and confirmed they had an input into the choice

available. This was reflected in the minutes of residents' meeting reviewed by inspectors. Staff spoken with were knowledgeable of residents and their life stories and were observed caring for residents in a respectful manner. Residents' privacy, dignity and independence were seen to be promoted during the inspection. Both the person in charge and the provider stated they were committed to the delivery of person-centred care and continuous improvement through staff training, audit and resident surveys.

The requirements 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 formed the basis for judgments made by inspectors. An action plan was generated at the end of the report which the provider was required to complete and return to HIQA.

**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 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:**

Inspectors were informed that interim deputising arrangements for the person in charge were in place, in the absence of the deputy person in charge. This role was currently filled by the provider. Inspectors found that there was a good level of staff supervision and mentoring in place. The induction process was detailed and informative. Staff spoken with were aware of the regulations and the updated national standards which were displayed in the hallway of the centre. Evidence of consultation with residents was available in a sample of survey results and in the minutes of residents' meetings. Inspectors found that resources were dedicated on a consistent basis to upgrading residents' environment and to the continuous professional development of staff, ensuring a high standard of evidence based care.

An effective audit system was in place which ensured that a learning organisation was promoted. The person in charge stated that the results of audits were evaluated and any required improvements were addressed. In keeping with statutory requirements the annual review of the safety and quality of care in the centre had been completed. The person in charge made this available to inspectors and 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 held the full-time post since March 2016. Residents, staff and relatives stated that they were familiar with the person in charge. They stated that any concerns could be raised with her and they were confident that she would address these. The person in charge demonstrated a good knowledge and understanding 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 2016. She was aware of the regulatory responsibilities associated with her role. She informed the inspector that she had a commitment to excellent care for residents and to compliance with the statutory requirements. She described the twice daily handover reports for staff which ensured that good team communication was fostered. She met daily with the provider and discussed care issues and health and safety events.

### **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:**

The policy on the prevention of elder abuse set out the protocol in place for the prevention, detection, reporting and investigating of allegations of abuse in the centre. This had been updated on 28 April 2017. Inspectors found that measures were in place to protect and safeguard residents and these were fully implemented and reviewed on a regular basis. Staff spoken with by inspectors, were aware of the procedure to follow if they witnessed, suspected or received an allegation of abuse. Training records confirmed that staff had received appropriate, mandatory training. In addition, a questionnaire was circulated to staff following this training to assess if staff understood and retained the training information. Residents spoken with said they felt safe in the centre and stated that staff were supportive and kind.

A policy was available to guide staff in interventions and approaches for residents who exhibited behaviours which were related to the behavioural and psychological symptoms of dementia (BPSD). A number of staff members confirmed that training had been provided to them in how to support residents with dementia. Individualised care plans on behaviour issues were in place, in a sample of residents' files viewed by inspectors. Inspectors noted that the use of psychotropic medication was regularly checked by the GP and the pharmacist. Inspectors observed staff interacting patiently with residents who had been diagnosed with dementia and intervening appropriately, when necessary.

Residents who required bedrails were checked regularly to minimise any risks. Records confirming these checks were viewed by inspectors. There was evidence that consent of the resident or a representative had been sought for the use of restraint and there had been multidisciplinary involvement in decision making. Inspectors observed that some residents had the use of low-low beds following risk assessment. Cushioned mats were placed next to a number of beds to mitigate the risk of injury should a fall occur. The results of audit in the use of bedrails and alarm mats indicated that the use of some restraints had reduced during the year.

Inspectors found that residents' finances were well managed in the centre. Two staff members signed for financial transactions and a sample of computerised records checked were seen to be accurate. A resident with concerns about pension matters was reassured following a meeting with the financial administrator, who explained the 'fair-deal' system to the resident.

**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):**

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

**Findings:**

The Health and Safety statement for the centre had been reviewed. There was a health and safety (HS) officer and HS committee in place which met at regular intervals. The risk management policy was seen to be compliant with regulations and there was an emergency plan available. A robust infection control procedure was supported by diligent housekeeping staff. There was clear colour-coded system in place for hygienic cleaning procedures.

Arrangements were in place for investigating and learning from serious incidents involving residents. Documentation reviewed included prevention measures and risk assessments. The risk register had been updated on 27 February 2017. The person in charge informed inspectors that incidents were reviewed on a monthly basis and learning was discussed with staff at handover meetings and staff meetings.

Suitable fire fighting equipment was provided and fire exits were unobstructed. A daily and weekly fire prevention checklist was maintained. Fire evacuation procedures were displayed in a prominent location. Servicing of fire equipment was carried out by a suitably qualified person at the specified intervals. However, documentation was not available for the quarterly emergency lighting service. These records were forwarded to HIQA following the inspection. Records showed that fire evacuation drills were carried out monthly and staff were up-to-date with mandatory training. A personal evacuation plan (PEEPS) had been developed for each resident and these were available in the bedrooms. Staff spoken with knew the procedure to be followed in the event of a fire. However, all staff had not taken part in a fire drill evacuation exercise since their previous fire training session. For example, one staff member stated that it was over a year since she had participated in a fire evacuation drill. The person in charge undertook to ensure that all staff would be facilitated to attend a fire evacuation drill at suitable intervals, as required by the regulations.

**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:**

Inspectors found that the pharmacist was involved with staff in auditing medicines management. The pharmacist was available to speak with residents and to assist with staff education needs. Residents who had been prescribed the use of an inhaler had been instructed by the pharmacist on 'inhaler technique'. Medications were stored safely and there was a locked fridge available in the clinical room for the storage of relevant medications. There were policies in place relating to the ordering, prescribing, storing and administration of medicines. A policy had been developed on the administration of PRN (as required) medicines. Documentation was maintained in the care plans of residents who required PRN pain medication. Medicines were reviewed regularly by the GP. For example, inspectors found that a medicine had been discontinued when adverse effects had been experienced by the resident.



There were process in place for the handling of medicines in the centre and medicine trolleys were seen to be securely stored. Staff nurses spoken with had received updated medicines management training. Staff were afforded a medication competency test following training. Specialist palliative services were available to residents. Supplementary dietary products had been prescribed by the GP for residents at risk of weight loss or dietary deficiency. There were seven residents in the centre who had diabetes. Staff informed the inspector that these residents had their blood sugar levels checked at intervals. A care plan had been developed to support a resident with diabetes. This was seen to be detailed and relevant.

**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:**

A comprehensive assessment of residents' health and social care needs took place prior to admission. The person in charge carried out these pre-admission assessments. Care plans were updated on a four monthly basis and a range of assessments were carried out for example, falls assessment, cognitive assessment, skin integrity assessment and nutritional assessment. Residents and their representatives confirmed that they had been consulted regarding these reviews. Residents had access to general practitioner (GP) services from a group of GPs who were attentive to residents' needs, according to the person in charge. Specialist services and allied health care services such as, physiotherapy, occupational therapy (OT), speech and language therapy (SALT) and dietitian, were available when required. Chiropody and hairdressing services were accessed on a private basis. Records were maintained of referrals and follow-up appointments to consultants or allied health services. The centre had a physiotherapist employed in the centre Monday to Friday. The physiotherapist trained staff in moving and handling techniques and carried out mobility and risk assessments for residents and staff.

There were systems in place to encourage early detection of ill health such as temperature and blood pressure monitoring and monthly weights. Residents' right to refuse treatment was respected and documented. Documentation for these care plans

was maintained and updated on an electronic system. Relevant grades of staff had access to information on residents' medical and social care needs.

There were opportunities for residents to participate in activities which suited their needs, interests and capacities. There was an emphasis on promoting health and general well-being. Residents were encouraged to partake in outings, walks, crosswords, bingo, conversation, card games and puzzles to promote and maintain their cognitive and physical capabilities. Throughout the inspection there were a number of activities undertaken. This were discussed in more detail under Outcome 16: Residents privacy, dignity and consultation.

**Judgment:**

Compliant

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**

Person-centred care and support

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

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

**Findings:**

Inspectors viewed the policy and procedure for making, investigating and handling complaints. The name and contact details of an independent appeals person were detailed on the complaints process and contact details for the ombudsman were displayed.

Inspectors reviewed the complaints log and found that complaints were responded to promptly. HIQA had been made aware of a number of concerns prior to the inspection which were seen in the complaints log. The satisfaction or not of each complainant was recorded on the electronic documentation system. However, inspectors found that one complaint had not been recorded in the complaints book but had been dealt with informally. The person in charge stated that she would records all complaints in the concerns and complaints log in future, in the interest of transparency.

**Judgment:**

Substantially Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to***

***exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

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

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

**Findings:**

Residents meetings were held on a monthly basis and minutes reviewed indicated that the meetings were well attended. Minutes of these were seen on the notice board and in residents' bedrooms. Ministers and priests visited the centre on a regular basis. Inspectors observed that notices were on display which indicated that residents and their representatives were provided with contact information for independent advocacy services.

Two staff members were employed as activity personnel. One of these staff was the recreation and social care manager. During the inspection activities such as bingo, physiotherapy-led exercises, newspaper reading, hairdresser appointments and external walks were undertaken by a number of residents in all units, including the dementia specific unit. There was a chicken coop in the garden of the dementia unit. The chickens had been incubated and hatched in the centre. Six hens were now occupying the coop. Residents were seen to walk freely in and out to the garden when they felt like going for a walk outside. According to the staff nurse on the unit this was beneficial to residents and positively supported their well-being.

A collection of photos inserted under the glass table top in one unit proved to be very successful as regards a focus of interest and conversation with residents. These photographs and the supply of interesting books were used as a reminiscence opportunity.

There were ornaments, art work and items of interest displayed on dressers and walls in the units. One resident proudly showed inspectors her lovely painting of a cottage. The person in charge stated that staff write up documentation while sitting with residents. Inspectors observed this practice and residents appeared content when staff were present. This optimised the time spent in the company of residents and enhanced the homely atmosphere in the centre.

A variety of sitting areas were made available where residents could meet visitors in private. Visitors were observed spending time with residents in the restaurant, in the bedrooms, in the sitting room and in the gardens. During the inspection, inspectors spoke with the recreation and social care manager who spent time with residents facilitating for example, outings, gardening, pet therapy, music sessions, hair dressing, religious services, hand massage and reading. Documentation to this effect was seen in residents' care plans.

Life story information was available which was used to inform the activity plan and the

daily choice of each resident. Residents with dementia received care in a dignified way that respected their privacy. Staff were observed knocking on bedroom and bathroom doors. Inspectors observed all staff interacting with residents in an appropriate and respectful manner. A care plan had been developed for each resident's communication needs and these were seen to be implemented for residents. There were sufficient staff on duty in the dining room at meal times. Staff and residents were seen to engage in social conversation. There was a calm and relaxed atmosphere in the dining rooms. Meals were relaxed occasions and residents were seen to spend time chatting at the table when the meal was finished.

Since the previous inspection the provider had reviewed the use of CCTV (closed circuit television). Cameras had been removed from the visitors' room and a dining room to further promote privacy and dignity for staff, relatives and residents. Signage was in place indicating the use of CCTV and the related policy had been updated.

**Judgment:**  
Compliant

***Outcome 18: Suitable Staffing***

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

**Theme:**  
Workforce

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

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

**Findings:**

Inspectors reviewed the staff rota which correlated with the staffing levels which the person in charge had outlined to inspectors.. Staff spoken with stated that they felt there were adequate numbers of staff available to meet the health and social care needs of the residents. The person in charge informed inspectors that following findings on the previous inspection she had now rostered an extra staff member to be available on the dementia specific unit after tea, for observation and resident support.

Staff had been afforded mandatory and appropriate training such as prevention of abuse, behaviour associated with the effects of dementia, fire safety training, manual handling, infection control and dysphagia (difficulty in swallowing) training. Minutes of staff meetings indicated that a variety of topics were discussed such as, staff education, quality and safety incidents audits and refurbishments. Meetings were attended by the

multi-disciplinary team.

Inspectors reviewed a sample of staff files and found that records were maintained in accordance with Schedule 2 of the regulations. Files were found to have the required information including up-to-date professional registration where applicable.

Documentation was seen which indicated that robust induction processes and annual staff appraisals were carried out. The person in charge stated that there were no volunteer staff in the centre. The provider stated that all staff in the centre had the required Garda Síochána vetting (GV) in place prior to taking up their employment in the centre.

**Judgment:**

Compliant

### **Closing the Visit**

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

#### **Acknowledgements**

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

#### ***Report Compiled by:***

Mary O'Mahony  
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<sup>1</sup>

<b>Centre name:</b>	Beech Lodge Care Facility
<b>Centre ID:</b>	OSV-0000408
<b>Date of inspection:</b>	25 May 2017
<b>Date of response:</b>	12 June 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 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:

Not all staff had attended fire drills at suitable intervals.

#### 1. 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

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

of fire.

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

A fire drill schedule including evacuation has been devised to ensure that all staff takes part in fire drill evacuations at suitable intervals between scheduled fire training.

**Proposed Timescale:** 09/06/2017

**Theme:**

Safe care and support

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

Documentation was not available at the time of inspection in relation to the quarterly servicing of emergency lighting in the centre.

**2. Action Required:**

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

All documentation in relation to the quarterly servicing of emergency lightening shall be maintained in accordance with Regulation 28(1)(c)(i).

Proposed Timescale: With immediate effect 29/6/17

**Proposed Timescale:** 29/06/2017

**Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

One complaint had not been properly recorded in the complaints log.

**3. Action Required:**

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

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

All complaints or concerns shall be logged on our system, with details including any investigation, the outcome and whether or not the complainant was satisfied.

<b>Proposed Timescale:</b> 26/05/2017