Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Beech Lodge Care Facility
Name of provider:	Beech Lodge Care Facility
Address of centre:	Bruree, Limerick
Type of inspection:	Unannounced
Date of inspection:	14 November 2019
Centre ID:	OSV-0000408
Fieldwork ID:	MON-0027366

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Situated in the village of Bruree, County Limerick, Beech Lodge Care Facility offers long term care, rehabilitative care, respite care and convalescent care for older adults. The age range catered from is 18 to 65+. Our care facility is a 66-bed facility which is made up of 48 single en-suite bedrooms and nine double en-suite bedrooms. There is 24-hour nursing care available from a team of highly trained staff. Our mission is to promote the dignity and independence of residents. The designated centre consists of the following two units: elderly care unit: providing short & long-term care, respite/convalescence and palliative care, and the dementia unit: our secure 15-bed unit catering specifically for residents with dementia. This unit (the Daffodil Unit) is a 15-bed unit which includes a nurses' station, a kitchen and dining room. Residents can also access the physiotherapy room, activities area, music room and spacious garden. Here at Beech Lodge an individual programme of activities is tailored to each individual resident. Referrals for admission may come from acute or long-term facilities, community services or privately. Private admissions are arranged following a pre-admission assessment of needs including medical background, dietary requirements etc. We aim to provide the best care possible and use a variety of care assessment tools to help us to do this. We also involve both the resident and their representative in this process. We provide a G.P. and physiotherapy service to all residents. We aim to make dining a social experience. Individual dietary requirements are incorporated into the menu planning process. Catering personnel are trained in the appropriate skills and are supported by the dietitian and the speech and language therapist (SALT). The facility has its own mini bus for the use of residents. There is a monthly residents' meeting to discuss issues ranging from activities, improvements in daily life, the environment and other issues. Activities include: newspapers, exercises, brain games, music, mass, art, baking, hairdresser, bingo, Sonas, and much more. We are interested in feedback to ensure that our service is continually reviewed in line with best practice. Visitors are welcome and local community events are accessible.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 14 November 2019	20:45hrs to 22:45hrs	Mary O'Mahony	Lead
Friday 15 November 2019	09:30hrs to 17:00hrs	Mary O'Mahony	Lead
Thursday 14 November 2019	20:45hrs to 22:45hrs	Ella Ferriter	Support
Friday 15 November 2019	09:30hrs to 17:00hrs	Ella Ferriter	Support

What residents told us and what inspectors observed

Residents with whom inspectors spoke said they were happy in the centre. They were complimentary of the staff whom they said were kind and respectful.

Residents said that the food was very nice and they felt that the kitchen staff were aware of their likes and dislikes. Laundry services had improved in recent months and their clothes were nicely pressed and returned to their wardrobes.

The new activities coordinator, the new person in charge and the clinical nurse manager were known to residents. An enhanced activities programme had been developed and residents said they particularly enjoyed the craft work and the outdoor walks. They spoke with inspectors about regular outings in the centre's own mini bus which provided opportunities for community engagement, movie attendance and shopping trips, among others.

A number of residents said they attended the monthly residents' meetings. They told inspectors that they felt that they could make a complaint if they had concerns. Residents said that issues were addressed and they felt that their views were taken on board. Residents said that families were welcome whenever they chose to visit. They also told inspectors that they were afforded choice in relation to their daily lives. Contact details for an independent advocacy service were on display.

Capacity and capability

This unannounced inspection of Beech Lodge Nursing Home took place in order to establish if the findings of non-compliance of the inspection of 29 and 30 May 2019 had been addressed and rectified. As a result of serious findings of non-compliance following the previous inspection the provider had been required to attend a meeting at the Office of the Chief Inspector as part of the external escalatory process. In addition, the provider was required to submit a number of compliance plan updates to provide assurances that actions in the compliance plan, submitted following the inspection, were being implemented in a timely manner.

On this inspection inspectors found significant improvements which were highlighted within this report. The management team were found to have been proactive in addressing the previous findings of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors found evidence that there where were effective management systems in the centre, ensuring high quality person-centred care was delivered to residents. As required by the Regulations the management structure identified the lines of authority and accountability for each member of the

management team. Senior managers informed inspectors that each of the team had carried out an unannounced out-of-hours visit to the centre in order to evaluate staffing levels and residents' quality of care. The registered provider representative (RPR) was involved in the day-to-day running of the centre and there was an effective system of communication established within the governance team. The person in charge confirmed that she had frequent meetings with the RPR in order to discuss audit results and review incidents in the centre, such as falls and other significant events. Staffing, admissions and concerns were discussed also and appropriate actions taken, where required. The person in charge was supported by an experienced clinical nurse manager (CNM). There was a robust audit system established which, the CNM told inspectors, provided an opportunity to review the service provided to ensure that residents were safe and well cared for. Inspectors saw evidence of monitoring of the quality and safety of care provided to residents in the minutes of the team meetings, as well as, in documentation of actions taken as a result of a wide range of audit outcomes. Quality of life of residents and residents' care plans were further discussed under the Quality and Safety dimension of this report.

Good systems of information governance were in place and the records required by the Regulations were effectively maintained. Copies of the Standards and Regulations for the sector were available and accessible to staff. Maintenance records were in place for equipment such as fire-fighting equipment. Records and documentation as required by Schedule 2, 3 and 4 of the Regulations were secure, well-maintained and easily retrievable for review and inspection purposes. Records such as a complaints log, records of notifications, daily and weekly fire safety checks and a directory of visitors were also readily available and effectively maintained. Moreover, previous concerns had been appropriately addressed and the findings of relevant investigations were documented and available to inspectors.

Minutes of management and staff meetings seen by inspectors indicated that there was clear communication amongst the staff group. Staff meetings and shift handover reports ensured that information on residents' changing needs was communicated effectively. This was further evidenced by inspectors' findings that staff were knowledgeable of the up-to-date status of residents' well being and of any ongoing issues in the centre pertaining to training, medical reviews and residents' preferences.

Staff training records demonstrated full attendance at a range of training programmes as highlighted in more detail under Regulation 16: Staff Training and Development. A sample of rosters were reviewed and staff and residents confirmed that there were adequate staff on duty during the day. Current registration with their professional body was in place for all nurses.

Nevertheless, inspectors highlighted concerns in relation to:

Staffing levels as evidenced by:

- night-time staffing allocation which was outlined under Regulation 15: Staffing, in this report

- call bell tied up out of reach as outlined under Regulation 15: Staffing, in the report

Health care: Regulation 6:

- a resident was not adequately assessed prior to psychotropic medicine being prescribed

Assessment and Care Plans:

- Inspectors found that there was a need for more detailed information required in a number of care plans to ensure optimal care

The RPR, the person in charge and staff demonstrated a commitment to continuous improvement and quality assurance. There was evidence found throughout the inspection of quality improvement strategies and monitoring of the service with resultant improvements in the quality of life and quality of care of residents.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the Regulations in relation to qualifications and experience in the sector.

Judgment: Compliant

Regulation 15: Staffing

The person in charge who was supernumerary to nursing staff, worked Monday to Friday and a senior nurse was identified on each weekend shift. Registered nurses were assigned to nursing duties each night. Care staff, kitchen staff and household staff provided the required additional support to residents.

At the time of this inspection there were 11 empty beds in the centre. There was one nurse on duty for 36 residents in the main section of the centre at night and one nurse in the secure dementia-specific unit and adjoining corridor for 19 residents. Even though the night-time, health care attendant (HCAs) staffing levels had been increased up to 23.00 since the previous inspection, inspectors still had some concerns in relation to staffing allocation at the early part of the night, particularly from 20.00 to 23.00. At this time nursing staff were engaged in handover report and medicine administration for at least the first two hours of the shift, which meant that they were not available to supervise staff allocation and duties.

The impact of this was seen during the night inspection of 14 November 2019 as follows: When inspectors arrived in the dementia specific unit, ten residents were seen to be sitting around and walking around unattended while the nurse was busy administering medicines. The two HCAs on duty with her were required to leave the unit for a period of time, to assist a number of other residents to bed in the adjoining 'corridor', outside the entrance door to the dementia specific unit. As there were three other HCAs on duty in the main section of the centre at this time inspectors formed the view that the staff allocation required review, in relation to resident support and supervision. For example, one HCA could have remained in the dementia unit with the nurse while the four other HCAs worked together for that period of time in the general unit. This finding was based on findings of the previous inspection in May 2019 related to the negative impact of inadequate staffing on the dementia specific unit, particularly where one or more of those residents presented with responsive behaviour, as a result of the impact of their dementia diagnosis.

On the second day of the inspection inspectors saw that the call bell of a vulnerable resident, who was in bed at the time, was tied up out of reach over the bed. This was of concern as the resident was required to spend large parts of the day in bed, due to a medical condition. This was brought to the attention of the person in charge, particularly as there was no other mechanism available for the resident to call staff, if necessary.

The provider was asked to review the allocation and to keep staffing levels and skill mix under continuous review and audit.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training in mandatory and appropriate training had been afforded to staff.

For example:

- training on infection control, fire safety, prevention of abuse, understanding the behaviour and psychological symptoms of dementia (BPSD), manual handling and medication management had been afforded to staff
- fire training was seen to have been scheduled for the remaining staff members, in order to fulfill the regulatory requirement for annual fire safety training
- a number of staff were interviewed regarding their recruitment, induction, and on-going professional development. They confirmed that they had received induction training which was augmented by the required mandatory training
- staff appraisals were undertaken

Judgment: Compliant

Regulation 19: Directory of residents

This document was seen to be maintained in line with Regulatory requirements.

Judgment: Compliant

Regulation 21: Records

A sample of staff files reviewed were seen to be general compliance with the requirements of Schedule 2 of the Regulations.

- In a sample of staff files reviewed however, a curriculum vitae for one staff member was not complete in relation to accounting for gaps in the CV. This was updated following the inspection.
- a Garda (police) Vetting (GV) clearance form for one person was not easily accessible to inspectors. It was later located in an old archived file. Evidence was seen by inspectors that an updated GV clearance had been applied for in line with the in-house policy, which required an updated clearance within a specified time-frame.

An up-to-date GV clearance was forwarded following the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found on this inspection that there was a robust system of governance and management in place.

- Incremental improvements were found in the management of audits, complaints, fire safety and documentation.
- Findings on this inspection were that the designated centre was safe, appropriate, consistent and effectively managed.
- There were regular meetings with all grades of staff and the minutes were seen to be informative and relevant.
- The annual review of the quality and safety of care had been completed for 2018 and was underway for 2019.
- Staff induction and staff disciplinary policies were implemented.
- The centre was adequately resourced and met the needs of the residents.

- The person in charge stated that she felt supported by the RPR who was always contactable and regularly on site.
- The person in charge and the RPR were aware of their regulatory remit.
- There was a wide-ranging system of audit in place to review, monitor and follow up on required actions to improve the quality and safety of care and the quality of life of residents

Judgment: Compliant

Regulation 24: Contract for the provision of services

Contracts were available for each resident and they contained the required information including additional fees.

Inspectors found that the contact for a new resident, who was not capable of signing independently, had been sent to the appropriate family member for signing.

Judgment: Compliant

Regulation 3: Statement of purpose

This document had been updated to include the new governance and management arrangements.

Judgment: Compliant

Regulation 30: Volunteers

Volunteers had the required documents available in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents were notified to the office of the Chief Inspector in accordance with Regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

- Complaints were seen to be addressed and followed up.
- The procedure was displayed in an easy-to-read format which made it accessible to all.
- Relevant personnel were identified and their contact details were clearly displayed.

Judgment: Compliant

Regulation 4: Written policies and procedures

The regulatory Schedule 5 policies and procedures were seen to be adopted and implemented in the centre.

There was a system in place in the centre to review a different policy each week. This meant that staff were aware of the contents and location of the policies and procedures which underpinned care giving.

Judgment: Compliant

Quality and safety

Findings on this inspection were that the quality and safety of care was supported by a system of robust and consistent management which had been re-established in the centre since the previous inspection. Areas of responsibility were now clearly defined and this had a positive impact on the development and maintenance of quality and safety systems.

The health of residents was promoted through ongoing medical review and assessment using a range of recognised tools. These assessments included communication, skin integrity, malnutrition, falls and pain assessments. Allied heath care professionals were accessible and available to residents and evidence of their input in care was seen in the care plans. Care plans were maintained electronically. These were person-centred and based on information and knowledge from residents' life stories and preferences.

Residents' social care was enhanced by the choice of appropriate and stimulating

activities available to meet their abilities and individual needs. These were facilitated by an enthusiastic activities coordinator and her team. Residents said that they liked the outings, music, crafts and the knitting, among all the other innovative ideas. Residents' meetings were held which provided opportunities for residents to voice their opinion. Minutes of these were documented and actions were seen to be completed. Mass was said in the centre weekly and communion was available on Sundays.

Residents' rights and safety were safeguarded by more robust systems which had been developed since the previous inspection such as:

- comprehensive fire safety procedures, including detailed documentation on regular fire drills
- audit of the use and rational for restraints and bed-rails
- psychotropic medication audit
- the provision of regular appropriate and mandatory updated training
- safe financial management
- outings and community involvement
- choice in mealtimes and bedtimes
- information on an independent advocacy service

Where there were findings which were not fully compliant with the regulatory requirements these were highlighted to the person in charge and the provider representative at the feedback meeting following the inspection, specifically in relation to the following issues:

- updating of care plans
- mealtime supervision
- developing a 'future plan' with the HSE for a resident under 65 years of age with specific needs
- suitable shower facility
- risk management
- communication
- health-care

The RPR was requested to submit an outline of the aforementioned 'future' plan for the resident involved when it had been agreed and developed.

Regulation 11: Visits

- Visitors were plentiful and they said that they visited at different times throughout the day.
- The person in charge told inspectors that there was a relatives' meeting scheduled for the end of the year.

- Visitors were seen in the centre during both inspection times and a number were spoken with by inspectors.
- Relatives now had independent key-pad access to the dementia specific unit.

Judgment: Compliant

Regulation 12: Personal possessions

Rooms were personalised. Residents said that they had sufficient space for their possessions. A list of each resident's possessions was seen to be available in the admission documentation.

Judgment: Compliant

Regulation 13: End of life

Inspectors found evidence of good practice in relation to this aspect of care.

- Residents' end of life wishes had been recorded.
- Relevant medical notes were available on residents' files.
- Staff were knowledgeable of the policy.
- Palliative expertise was accessible when required.

Judgment: Compliant

Regulation 17: Premises

The premises was well maintained, repairs were attended to without delay and there was daily access to maintenance personnel.

- The doors in the dementia specific unit were being painted in various colours at the time of the inspection and this created a bright, colourful environment for residents.
- Signage around the centre was clear and contained details such as the name of the complaints officer and what to do in the event of a fire.
- Notice boards held relevant information including information on upcoming events and medical advice.
- Residents had access to en-suite shower and toilet facilities in their bedrooms, as well as accessible communal toilets.

- There were adequate sitting and dining areas in the centre, as well as a physiotherapy gym, "dome" communal areas and a visitors' room.
- The hairdressing salon was being decorated, with residents' involvement, at the time of inspection.
- Soft, and contrasting paint colours had been used in one sitting and dining space and new voile curtains had been bought for some communal rooms which all added to the homely feeling in the centre.
- The entrance hall was warm and welcoming with colourful crafts and photographs on display.
- Gardens were well maintained and accessible to residents.

Nevertheless, inspectors found that one resident could not have a shower as there was not a suitably accessible shower facility available for his very specific needs. For example, access to a 'shower trolley' on which he could avail of a shower in the supine (lying) position, if required.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Food was well presented. The menu was presented on a four weekly rota basis which ensured variety and choice.

There was evidence of the involvement of the dietitian and the speech and language therapist (SALT) in residents' files.

The chef was aware of residents' specific dietary modifications.

Staff had attended a training day on 'the dining room experience for residents'.

When support was offered with meals it appeared to be offered with discretion and appropriate care.

Nevertheless, there were a number of issues noted by inspectors in relation to the lunch time dining experience of residents in the dementia specific unit :

- staff wore blue gloves when supporting residents with their meals; this had the effect of making what should be a sociable event appear clinical
- one resident's meal was not served for over 15 minutes, which meant that the majority of residents were finished their meal before that resident was served
- there was a need for supervision in the dining room and enhanced checks on the meal delivery service to ensure that all meals were served on time

Judgment: Not compliant

Regulation 26: Risk management

The risk register was maintained and updated. The risk management policy addressed the specific risks as required under this regulation which included the risk of absconsion and the risk of elder abuse.

However, on the first night of inspection inspectors found that there was an unlocked store room on the dementia specific unit. As this was a store room for activity provisions, inspectors saw that a bag of "marbles" and a number of "squeeze" bottles of paint were easily accessible to vulnerable residents. This was of particular concern as one resident who was walking about was seen to attempt to open doors as part of his 'exit seeking' behaviour.

In addition, the door of a sluice room in this unit was also unlocked even though there were clear instructions displayed to keep these doors locked at all times.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was very clean. There was adequate access to hand sanitising gel and staff were seen to wash their hands when appropriate. Staff had been afforded relevant training in infection control practices.

Judgment: Compliant

Regulation 28: Fire precautions

All relevant daily, monthly and quarterly checks were documented in the fire safety log.

Fire training was scheduled throughout the year and all staff engaged in the annual mandatory training.

Fire drills were on going and staff spoken with described the different scenarios which they had undertaken.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were managed well in the centre as follows:

- There was very good pharmacy support and involvement.
- Two recent audits by the pharmacists had shown incremental improvements.
- The controlled drug sample checked was seen to be correct and the medicines were appropriately checked and signed by staff.
- Staff on-line training was augmented by face to face classroom training and discussion on audit results.
- A drug was identified for discussion and learning on a weekly basis which meant that staff knowledge was up to date and their continuous learning was supported.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were informative, person-centred and detailed. Care plans were maintained electronically. These were based on information and knowledge from residents' life stories and preferences.The language used when describing elements of responsive behaviour (behaviour which was impacted on by the effects of dementia) was appropriate and respectful of residents' medical condition. Residents said they were involved in care plan development and were informed of changes.

The pre-admission assessment document had been enhanced since the previous inspection. The RPR stated that if there was any concern raised in relation to an admission there was an arrangement with the relevant hospital, to assess the resident for a period of one month within the nursing home. The admission would then be mutually reassessed, in relation to suitability for the nursing home and decisions made in relation to future care.

Inspectors found that there was a need for more detailed information required in a number of care plans to ensure optimal care:

- providing a comprehensive care plan for one resident who had a very serious medical condition
- completion of all comprehensive assessment documentation
- developing a 'future' plan with the Health Services Executive (HSE) plan in relation to the supports required for a resident under the age of 65 years to enable him to fulfil his potential and lead a full, active life. This resident was in the centre for a period of one month as described above.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical expertise from the general practitioner (GP) and relevant consultants when required.

Residents were seen to access the dietitian, speech and language services (SALT), chiropody, optician, dental, palliative, public health nurses and the psychiatry of old age services. Evidence of these referrals was seen in the sample of care plans reviewed.

There was a replacement physiotherapy service at the time of inspection as the regular physiotherapist was not due to return to the centre until early December. The physiotherapist was responsible for training in the prevention of elder abuse with support from the management staff, manual handling assessments, auditing falls and restraints.

However, inspectors were not assured, based on evidence seen in the resident's care plan, that all alternatives to medication had had been explored prior to one resident being prescribed a psychotropic medicine on a 'trial basis'.

In addition, inspectors saw that while pain relief had been prescribed for a resident who required dressings for a significant wound, it was not administered at an optimal time to prevent discomfort or pain at the time of the dressing.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Appropriate care plans on BPSD and relevant supportive information was in place to support residents' needs. Training was available in dementia care and related behaviours, from a member of the management team who had extensive experience in this aspect of care. All staff had been afforded this training and staff said that it was made more relevant by the use of case studies, in order to understand the care needs of the individuals involved.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that there was evidence of a number of improvements in relation to fulfilling the Regulations on the protection of residents from abuse:

- All staff had been afforded the mandatory training training required to identify and address allegations of elder abuse.
- Management and training staff were seen to be scheduled to attend updated training provided by the HSE in best evidence-based practice in safeguarding of older people.
- Residents said they felt safe in the centre.
- They expressed confidence in the management staff.
- Visitors stated that they felt they could raise concerns with the person in charge and that their concerns would be addressed.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were generally promoted and protected in the centre.

- They had access to their visitors, to community events and to meaningful activities.
- Residents meetings were held and residents were consulted about changes in the centre.
- Any concerns raised were addressed.
- Their laundry was carefully managed and this was returned to them in a neat and tidy manner.
- Residents were seen to be nicely and appropriately dressed.
- Residents had outdoor access on a daily basis.
- The activity coordinator said that she often accompanied residents for walks to the nearby town.
- Residents said that they had voted in elections and that they could attend religious services of their choice.

Inspectors found that the in-house advocate did not have relevant training to provide the independent advocacy service required under the Regulations. This was an informal advocacy arrangement which residents could access. However, notices for residents and their relatives to access an independent, national advocacy service were on display, should a resident or relative wish to access this service.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Beech Lodge Care Facility OSV-0000408

Inspection ID: MON-0027366

Date of inspection: 15/11/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Roles and responsibilities of night duty Health care assistance's had being discussed at previous staff meetings including the introduction of two new shift's 17.00-23.00 hours and 15.00 -22.00 However on the night of inspection staff did not adhere to same therfore management have devised clear written guidelines on the role and responsibilities of additional HCA's and what areas they are resposible to during their shift. • Nursing staff have being advised to become more proactive when designating duties to HCA's to ensure safe and effective services are been delivered to residents. • To ensure future compliance management will continue to support staff through observation audits, supervision on both shifts, monitoring standards of care, will provide training where necessary and continue to communicate all finding post audits with staff.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • An up-to-date GV clearance was forwarded following the inspection 21/11/19. • The gap identified in one employee's CV was recertified immediately.14/11/19 At Interview stage, gaps in CV must be clarified by new employees and same documented and recorded in their CV. A full review and audit of all staff files in progress to ensure compliance. For Completion by 15/01/2020	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Management have been aware of this situation since pre admission as outlined in care plan and are working closely with resident disability Services and MDT. (Detailed Documents forwarded to HIQA) to obtain correct shower cradle for resident.
• At present in conjunction with resident day service, resident has access to shower facilities daily. All MDT Members are very happy with this comprehensive plan ensuring that residents care needs are meet to the high standards at all times.

• Risk assessment completed and on Risk Register re same, and sent with HSE Funding application

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• As outlined during the inspection the wearing of Blue glove is not normal practice during meal times only when handling food. All staff have being re- educated re the wearing of blue gloves. Ongoing monitoring with Management and senior staff to ensure compliance.
• Residents preference catering list is updated along with checklist has been implemented 20/11/19 for both the kitchen and Daffodil unit to ensure the appropriate supervision and required meals are in place prior to leaving Kitchen. Meals are signed off by Chef and Kitchen assistance before leaving kitchen and on arrival to Daffodil Unit meal check is carried out by staff nurse and Kitchen Assistant and signed off prior to commencement of dining. Management will monitor compliance by completing daily spot checks.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• We have added in to the nurse's daily checklist a list of all the high risk rooms' e.g. Clinical, sluice and activity store with a door checking system.
• To ensure ongoing compliance, management will continue to carry out daily spot checks and monthly Management walk around audit.
• At the end of day shift the activity coordinator must sign and state activity door is locked and keys to be given to staff nurse on duty.

• Risk assessment completed for high risk rooms and updated in Risk Register 19/11/19.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• Residents medical condition was mentioned in the detailed care plan under maintaining a safe enviroment – Separate care plan under a seperate heading and put guidelines in residents bedroom for all staff to ensure best quality care. Same completed and forwarded to HIQA on 20/11/19

• The Comprehensive care plan and Comprehensive Assessment documentation reviewed and updated for one resident and forwarded to HIQA on 20/12/19

• As discussed during feedback meeting the resident under age of 65 years was here on a month's trial to assess care needs and if these needs could be met in care facility. Referral sent to appropiate agencies, consultant and GP to support the application to reintergrate the resident into the local community and to find meaningful purposeful activities to improve the quality of life for this resident. Documentation sent to HIQA 20/12/19

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• Pain relief for wound care was reviewed by residents GP 1/8/19 and was prescribed prolonged release opioid analgesia BD and regular analgesia QDS.
- GP was asked to review frequency and times of analgesia to ensure resident was not in pain or discomfort especially prior to wound care. Post assessment review of resident by GP 12/12/19, no change to medications or times of administration.
• To ensure resident is Pain free, Abbey pain score is continued and completed prior to wound care.
• Psychotropic medication was prescribed by GP on a PRN basis and had never been administrated. Further discussion with GP, same was discontinued.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/11/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/02/2020
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Not Compliant	Yellow	20/11/2019
Regulation 21(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	15/01/2020

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	19/11/2019
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	20/12/2019
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the	Substantially Compliant	Yellow	20/11/2019

	designated centre concerned.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	20/11/2019
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	12/12/2019