Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Beaufort House
Centre ID:	OSV-0000709
Centre address:	HSE Navan Community Health Unit, Beaufort House, Athboy Road, Navan, Meath.
Telephone number:	046 909 9101
Email address:	
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Una Fitzgerald
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	44
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

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.

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor 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:
06 March 2018 10:00	06 March 2018 18:00
07 March 2018 10:00	07 March 2018 15:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Substantially Compliant
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. Prior to the inspection, the centre completed the provider's 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 Standards for Residential Care Settings for Older People in Ireland (2016).

The inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The person in charge had proactively engaged with all stakeholders to ensure that the culture within the centre was open and transparent. The management team responsible for the governance, operational management and administration of

services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff of the centre were striving to continuously improve residents' outcomes. A person-centered approach to care was observed. Residents appeared well cared for. There was good evidence that independence was promoted and residents had autonomy and freedom of choice. Residents spoke positively about the staff. The inspector met with the residents, some of whom had advanced dementia. The inspector also spoke with family members of residents who had dementia. The feedback was overwhelmingly positive.

The case files were examined and of a number of residents including those with dementia were tracked. A validated observation tool was used to observe practices and interactions between staff and residents within the centre. Specific emphasis focused on residents who had dementia. Documentation such as care plans, clinical records, policies and procedures, and staff records were reviewed. The centre was in transition of implementing an electronic system of capturing clinical data.

Beaufort House is a registered designated centre that provides care for a maximum of 44 residents. On the day of inspection there was a total of 13 residents with a formal diagnosis of dementia and a further 11 residents who have symptoms of dementia.

The inspector observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. The results from the formal and informal observations were positive and staff interactions with residents promoted positive connective care. The living environment was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness. Residents had access to multiple outdoor gardens that were well maintained.

There were policies and procedures available to inform safeguarding of residents from abuse. Staff spoken with adopted a positive approach towards the management of responsive behaviours. The centre promoted a restraint free environment. However, improvement was required to ensure that residents who used bedrails were appropriately monitored and safe.

The action plans from the previous inspection was followed up and found to be addressed satisfactorily. Garda Vetting disclosures are in place for all staff and volunteers. The findings and improvements required are discussed within the body of this report and set out in the action plan at the end for response.

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

Outcome 01: 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:
This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The centre is currently in progress of transferring all clinical care plans and documentation onto an electronic system.

The inspector focused on the experience of residents with dementia and tracked the journey prior to and from admission into the centre. In addition files were reviewed on specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medication management and end of life care.

Arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge or deputy visited prospective residents prior to admission. This arrangement gave the resident and or their family an opportunity to meet in person, provide information about the centre and assess or determine if the service could adequately meet the needs of the resident.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. In addition, an assessment using a validated tool of the level of cognitive impairment of residents admitted with a diagnosis of dementia was recorded and subject to regular review.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to a general practitioner (GP) and allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, dental, ophthalmology and podiatry services were available.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. A care plan was developed following admission. In the sample reviewed, information following the assessment, involvement and recommendations of allied healthcare professionals was reflected.

Arrangements were in place to evaluate existing care plans routinely on a four monthly basis. The care plans examined were updated or revised to reflect the residents' changing care needs. However, evidence that residents and or family, where appropriate, participated in care plan development and review required improvement. A record to demonstrate their involvement was not routinely maintained.

Staff provided end of life care to residents with the support of their GP and community palliative care services. 'End of life' care plans were documented in all files. Some included residents' expressed preferences regarding their preferred setting for delivery of care while others included that the family were to direct care at the end of life. The centre has a family room that is designed to meet the needs of family and friends who wish to stay overnight within the centre.

Staff outlined how religious and cultural practices were facilitated within the centre. Residents were satisfied with the arrangements in place. There is daily televised mass and weekly mass in the unit.

There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Procedures and care plans were in place in relation to nutritional care.

The inspector saw that a choice of meals was offered and available to residents. There was the system of communication between nursing and catering staff to support residents with special dietary requirements. The inspector was told by the chef on duty that the menu had been subject to review by a dietician.

Dining arrangements were set up in three separate locations, the main dining hall and two smaller dining rooms. Mealtimes were seen as a social event with appropriate table settings. Staff sat with residents while providing encouragement or assistance with the lunch-time meal observed. The catering staff were familiar with the likes and dislikes of all of the residents. The inspector observed on two separate occasions a resident request an alternative choice that was not on the menu. This was facilitated.

Resident's skin integrity was constantly monitored. A system was in place to highlight and communicate the risk rate to all staff. The use of a traffic light system with symbols was seen on all resident's bedroom doors. The inspector was informed that this system had been introduced to highlight and remind staff of the resident's risk on pressure sore development. All staff spoken with were able to explain the purpose and function of the symbols and colour codes seen.

Residents had access to a pharmacist and general practitioner (GP) of their choice. A multidisciplinary team that involved the pharmacist, GP and a clinical nurse manager reviewed medication kardexes and medicines management practices. Residents were protected by medication practices and procedures found. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents that were implemented in practice. Medicine administration records were

maintained in accordance with relevant professional guidelines.

Judgment:
Substantially Compliant

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:
The centre had policies dated January 2017 in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. The centre has a dedicated safeguarding officer who is certified to deliver the training. All staff had received training on identifying and responding to elder abuse. Staff were able to explain the different categories of abuse and had knowledge of what their responsibility was should they suspect abuse. In addition staff spoken to were clear about who they would report any concerns too.

The centre had a policy dated May 2017 on the procedures in place to support staff in working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. There was no resident within the centre on the day of inspection who had responsive behavioural issues.

The centre promoted a restraint free environment. Additional equipment to reduce the use of restraint such as low level beds and sensor alarms were available. The inspector reviewed the care plans of some residents currently using bedrails. The documents and procedures in place required a full review. Risk assessments were not routinely carried out. The care plans did not guide practice. The clinical nurse managers report and staff confirmed that an hourly check is carried out nightly on all residents. Safety checks for residents with bedrails in use were not in place. This was discussed with the nursing management during the first day and an immediate action was taken by the person in charge. A new safety check system was implemented and the evidence of this was seen on day two of the inspection.

Systems and arrangements were in place for safeguarding residents' finances and property which met the requirements of the regulations. The accounting process was demonstrated to the inspector by staff. The procedures and processes for safeguarding residents' finances were clear and transparent. The centre was a pension agent for seven residents. The administration staff confirmed that the centre management is in line with the Department of Social protection guidelines. Procedures were in place to

facilitate residents to access their money when required.

Judgment:
Substantially Compliant

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:
Residents are consulted about how the centre is planned and run. There are monthly resident and family forum meetings that are documented. During the first day of inspection the monthly meeting was held and the inspector observed that there was good resident representative at the meeting, including residents with dementia. There was a resident survey conducted in July 2017 as evidenced in the annual report. The feedback was very positive. The survey results were reviewed and three actions were taken as a result of resident feedback. Residents also have access to independent advocacy services.

Residents are facilitated to exercise their civil, political, religious rights and are enabled to make informed decisions about the management of their care through the provision of appropriate information. There are information notice boards at strategic locations throughout the centre. There is a display board at the main sitting room that has the names and pictures of all staff identifying their role. There are arrangements in place for each resident to receive visitors in private.

Residents with dementia receive care in a dignified way that respects their privacy at all times. Residents availed of a varied activity programme. Activities developed for resident with dementia formed part of this programme, and this had a positive impact on those who participated. There was a big emphasis on music and the inspector observed an afternoon of music that was thoroughly enjoyed by the residents and family members that attended. The atmosphere in the room was positive, welcoming and inclusive of all. Residents sang along. The staff who were supervising the room were actively involved.

Residents' links with the local community were maintained where possible, and this was supported by access to local media, Internet and telephone services. Frequent visits from members of the local schools were also well-received by residents.

Each resident has opportunity to participate in activities that are meaningful and purposeful to their needs, interests and capacities. Residents with advanced dementia were included in group activities. The activities staff conducts one to one activities when possible. The staff were knowledgeable on the lives and life stories of residents prior to

living in the nursing home. Each resident with dementia has a comprehensive and detailed document titled "Remembering Yesterday living Today". This document was person centred, individualised and gave excellent insight into the individual resident likes, dislikes, and social background prior to living in Beaufort House.

Judgment:
Compliant

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:
There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place in the reception area. The person in charge was involved in the management of complaints received. The inspector reviewed the complaints log. Records indicated that complaints were minimal, a total of three in 2017 and one in 2018. Residents were informed on admission of the complaints procedure.

The management of all complaints received had been investigated promptly, a record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome.

Residents spoken with on the day told the inspector that they would not hesitate to make a complaint if they had one. Relatives voiced satisfied with the care and were aware of who they could complain to if they needed.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Ongoing review of resident

dependency and staffing levels were monitored to inform staffing levels and skill mix. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities.

The education and training available to staff enables them to provide care that reflects up-to-date, evidenced based practice. Education and training provided reflects the Statement of Purpose. The training matrix evidenced that all mandatory training is current and there were no gaps identified .Evidence of current professional registration for all registered nurses was seen by the inspector. Recruitment and induction procedures were in place. Staff spoken with felt supported by the management team. The clinical nurse manager team carry out annual appraisals and staff are supervised appropriate to their role.

All documents required under Schedule 2 of the regulations are contained in the personnel files. All staff files had Garda Vetting disclosures in place.

All volunteers working within the centre had completed Garda Vetting in place and their role and responsibilities were clearly outlined.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The action plan response included improvements to be made in relation to painting and refurbishment which had been completed.
Beaufort House is purpose built and can accommodate up to 44 residents. There are 35 ensuite single rooms, three double ensuite rooms and one treble ensuite room. The design and layout of the multiple occupancy rooms met with current residents needs and there was appropriate screening in place to ensure that their privacy and dignity was not compromised.

The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre.
The centre was found to be well maintained, warm, comfortably and visually clean in most parts. Heating and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day. the roof lights at the two nurses stations was observed to be dark and was a potential risk for mobile residents at risk of falls. The management team had highlighted this as a concern and is in progress of changing the lighting in this area. The timeline for completion will be addressed in the action plan response.

At the entrance to all bedrooms was a framed picture, chosen by the residents, with their name in large writing. There was also signage with a picture on communal rooms stating the purpose and function of the room. For example, communal toilets had a picture of a toilet. However, the inspector noted that residents with dementia who were mobile had no directional signage or cues to support them navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

Sitting rooms, lounges and dining rooms were spacious and decorated to a reasonable standard with colourfully co-ordinated soft furnishings. The centre has a large number of residents with maximum dependency rooms and so the residents have large specialised seating. However the inspector did observe that there is no seating in communal rooms for visitors. The inspector observed visitors standing while trying to converse with residents who were seated. This arrangement did not support good communications or eye to eye contact.

Corridors and door entrances used by residents were wide and spacious to facilitate movement and aids used and required by residents. Bedrooms were spacious to accommodate personal equipment and devices required by existing residents. Handrails were available in all circulation areas throughout the building, and grab rails were present in all toilets and bathrooms. Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, remote control devices, ceiling hoists and mobility aids were seen in use by residents that promoted their independence.

Inspectors found that the privacy and dignity of residents was promoted in each bedroom and by its layout. Rooms were personalised with photos, memorabilia and artefacts. Residents confirmed that they were encouraged to bring in items from home. Some rooms had clocks which help to orientate residents to time.

Catering and laundry facilities were available in the centre.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Beaufort House
Centre ID:	OSV-0000709
Date of inspection:	06/03/2018
Date of response:	29/03/2018

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:
Documentation relating to residents and or family, participation in care plan development and review required improvement. A record to demonstrate their involvement was not routinely maintained.

1. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

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

4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
The PIC accepts the findings of the inspector. All Residents care plans / documentation will be reviewed to ensure residents and or family are involved and consulted with to ensure they have participated in care plan development and the review process. The PIC will conduct an audit thereafter, to ensure that the updated information reflects the current and up to date practice, interventions or arrangements for each resident.

Proposed Timescale: 30/06/2018

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector reviewed the care plans of some residents currently using bedrails. The documents and procedures in place required a full review. Risk assessments were not routinely carried out. The care plans did not guide practice.

2. 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:
The Registered Provider (Stakeholder) accepts the findings of the inspector. An audit will take place to review the current practice and usage of bedrails. A full review of procedures and documentation around risk assessments and consent on the use of bedrails will take place to ensure restraint is used in accordance with the Department of Health national policy and reviewed 4 monthly or sooner if required.
All Residents will have a risk assessment completed on admission and reviewed 4 monthly thereafter.
Each Resident will have a personalised care plan to guide practice.
Each Resident has an individual bedrail checklist now in place when a Resident is in bed.
The Residents using bedrails will be kept in a register and reviewed monthly with the aim of reducing their use.

Proposed Timescale: 30/06/2018

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management team had highlighted the roof lights at the nurses stations as a concern and is in progress of changing the lighting in this area. The timeline for completion will be addressed in the action plan response.

The inspector noted that residents with dementia who were mobile had no directional signage or cues to support them navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

The inspector observed that there is no seating in communal rooms for visitors. The inspector observed visitors remained standing while visiting.

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

Please state the actions you have taken or are planning to take:
The Registered Provider (Stakeholder) accepts the findings of the inspector. The existing lights will be replaced at the 2 Nurse Stations and thus reduce the risk of falls for mobile Residents.
Dementia specific directional signage will be put in place to support and direct Residents in navigating their way around the Centre and locate their bedrooms, bathroom facilities and indoor and outdoor communal areas.
The PIC has carried out a review on seating available for visitors in the communal areas and stackable stools have now been put in place. Additional stools will also be purchased.

Proposed Timescale: 30/09/2018