

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Beechwood House
Centre ID:	OSV-0000409
Centre address:	Newcastle West, Limerick.
Telephone number:	069 62408
Email address:	beechwoodhouse@live.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Beechwood House Nursing Home Limited
Provider Nominee:	Nora Raleigh
Lead inspector:	Margaret O'Regan
Support inspector(s):	Maria Scally
Type of inspection	Unannounced
Number of residents on the date of inspection:	64
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. 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:
21 September 2015 09:30	21 September 2015 18:30
23 September 2015 07:00	23 September 2015 19:30

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

Outcome	Our Judgment
Outcome 01: Health and Social Care Needs	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 04: Complaints procedures	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. It also examined issues raised in recent information received by HIQA about inadequate staffing levels in the centre.

Inspectors met with residents, relatives, staff members, the person in charge and the provider. Inspectors tracked the journey of residents with dementia. They observed care practices and interactions between staff and residents. They used a formal recording tool for this. They also reviewed documentation such as care plans, medical records and staff files.

The person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider assessed that overall, the centre was in substantial compliance. One area was assessed by the provider as moderate non compliance. However, inspectors found moderate and major non compliances in these same areas. These are discussed throughout the report.

On the day of the inspection there were 64 residents. The provider, in her self

assessment, estimated 23 residents had dementia. The centre did not have a dementia specific unit; however, a number of residents with dementia were provided with care in the centre's high dependency unit.

The high dependency unit provided an environment for mobile residents to move around the corridors as they wished. Access to the unit was controlled by key pad access. Residents in this unit did not have free access to a courtyard; however, plans were in place to facilitate this. At the time of inspection mobile residents who wished to access the outdoors had to be accompanied by staff.

There was a variety of sitting rooms and dining areas throughout the centre. All were an appropriate size to meet the needs of residents. However, there was limited use of signs and colours in the high dependency unit and throughout the centre, to support residents to be orientated to where they were.

There were policies and procedures in place around safeguarding residents from abuse. Most staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or were informed of any abuse taking place. However, newly employed staff did not have this training. There were also policies and practices in place around managing behaviours that may be challenging and the management of restraint. In some instances risk assessments were completed in relation to the use of restraint but not in all cases. This is discussed in Outcome 2.

The resident files inspected indicated that a pre assessment was rarely completed but an assessment of residents needs was completed within 48 hours of admission. Care plans seen, set out residents' needs and provided guidance about how those needs were to be met. However, there was limited family involvement in care plans.

While it was reported to inspectors that residents had a choice of interesting things to do during the day, on the days of inspection there was limited meaningful activity provided. This is discussed in Outcome 1. Arrangements were in place to support the civil, religious and political rights of residents with dementia.

Some staff had received training in dementia care; however, the learning from this training was not fully utilised. Staff shortages were reported as part of the reason that the suggestions made at training weren't implemented. However, inspectors noted a culture within the centre of task based care as opposed to good person centred care. It was unclear if staff were trained to communicate effectively with people who had dementia. The observational tool used by inspectors showed that over several periods of the day staff engagement with residents was task orientated and there were several missed opportunities for more meaningful engagement. This is also discussed in Outcome 1 and throughout the report.

Mandatory staff training took place but it was unclear as to the content of this training. Some staff undertook courses outside of work hours and at their own expense. Some of the sample of staff files examined were incomplete. This is discussed in Outcome 5.

There were gaps in the management of complaints and this is discussed in Outcome

4. The premises were generally well maintained, spacious and clean. However, it was in need of some upgrading and this is discussed in Outcome 6.

Overall, inspectors were not satisfied that the management style of the centre maximised residents' capacity to exercise personal autonomy and choice. Residents had limited freedom to plan their own day as most were awoken early to be given their medication and breakfast. As already mentioned, inspectors noted there were limited meaningful activities. From their discussions, inspectors noted that both residents and staff saw the provision of an improved activities programme and an increase in staffing levels as the two main areas where improvement could take place. However, there was no evidence that this type of feedback was captured in the documented resident forum meetings or staff meetings.

The centre was non compliant in the six areas inspected. These are discussed in this report.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Residents' healthcare needs were generally maintained to a good standard. For example, doctors visited regularly; where needed, residents were transferred to hospital; residents were facilitated to attend specialist medical appointments. There was a policy in place that stated how residents' needs would be assessed prior to or on admission, and then reviewed at least four monthly.

Assessed needs were set out in individual electronic care plans. A review of the written and the electronic records showed that an assessment was carried out within 48 hours of admission and reviewed at least four monthly thereafter. The electronic system was updated and signed by the nurses and care assistants responsible for the records. However, it was unclear as to the extent the pre-admission assessment considered if the centre would be able to meet residents' needs.

There were inaccuracies in the touch screen electronic records. For example, residents were marked as having eaten their meal prior to the actual mealtime. Soup that was offered to one resident was not recorded.

Nursing staff had put much work into developing the care plans. In general they were written in a person centred manner. They were developed from assessments which nurses undertook. These included falls assessments, nutritional assessments, fluid intake assessments, pressure risk assessments and mental test scores. However, there was little evidence to show that residents and families were involved in developing the plans. The person in charge said involvement in care plan reviews was happening, but arranging meetings with families could be difficult.

While the plans were good in relation to healthcare needs, they were limited in their detail around residents' interests or preferences. Residents' life stories were not fully captured in these plans. Specific nurses were responsible for a set number of resident care plans. Regular staff had a good knowledge of residents' needs. However, as discussed in Outcome 5, there were regular changes in staff and this interfered with the continuity of care and the level of knowledge some staff had about the residents they were caring for.

Many of the interventions observed were task orientated. Residents in the high dependency unit had limited choice of objects to interact with. For example, there was no rummage boxes or tactile materials provided. The culture, practice and procedures of the high dependency unit did not provide the additional time needed to enable independence and functioning to residents' highest possible level. Staff worked swiftly, they got tasks completed in time and the routine was adhered to. This was the way care was directed and staff followed it. Breakfast was provided to the majority of residents between 06:00hours and 08:00. This was an unreasonable time to provide this meal.

Where residents had religious or spiritual needs these were recorded in the care plans, and it was set out how they would continue with them in the centre; for example, attending the services provided in the centre, or receiving sacrament of the sick from the visiting priest. Inspectors observed this taking place on the day of inspection.

In so far as possible, residents were facilitated to retain their regular general practitioner (GP). Referrals had been made to other services, for example to speech and language therapy and dietician. A physiotherapist worked in the centre on a full time basis. She was on leave on the days of inspection. The physiotherapist, as well as reviewing residents' needs, also provided a mobility plan for all residents and a plan to promote residents exercising. On the days of inspection, inspectors noted there was limited adherence to the physiotherapist's mobility plans. For example, staff did not always provide or support residents to stand or move. One resident, keen for a long period of time to get up from their chair but prevented from doing so by the placement of a table in front of the resident, was advised in a kindly voice by a staff member to "sit back and relax". The staff member did not appear to have awareness that the resident had been making attempts to get up for a long time. According to the physiotherapist report and confirmed by staff, this resident was able to walk with a walking frame. However, there was no walking frame in the room where this resident was seated. The physiotherapist also prescribed arm movements for this resident and the inspector did not see the resident being mobilised or supported to undertake the arm movements recommended. This resident's care is also discussed under restraint in Outcome 2. Another resident, who according to the physiotherapist plan, needed to be supported to use a rollator (walking aid). No rollator was seen by the inspector in the sitting room that this resident sat in throughout the two days of inspection. The resident was seen being brought to the sitting room in a wheelchair with the wheelchair tilted on its back wheels as there were no foot plates on the chair for the resident to rest their feet. The resident was then manually moved onto an arm chair by two staff. This was an unsafe practice for the resident and the staff. It was unnecessary, as the physiotherapy record stated the resident was able to stand and move with the assistance of a walking aid.

Referral to occupational therapy for seating assessment was inadequate. Two residents were seen to be inappropriately seated. This situation had been ongoing for a number of months. One of these residents was in the process of getting a new chair. This was confirmed by a family member. The other resident was in a semi prone position throughout the day. The resident did not change position significantly at meal times. It was unclear when or if this resident would get a seating assessment. Neither was it clear whether or not any new seating recommended would be provided.

The person in charge explained the system of information transfer that accompanied a resident to hospital or another health care setting. Where residents had been admitted to hospital, records were seen that detailed what the residents needs were, and included any medication they were prescribed. Records also showed that when residents returned from hospital, discharge notes accompanied them. These notes provided updated details about their healthcare needs and medications.

A range of evidence based tools were seen to be in use to support nursing staff in identifying any changes in areas such as nutrition and hydration, continence, depression and risk of falls. Where these tools identified a need, inspectors saw a corresponding risk assessment and care plan. For example, in relation to wound care there were clear care plans, a wound record to detail treatment, photographs to chart the wound, and GP notes to evidence the medical treatment prescribed. There was also pressure relieving equipment available such as pressure mattresses and cushions.

Judgment:

Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy in place that covered prevention, detection, reporting and investigating allegations or suspicion of abuse. The policy document gave definitions of the different types of abuse. Staff with whom inspectors spoke with had knowledge of the signs to look out for. Staff stated that if they had concerns about adult protection they would be dealt with by the provider. Such a situation had never arisen for staff. However, inspectors found there were gaps in the measures in place to protect residents from suffering abuse in that not all staff had been provided with appropriate mandatory training.

In relation to residents with dementia, the provider and staff spoke of the importance of interacting appropriately with people and listening to what people were saying to them. However, as referenced in Outcome 1, inspectors observed incidents where residents were not communicated with effectively. When staff entered a room there was limited verbal or eye contact with some of the most incapacitated residents. One incident was observed where a resident opened the door from the sitting room to a corridor in an attempt to attract staff attention. Four staff passed, not noticing that this attention was being sought.

As referenced in Outcome 1, a bed table was placed in front of a resident in such a manner to restrain the resident from standing up and mobilising. However, management staff did not view this as restraint. The resident was assessed as being at risk of falling

but there was no documentation in place to indicate that this type of restraint (the placing of a table in front of the resident) was the option of last resort. When, after an hour and a half, a staff member noticed the resident was trying to stand, no attempt was made to assist the resident to stand or walk about. This resident was capable of walking with assistance. The placing of a table in front of a resident for extended periods of time was not in line with current national guidelines or with the centre's policy on restraint.

The person in charge stated she carried out a restraint review which included eliminating the use of bedrails. This was also part of the action plan from the provider's self assessment of dementia care. It was not possible for inspectors to establish how many residents used bed rails as a form of restraint. Different staff reported different numbers and these numbers varied significantly. All beds which inspectors saw had bed rails attached. In some instances, where it was confirmed bedrails were used, a restraint assessment was not completed. Neither was there any documentation to show that where restraint was used, it was checked on a regular basis. The centre's policy on restraint referenced the use of alternative nursing measures. However, there was no evidence that alternatives were given due consideration. Beds which lowered to the ground were not in use. It was unclear whether or not one such bed was available. One staff reported a bed which lowered to the ground was available, another stated there were none but a crash mat was available and not currently in use. Some restraint records seen were not dated nor was it clear what type of restraint was to be used. In one record, the relative gave consent for restraint use which is not in line with national or international guidelines.

The use of psychotropic drugs was not routinely audited but medication was reviewed by general practitioners (GP) at least three monthly. The person in charge was clear on the considerations she would give with regards to whether or not psychotropic medication was needed. The person in charge spoke of monitoring such issues as infections, constipation, and changes in vital signs in order to establish the cause of behaviours that challenge. In general, staff were competent at managing behaviours that challenge and there appeared to be few instances of concern for staff.

Staff training records were reviewed which indicated not all staff had received the mandatory training in protection of vulnerable adults. Such training was not a routine part of the staff induction process. Some staff recruited within the previous month confirmed they had not received this training.

Residents with whom the inspectors were able to communicate verbally said they felt safe and secure in the centre, and felt the staff were supportive. A relative spoken with felt their relative was being supported by caring staff and receiving good care. Staff reported to inspectors they had attended an in house, one day training on dementia care in 2014. Staff reported this training to be interesting and helpful in gaining a greater understanding of the needs of residents with dementia. However, suggestions of good dementia care practices, discussed at the training day, had not been implemented. For example, life stories, discussed at training had not been implemented. As observed on the days of inspection, the most vulnerable residents spent long periods of time without any meaningful activity or engagement with staff. Given these findings the inspectors concluded there was a lack of leadership,

commitment or belief that the good care practices discussed at training, should or could be implemented.

Inspectors saw records that showed a range of training courses completed by staff around managing behaviours that challenge. The most recent training took place in March 2015 and 19 staff were recorded as having attended.

On 10th June 2015, 27 staff attended training on the use of restraint. It was unclear what was covered during the restraint training in June 2015 or how long the session lasted. A number of other training sessions also took place on that day. This is further discussed under staffing in Outcome 5.

Judgment:

Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors saw records which showed that residents were met with on a monthly basis to establish if they had any complaints or matters they wished to discuss. The minutes of these meetings showed that in general, residents stated they had no complaints and were happy with the care and service provided. An advocate visited the centre every week and was available to speak with residents. The advocate's primary role was the provision of pastoral support. No advocate represented people with cognitive impairment at the resident forum meetings. It was not possible to establish from the forum minutes if matters identified at previous meetings had been acknowledged, responded to and recorded, including the actions taken in response to issues raised. It was not the practice in the centre to formally conduct surveys of family members about the quality of the service provided to their relatives. The suggestion box was not easily accessible. It was kept on a high shelf at the nurse's station.

Residents with good cognitive ability choose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup. However, many male residents with dementia wore track suit pants which was not their normal style of attire. The provider and person in charge stated this helped the residents to remain independent with regard to toileting.

This was a busy centre, catering for up to 69 residents. There was a relatively high turnover of staff, which made it impossible for staff to know each resident's individual preferences. A key worker system was not in place. Activities were primarily dictated by the routine and resources of the centre, as opposed to the wishes of residents or the suitability of the routines.

Inspectors noted how nursing staff interacted with residents in a kind, attentive and respectful way. However, there were numerous missed opportunities for residents to experience a more meaningful engagement with staff. This was noted when inspectors carried out formal observations and recorded their findings. For example, when staff entered a sitting room the purpose appeared to be, to physically check that everyone was alright or to collect something. When communication was made with a resident, it was normally with the resident who was best able to attract attention. During the days of inspection there were a limited range of activities taking place. As noted on formal observations, some residents spent up to one and half hours with no communication with staff or with anyone. Throughout the two days of inspection, apart from providing assistance at meal times, neither inspector saw staff sitting and talking to residents on a one to one basis.

The main dining room was seen to be used by many residents and was attractively decorated. Tables were nicely set and there was good attention given to creating a pleasant dining experience. Residents in the high dependency unit had access to dining tables but the setting of tables was haphazard. Notwithstanding that it would be more of a challenge to maintain a nicely set table in this unit; minimum effort was made to ensure that mealtimes were social, unhurried occasions. Efforts were made to support residents to eat independently with plates adapted to support self feeding. However, inspectors noted there were a few occasions where residents were encouraged to eat more quickly or were spoon fed unnecessarily. When assistance with meals was offered, it was sometimes without any communication and in one instance the staff member stood over the resident while providing assistance. One resident with dementia acted in a child like manner; for example, the resident talked about doing lessons, being quiet and referred to her mother. The resident was able to feed herself albeit she was forgetful about eating. Assistance was given to her by means of spoon feeding and telling her "I'll have to tell your mother about you". Although the intension was to ensure the resident ate her meal, this approach was unnecessarily paternalistic and could potentially be interpreted as a threat.

There were some practices observed which compromised modesty, privacy and dignity. For example, the inspector saw one instance where a toilet door which opened onto a corridor, was left open while the resident was being assisted to use the toilet. In another instance, a staff member made a joke which a resident appeared to take exception to. Screening curtains were not in place in all twin rooms.

The person in charge and provider told inspectors, that residents were supported to exercise their political rights in past elections and referendums.

Overall, residents had limited freedom to plan their own day as most were awoken early to be given their medication and breakfast. As discussed in Outcome 1 there were limited meaningful activities observed. Residents had not been on an outing this year, reportedly because of staffing limitations. As discussed in Outcome 6, access to the outdoors was restricted for residents in the high dependency unit.

Judgment:
Non Compliant - Major

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

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

Further updates were also required to ensure the policy complied with regulations. The policy did not reflect practice in the centre. It stated that the complaint was to be reviewed by the nurse in charge; however, the provider nominee informed inspectors that she was the nominated complaints officer in the centre. Also, the policy stated that complaints data was analysed twice a year and that an annual audit was undertaken to determine compliance with the policy and procedure; however, this was not evident in practice. It was not set out in the complaints policy who the independent nominated person was to oversee that all complaints were appropriately responded to and records maintained; however, inspectors were informed that this person had been identified by the provider. The complaints policy also required updating to reflect details of the appeals process.

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

Judgment:

Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

The inspector looked at a sample of staff files and found that they did not all contain the required information in relation to matters identified in Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013. Two staff files viewed did not contain full employment histories. One staff file did not contain evidence of application for Garda vetting. A staff appraisal system was implemented for staff and the inspector saw evidence of this in staff files viewed.

There was a clear management structure and staff were aware of the reporting mechanisms and the line management system. The provider had adequate changing facilities in place for staff.

While residents and relatives indicated that staff treated them with respect and dignity; some residents informed inspectors that they might be waiting quite a while for drinks. They said they would not like to bother staff as they appeared to be "rushed off their feet". During the inspection, residents were seen to receive attention from staff. There were examples of good interaction where staff and residents chatted with each other. However, there were also examples of poor interactions or no interaction. This was noted in particular in the high dependency unit. Some staff engaged well with residents when assisting at meal times, others held no conversation or spoke with someone other than the person they were assisting.

Inspectors reviewed staffing rotas, staffing levels and skill mix and found that on both days of inspection, there was one nurse on duty in addition to the person in charge and six care staff to meet residents' care needs. The staffing level at night was one nurse and three care staff. These staffing arrangements, supports and working conditions, did not take adequate cognisance of the complex cognitive, physical, psychological and social needs of residents with dementia.

Due to the number of residents in the centre and the layout and design of the centre (three floors), inspectors found that one nurse was insufficient in order to ensure safe medication administration practice. The administration of the morning medication was primarily the duty of the night nurse who reported that she started her medication round at 06:00hours in order for it to be completed by 08:00hours. The night nurse reported she regularly stayed on duty after 08:00hours to complete the medication round. The person in charge stated she regularly came on duty early to assist with medication administration. This dependency on the goodwill of staff to provide extra hours to ensure medication was administered, was unsustainable. For one nurse to administer early morning medication to approximately 57 residents, practices had developed which were unsafe and not in line with professional guidelines. For example, medication requiring to be crushed was crushed during the night to save time in the morning. Part of the administration record was completed during the night and signed off at the time of actual administration. Some medication pods were removed from their tray during the night in readiness for the morning. When medication errors happened there was very little reflection or examination of the reasons why the event occurred. Medication charts were transcribed every three months. The transcribing nurse did not sign these sheets as per professional guidelines nor were the transcribed charts checked by a second nurse. The charts were signed by a GP.

The majority of residents were awoken early for their medication and their breakfast.

The inspectors considered this to be an institutionalised practice. In addition, the observations that inspectors noted during formal observation, indicated task based care. There was a sense that the routine dictated the way the centre was run. Residents were generally safe in the centre but there was much more that could be done to make the environment a better place for residents to live, in particular those with dementia.

Inspectors viewed staff training records. However, it could not be discerned from the records whether all staff had completed mandatory fire and evacuation training, manual handling training and training in relation to the detection and prevention of and response to abuse. An overview sheet or a staff training matrix was not available. Two staff informed inspectors they had not yet received training in the detection and prevention of and response to abuse.

Two in house training sessions were carried out on 10th June 2015, one in the morning and one in the afternoon. It was provided by the person in charge and the physiotherapist. Many staff attended and records of attendance were maintained. It was unclear how long each session lasted; some staff reported two hours others said four hours. Seven different training topics were covered in each two to four hour session. The topics included adult protection training, moving and handling training, end of life care, use of defibrillator and cardiopulmonary resuscitation (CPR), falls and chest infection management, use of restraint and oral hygiene. Even allowing that some of these topics were updates for staff rather than first time training, it was difficult to see how all of these topics could be covered at the required depth in a few hours. In the case of manual handling, the last training before the 10th June 2105 training was recorded as having taken place on 27 November 2012. Also in that two and a half years there were new staff employed and new moving and handling equipment purchased. The person in charge had trained as a manual handling instructor and was assisted on the training by a physiotherapist; however, this instructor training took place in 2009. It had not been updated and was not current. As discussed in Outcome 1, the inspector observed poor lifting and transfer practices. Inspectors concluded a more comprehensive moving and handling training programme needed to be provided.

Shift handover meetings took place at the beginning of each shift. Another meeting took place at 12noon. Staff reported the 12noon meeting to be particularly beneficial as it was an opportunity for staff to report on the findings from the morning's work. Staff meetings took place approximately twice yearly. Minutes were maintained of these. Meeting also took place between management staff but these appeared to be informal and no minutes were maintained.

In theory there was a system in place to induct staff and a staff member was assigned to this. However, in practice this was not effective. For example, the person responsible for staff induction did not know if new staff had or were awaiting mandatory training. In some instances staff were rostered for night duty without completing an induction process. The person assigned to induction did not have up to date fire training.

The person in charge stated that the level of resident dependency guided staff numbers. Both the provider and the person in charge were aware of the need to recruit extra nurses. Inspectors were informed by the provider that she was in the process of recruiting through a number of employment agencies. A new staff member was due to

commence night work on the second day of inspection. This was to be an extra staff member over and above the regular three staff that were on duty. However, when inspectors visited the centre at 07:00 hours, inspectors were informed this new staff member had not turned up for duty the previous night. The issue of inadequate staffing had arisen in a number of previous reports and continued to be a serious concern on this inspection. In the weeks prior to this inspection, inspectors received information expressing concern with regards to staffing levels at this centre.

Inspectors had concerns about skill mix and the limited options on some shifts for residents to have a female member of staff attend to them. There was an inaccuracy in the roster in that one staff member was rostered for two different duties at the same time. To alleviate the staffing situation administrative staff provided on the floor assistance throughout the two days of inspection.

From examination of the roster it was evident that staff, in particular nurses, worked many hours over and above a 40 hour week. This was to cover for annual leave, sick leave and uncovered shifts. Even with these extra hours there was only one nurse (apart for the person in charge) on duty at any time. The shortage of nurses has been a long standing issue at this centre as evident from previous reports.

Inspectors concluded that the number and skill mix of staff was inappropriate to the needs of the residents and the size and layout of the centre.

Judgment:

Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The older part of the building was originally a private home. This part of the centre was now used primarily as sitting, dining and therapeutic areas and staff facilities. Bedrooms were located in the purpose built extension. This extension was three storeys. There were several interesting seating areas throughout the centre. Some of which had access to a secure outdoor area. Improvements since the last inspection included the provision of visual aids such as picture menu boards and picture weather boards. Also a phone was made available in a quiet room for residents to take private calls.

The location, layout and design of the centre was generally comfortable and homely. However, parts of the premises required redecoration and upkeep. For example, some upholstery was stained, some bedspreads were torn, a picture frame was broken and many bedrooms were not personalised. A section of the ground floor was designated a

high dependency unit. A number of residents in this area experienced dementia. In this unit there was limited appropriate signage and use of colours and lighting in line with best practice dementia care principles. Access to the garden from this unit was restricted. Most of the residents in this unit could only access the garden/outdoors on request.

Access to the high dependency unit was via keypad code. The inspectors were advised by the person in charge and provider that this was to ensure the security of who was entering and leaving the centre. They explained residents who had capacity to manage the keypad safely, had access to the code.

All bedrooms had an en-suite facilities. The full ensuite facilities were generous in size and helped to promote independence and dignity. There were also bathrooms and toilets along the corridors for residents to access. The seating areas in the high dependency unit had scope to be decorated in such a manner to provide a greater level of stimulating décor for residents to look at. For example, there was little use of contrasting colour on walls or doors.

There were limited visual cues for people to recognise their bedroom. Some residents had brought their own furniture as well as pictures and ornaments; however, this was the exception. The provider informed inspectors that, residents and/or their families were not keen to bring personal effects into the centre. Several residents had in their rooms, a painting they made while in the centre. The provider needed to create more opportunities for display of such work or revisit the discussion with residents and their families about bringing in photographs or other memorabilia to assist with reminiscence. Inspectors concluded that staffing levels and the emphasis on task based care stymied opportunities to attend to these aspects of care. Staffing is discussed in Outcome 5.

It was observed that there was adequate room in the bedrooms for furniture including a bed, a chair and storage, albeit that not all rooms actually had a chair for each resident. The rooms also had enough space for equipment such as hoists to be used, with sufficient space to access the beds from either side.

Bedrooms, bathrooms and communal areas had access to a call bell, with the exception of a small sitting room in the high dependency unit. In bedrooms viewed by inspectors, the call bells were accessible to residents when in bed. Residents had access to a visitors' room whereby they could meet with family and friends in private.

There was a well equipped kitchen and a range of other rooms including a physiotherapy room, laundry, a treatment room and other offices. Corridors had grab rails, and were seen to be clear of any obstructions. Residents who did not require assistance with mobilising were seen to be moving as they chose within the centre. Hoists seen in the centre were in working order and were regularly serviced.

Wheelchairs were regularly operated without footplates. In one instance where a resident was being transferred from the bedroom to the sitting room, the wheelchair (which was missing the footplates) was tilted on its two back wheels and pushed along in this manner. There were instances where hoists were used to transfer residents when the resident had capacity to weight bear or walk. This is further discussed in Outcome 1.

It was unclear if this was a result of poor practice, staff being rushed or staff having had inadequate training. Training is further discussed in Outcome 5. Such practices did not aid people to maintain their mobility as long as possible.

Judgment:

Non Compliant - Moderate

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:

Margaret O'Regan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Beechwood House
Centre ID:	OSV-0000409
Date of inspection:	21/09/2015
Date of response:	11/01/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

There was inadequate information available to confirm that residents and/or their families were involved and had access to the resident's care plan.

1. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent

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

of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

All care plans are in the process of being reviewed with the input of resident and family

Proposed Timescale: 15/01/2016

Theme:

Safe care and support

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

The assessed physiotherapy needs of residents were not met.

The culture, practice and procedures of the high dependency unit did not provide the additional time needed to enable independence and functioning to residents' highest possible level.

2. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

The provider instructed all the staff about the person centred care. The provider increased staffing levels which will provide additional time needed to enable independence and functioning to the residents highest possible level. The provider will ensure all the staff will adhere to the physiotherapists mobility plan. The residents walking aids will be available in the same room and staff members will assist if the resident wishes to mobilise.

Proposed Timescale: 14/12/2015

Theme:

Safe care and support

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

Inadequate provision was made for access to appropriate seating assessment.

3. Action Required:

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

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

Have acquired the services of an O.T. Assessment record is attached for the resident. 4

new recliners have been ordered and we are awaiting delivery.

Proposed Timescale: 23/12/2015

Theme:

Safe care and support

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

Inaccuracies in information inputted into the electronic records impacted on knowing whether each resident was provided with adequate quantities of food and drink which meet the dietary needs.

4. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

This error has been rectified and the nurse in charge will supervise to make sure that all residents are provided with adequate food and fluid intake which will meet with the resident's needs and are recorder accordingly. The nutritional assessments are done monthly and the high risk assessments are done weekly by the nursing staff. The food charts are being maintained for the residents who are at high risk of MUST. Copy attached

Proposed Timescale: 06/12/2015

Theme:

Safe care and support

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

Breakfast was provided to the majority of residents between 06:00hours and 08:00. This was an unreasonable time to provide this meal.

5. Action Required:

Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

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

The person in charge will ensure the residents breakfasts are provided from 7am to 10 am or at whatever time is requested by the resident

Proposed Timescale: 25/11/2015

Theme:

Safe care and support

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

Inadequate records were maintained of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet was satisfactory in relation to nutrition and otherwise.

6. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

The provider will ensure that the fluid and food charts are maintained in writing and the nutritional supplements are given to the resident in relation to their nutritional needs. Attached is a copy of a current food chart and the electronic record is being checked by the nurse in charge on each shift.

Proposed Timescale: 06/12/2015

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Assessment did not always take place prior to the use of restraint. There was inadequate evidence that alternatives were considered prior to restraint being used. It was not possible to establish the number of residents using restraint. Where restraint was used there was no evidence to show when it was put in place, when it was removed or the frequency in which it was checked.

7. Action Required:

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

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

We have removed bedrails that are not in use and the restraint folder is available for inspection. The restraint assessments are updated. Restraint release form will be available for inspection.

Proposed Timescale: 18/12/2015

Theme:

Safe care and support

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

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

8. Action Required:

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

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

Staff training records were reviewed and staff who did not attend the elder abuse course have been trained. Staff training matrix has been put in place. Copy attached.

Proposed Timescale: 20/11/2015

Theme:

Safe care and support

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

Records were not maintained of all occasions in which restraint was used.

9. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

The registered provider has ensured the restraint assessment is completed for the residents and is available for inspection

Proposed Timescale: 18/12/2015

Outcome 03: Residents' Rights, Dignity and Consultation**Theme:**

Person-centred care and support

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

There were inadequate opportunities for residents to participate in activities in accordance with their interests and capacities.

10. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to

participate in activities in accordance with their interests and capacities.

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

The provider will ensure that the residents will participate in activities in accordance with their interests and capacities. An activities co-ordinator has been recruited for 5 days a week 4 hours a day.

Proposed Timescale: 07/12/2015

Theme:

Person-centred care and support

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

Residents had limited choice in relation to breakfast and morning medications times. Some residents had limited freedom with regards to accessing the outdoors.

11. Action Required:

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

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

Breakfast and medication times have been changed to a later time as per the resident choice. Residents in the high dependency will have access to the outdoors independently or accompanied by a member of staff weather permitting. Safety gates have been ordered for the stairs enabling the residents more freedom independently.

Proposed Timescale: 30/01/2016

Theme:

Person-centred care and support

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

There was an instance where the toilet door was not closed when the resident was being assisted in the toilet.

12. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

The provider has instructed all staff to be more observant and to maintain the residents privacy and dignity when toileting and during their personal activities.

Proposed Timescale: 24/09/2015

Theme:

Person-centred care and support

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

From observations it was noted that some residents communication needs were not met.

13. Action Required:

Under Regulation 09(3)(c) you are required to: Ensure that each resident may communicate freely.

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

Staffing levels have been increased and duties have been reviewed. This enables staff to have more time to sit and communicate with the residents especially those in the HDU who have communication difficulties.

Proposed Timescale: 23/12/2015

Theme:

Person-centred care and support

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

Each resident, in particular those with dementia did not have adequate access to independent advocacy services. Their views/needs were not represented at the resident's forum.

14. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

All residents have now been included in the residents council meeting which takes place monthly. Their views and needs were represented by a member of staff. Their issues will be responded to and recorded including the actions taken in response to issues raised. Copy of feedback form is attached. Independent advocate to be arranged

Proposed Timescale: 30/01/2016

Theme:

Person-centred care and support

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

Some residents who had communication difficulties were not facilitated to communicate

freely, having regard to their wellbeing, safety and health.

15. Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

The registered provider has ensured that extra staff have been employed to look after the residents wellbeing, safety and health.

Proposed Timescale: 23/11/2015

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy had not been reviewed since 12/08/2012. This was a period exceeding three years

16. Action Required:

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

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

The complaints policy has been reviewed and updated.

Proposed Timescale: 25/09/2015

Theme:

Person-centred care and support

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

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

17. 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:

The complaint book has been reviewed and updated and the provider will ensure the procedure will be maintained at all times

Proposed Timescale: 25/09/2015

Theme:

Person-centred care and support

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

Not all complaints were fully and properly recorded with the results of any investigations into the matters complained of and any actions taken on foot of a complaint included.

18. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

The provider will ensure that results of any investigation and action taken on foot of a complaint will take place in a proper period of time and recorded in the complaints book. Seperate complaints book maintained and kept in the designated centre other than residents individual care plans.

Proposed Timescale: 09/11/2015

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Over the course of the inspection, inspectors observed that there was insufficient staff with the skills and experience to meet the assessed needs of the residents.

19. Action Required:

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

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

Extra staff have been recruited, the key worker system will be in action by 2nd January

2016 on all shifts. The rosters will; be done as per the skill mix requires for the best needs of residents. Paper work attached.

Proposed Timescale: 02/01/2016

Theme:
Workforce

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

It could not be discerned from the records whether all staff had completed mandatory fire and evacuation training, manual handling training and training in relation to the detection and prevention of and response to abuse. Two staff spoken with informed inspectors they had not yet received training in the detection and prevention of and response to abuse.

20. Action Required:

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

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

The person in charge has ensured all staff are up to date with training standards including fire and evacuation, elderly abuse and all other mandatory training. The new employees will not be rostered as extra staff until all mandatory training is completed

Proposed Timescale: 26/11/2015

Theme:
Workforce

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

Two staff files viewed did not contain full employment histories including satisfactory history of any gaps of employment. One staff file did not contain evidence of Garda vetting.

The duty roster of persons working at the centre was inaccurate.

21. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All staff files are currently being updated to include employment history. A copy of garda vetting forms sent away in the future will be kept in the staff file until the original comes back.

Proposed Timescale: 18/12/2015

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

The premises were clean and well maintained but in general bedrooms were not personalised.

Parts of the premises required redecoration and upkeep. For example, some upholstery was stained, bedspreads were torn, a picture frame was broken.

There was a safe outdoor space for residents but for many residents with dementia it could only be accessed on request.

Wheelchairs were frequently used without footplates in place. This improper working order of wheelchairs compromised resident safety.

An emergency call bell was not available in one sitting room.

22. 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:

The provider has contacted relatives and encouraged them to bring in personal effects to recall and maintain the residents memories. The bedrooms will be decorated with the residents arts and crafts. The torn bedspread is replaced, broken picture frame removed. Residents with dementia will be taken outside on a regular basis weather permitting. All foot plates have been fitted on the wheelchairs. Emergency call bells have been ordered for the sitting room in the HDU.

Proposed Timescale: 28/02/2016