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Beech Lodge Care Facility, OSV-0000408, 12 January 2022

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Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Beech Lodge Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Bruree, Limerick
Type of inspection:	Unannounced
Date of inspection:	12 January 2022
Centre ID:	OSV-0000408
Fieldwork ID:	MON-0034109

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 12 January 2022	09:00hrs to 16:30hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in Beech Lodge Care Facility told the inspector that they enjoyed a good quality of life, received good quality health and social care, and that staff were kind and treated them with respect.

This one day unannounced inspection was carried out during the COVID-19 pandemic. At the time of the inspection, the centre had not experienced an outbreak of COVID-19.

On arrival to the centre, the inspector was met by the person in charge and guided through the centre's infection prevention and control procedures that included symptom monitoring, temperature check and hand hygiene. As the inspector waited in the reception area, some residents were observed in the dining room having breakfast and engaged in polite conversation with staff who were available to provide support to residents.

Following an opening meeting, the inspector walked through the centre with the person in charge. Residents were observed moving through the centre unrestricted. Some residents were in their bedrooms watching mass on television while others were in the communal dayroom and dining room reading newspapers and chatting with one another. It was evident that the person in charge was well known by residents and the person in charge introduced the inspector to residents and explained why the inspector was present in their home.

The inspector spoke with seven residents during the course of the inspection. Overall, resident's feedback about the service was positive and residents described their satisfaction with how staff supported them with their daily routine, the quality of the food and the daily activities that kept them physically and mentally engaged. Residents told the inspector that they knew each member of the management team and they were a visible presence in the centre. Some residents had lived in the centre for many years and described the centre as their home where staff made them 'feel safe' and they 'could not imagine living anywhere else'. Some residents commented on how the pandemic had impacted on the staffing which, on occasions, meant some residents had to wait longer than usual for assistance but overall residents were satisfied with the length of time taken to answer call bells. Residents complimented the management and staff on their ongoing efforts to protect them from COVID-19, and the inspector spent time listening to residents' experiences of the pandemic which was described as challenging.

Beech Lodge Care Facility is a purpose-build facility registered to provide accommodation to 66 residents in both single and multi-occupancy bedrooms. The inspector observed that the premises was maintained to a good standard and generally clean in all areas occupied by residents. The inspector observed that further attention to areas such as store rooms, laundry rooms and treatment rooms was required in regard to the cleaning procedure. The centre was adequately lit

through natural and artificial light, and walls were decorated with various pictures that included past activity events. Notice boards contained information such as the complaints procedure, COVID-19 guidelines and upcoming activity events. Corridors were fitted with handrails and signage to support residents to move freely. The inspector spent time in the dementia care unit that accommodated 15 residents. Residents appeared to enjoy the décor of this area, such as the traditional style furniture and sensory light display being projected on the walls and ceiling. Residents could access secure outdoor gardens at will that were appropriately furnished. Some improvements were required throughout the centre to enhance the décor, such as doors and walls where paint was chipped, and the person in charge confirmed that a programme of maintenance was due to commence in the week following the inspection.

Residents' bedrooms were observed to be personalised and residents were encouraged to decorate their bedrooms with personal items of significance such as ornaments and photographs. There was adequate storage in bedrooms for residents to securely store personal possessions and clothing. Residents' clothing was laundered on site and residents reported being satisfied with this service.

The centre employed two activities co-ordinators who provided small group and one-to-one activities on a daily basis. Residents were observed to be engaged in meaningful activities throughout the day and residents confirmed that 'no two days were the same' and there was 'always something entertaining to do'. The activities schedule was kept under review in consultation with residents. The inspectors observed that residents had undertaken many furniture restoration projects of book shelves, larder presses and had repainted the dining room furniture. Their work was displayed throughout the centre. Residents were supported to maintain connections with their community and were actively involved in charity fundraisers for local services. Monthly newsletters were prepared detailing past and future events in the centre and these were made available to residents, relatives and staff. In the afternoon, residents were observed walking around the centre with the support of staff and the physiotherapist.

Resident meetings were held monthly and records of the meetings evidence a high attendance from residents. Topics discussed at these meetings included food, the quality of care, COVID-19 and laundry service. Where complaints were raised during these meetings, they were appropriately progressed through the centre's complaints procedure and resolved.

The inspector observed that residents had a pleasant dining room experience with a relaxed atmosphere. Menus were prominently displayed at the entrance to the dining room and also on a large white boards. Residents told the inspector that they looked forward to mealtimes as the choice of meals were 'high quality'. Some residents chose to remain in their bedrooms and staff were available to provide support with meals and snacks and drinks at the resident's request.

Overall, residents spoke highly of the care they received and felt they could express their opinions openly and their voice was listened to and their suggestions acted upon. Residents told the inspector that they could speak to a member of the

management team with ease in regard to any concerns they may have and would not hesitate to do so.

The following sections of this report detail the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

The findings from this inspection were that the registered provider, Beech Lodge Care Facility Limited, had an established governance and management structure in the centre where the management team provided effective leadership to a team of staff committed to ensuring ongoing quality improvements in the service provided to residents. Action had been taken since the previous inspection to address substantial compliances found with the premises and individual assessments and care plans. However, some improvements were required by the registered provider in the following areas:

- Further oversight of staffing resources in line with the centre's statement of purpose to which the centre was registered against.
- The allocation of staffing resources to cleaning at weekends.
- Record keeping and some documentation required improvement.
- Further oversight of the maintenance of the premises.

This was an unannounced risk inspection conducted over one day by an inspector of social services to:

- Monitor compliance with the Health Act (2007), as amended and the Regulations and standards made there under.
- Follow up on the actions taken to address non-compliances found on the previous inspection in October 2020.
- To review the centre's infection prevention and control standards and the COVID-19 preparedness plan.

Beech Lodge Care Facility Limited is the registered provider of this centre and the provider board is comprised of three company directors, one of whom is the registered provider representative who visits the centre weekly and provides daily support via telephone to the person in charge. The clinical management team consisted of the person in charge and supported by two knowledgeable clinical nurse managers with responsibility for supervising the quality of care provided to residents. The inspector found that the management team worked cohesively towards implementing systems to continuously monitor, evaluate and improve the quality of the service and the inspector saw evidence of good communication structures between the management team and staff.

Systems were in place to gather and manage information about the quality of the

service. The person in charge, with the support of the clinical nurse managers, had implemented a comprehensive auditing systems that critically examined aspects of the service that included infection prevention and control, maintenance and facilities, the quality of clinical care provided to residents and the supporting documentation of this care. Where areas of the service requiring improvement were identified, there was a corresponding, time-bound quality improvement plan in place that was reviewed and progressed weekly. Information was collated from audits, incidents, complaints and residents meetings and this information was used to inform ongoing quality improvements and was discussed at weekly governance and management meetings with the registered provider representative and shared with the wider staff team.

The person in charge maintained a record of incidents involving residents and records were seen to be appropriately documented, analysed and controls put in place to mitigate the risk of such incidents occurring again. For example, the person in charge conducted a falls analysis on monthly basis that included a root cause analysis, trending of information such as specific times and this supported the implementation of measures to support residents to minimise the risk of further falls such as review by physiotherapy, increased supervision and falls prevention aids. There was evidence that learning from incidents was shared with staff.

Records set out in Schedules 2, 3 and 4 were kept in the centre, securely stored, accessible and available for inspection. Nursing records were maintained on an electronic system that was made accessible to the inspector for review. Daily health and social care provided to residents was documented in the electronic system for each resident. The inspector reviewed a sample of four staff personnel files that contained the necessary information as required by Schedule 2 of the regulations including evidence of a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Further improvement was required in the maintenance of the staff training records, records of risk in regard to restrictive practices and records in regard to the care planning process.

As previously stated, the centre had not experienced an outbreak of COVID-19 through effective and ongoing review and implementation of preparedness and contingency planning. The inspector reviewed the centre's COVID-19 preparedness and contingency plans that set out the actions to be taken in the event that a residents or staff member displayed symptoms consistent with COVID-19. The plans identified the COVID-19 lead responsible for coordinating and implementing the plan and the inspector saw evidence of daily outbreak control meetings between the management and department heads in the centre during a time when there had been isolated positive cases of COVID-19 in the centre. These meetings discussed the health status of residents, housekeeping requirements, staffing, recommendations from public health meetings and daily action plans were developed for each of the departments in efforts to prevent an outbreak in the centre. Management reported that, to date, the plan had been effective in preventing an outbreak of COVID-19 resulting from community transmission.

On the day of inspection, there were 61 residents living in the centre. The team providing direct care to residents was divided between the dementia care unit, that

accommodated 15 residents, and the main building that accommodated 46 residents. Staffing in both the dementia care unit and the main building consisted of a registered nurse on duty at all times supported by a team of healthcare assistants. Since the previous inspection, the provider had introduced an additional nursing shift from 07:45 to 15:00 and from 15:00 to 21:15 in response to previous inspection findings of inadequate nursing staff. The management team reported that this additional resource had been audited and the results indicated that there was appropriate supervision of residents and staff, safe and timely administration of medications and reduced wait times for residents to receive assistance from staff. The inspector acknowledged this positive additional resource, but there continued to be some staffing challenges in regard to maintaining planned rosters.

Staff whom the inspector spoke with stated that they felt supported in their role and were provided with ongoing opportunities to attend training to develop and enhance their skills. Staff were knowledgeable in regard to the procedure to take in the event of a fire alarm activation, infection prevention and control and detailed their role and responsibility in the safeguarding of vulnerable people from the risk of abuse. Newly recruited staff completed an induction period with the senior members of staff and their training needs were identified during this induction. On the day of inspection, there were a number of gaps in the training records for newly recruited staff. However, the inspector was assured that formal training was scheduled for staff in the coming weeks and staff were closely supervised by nursing staff until this training was completed.

Complaints were managed in line with regulatory requirements and there was evidence of learning from complaints to improve the quality of the service.

Regulation 15: Staffing

On the day of inspection, there was an appropriate number of staff on duty with the appropriate skill mix to meet the health and social care needs of the current residents.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training records of all staff and was assured that analysis of staff training needs were kept under review by the management team.

Staff were facilitated to attend mandatory training in fire safety, manual handling and safeguarding of vulnerable persons. All staff had completed training in infection prevention and control that was comprised of hand hygiene, breaking the chain of infection and training specific to the centres contingency plan to manage an

outbreak of COVID-19. Additional training was provided to staff to support residents living with dementia, and training was being scheduled by the person in charge to support staff in providing compassionate end-of-life care.

Staff were appropriately supervised by the management team and clinical nurse managers were rostered on duty at weekends to ensure there was effective clinical supervision at all times. Management also attended the centre outside of normal working hours, such as night time, to audit the quality of care being provided to residents and to ensure staffing levels were appropriate to meet the needs of residents.

Records reviewed evidenced that all staff completed a period of induction and annual appraisals were completed for staff.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained and included the information specified in paragraph (3) of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Record-keeping and file-management systems required review to ensure records were appropriately maintained. For example:

- While risk assessments for the use of bedrails were in place, in some instances the risk had not been reassessed at three monthly intervals as detailed on the risk assessment, and while alternatives to bedrails were trialled, the records did not capture this good practice.
- Records in regard to residents' care plans did not consistently capture the consultation process with residents and relatives when three monthly reviews of assessments and care plans occurred.
- Training records required further oversight to ensure they accurately reflected the courses and their dates of completion by staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure that identified the lines of accountability and authority and detailed the responsibilities for each area of care provision. The inspector found that the systems in place to monitor, evaluate and improve the quality of the service were effective in promoting ongoing quality improvements.

While the COVID-19 contingency plan detailed the staffing requirements of the centre in the event of an outbreak, the current staffing whole-time equivalents were not adequate to support full implementation of this plan in the context of the current challenges in maintaining planned rosters.

As found on previous inspections, the oversight of the staffing resources required strengthening to ensure that resources were sufficient to provide effective and consistent care in accordance with the centre's statement of purpose. The inspector found that:

- There was inadequate staffing resources allocated to the cleaning of the centre at weekends. While this deficit was identified by the person in charge, action had not been taken to address the issue.
- The healthcare assistant staffing levels on the rosters were not aligned with the staffing requirements for the provision of care as detailed in the centre's statement of purpose. There was evidence of challenges in maintaining the planned rosters during unplanned leave.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifiable incidents as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frame. The inspector followed up on incidents that were previously notified and found that they had been managed in line with the centre's policy and procedures.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed prominently in the centre and was provided in a format appropriate to the communication needs of residents. For example, in large text with pictures of the personnel involved in complaints management.

The inspector reviewed four complaints that had been received by the person in charge in 2021. Each complaint was appropriately documented, acknowledged,

investigated and the outcome of the investigation was shared with the complainant in line with the requirements of the regulation and the centre's own complaints policy.

Judgment: Compliant

Regulation 4: Written policies and procedures

The required policies and procedures were in place in line with the requirements of Schedule five of this regulation. Policies were updated to provide guidance to staff in the event of an outbreak of COVID-19.

Policies and procedures were accessible to all staff and provided appropriate guidance and support on the provision of safe and effective care to the residents.

Judgment: Compliant

Quality and safety

Residents living in Beech Lodge Care Facility received person-centred care and support from a team of staff who knew their individual needs and preferences and promoted their independence. Residents were provided with meaningful activities on a daily basis and were supported to maintain connections with their community. Nonetheless, there were some issues to be addressed under:

- Regulation 17: Premises
- Regulation 28: Fire precautions.

Each resident, upon admission to the centre, had a comprehensive nursing assessment completed that gathered information about their health and social care needs. Validated assessment tools were used to identify residents at risk of impaired skin integrity, falls, malnutrition and their dependency needs based on physical and cognitive needs. The information arising from these assessments informed the development of person-centred care plans and the detail contained in each care plan evidenced that residents and, where appropriate, their relatives were involved in the care planning process. Where clinical risks were identified, interventions were put in place support and monitor such risks. For example, a small number of residents identified as nutritionally at risk had their weight monitored weekly and were reviewed by their general practitioner (GP) and dietitian. Where interventions were recommended, these were appropriately updated into the residents care plan and their effectiveness monitored. The inspector reviewed the management of residents' wounds in the centre and found that wound care was guided through evidence-based practice and through the recommendations of tissue viability experts. The

documentation was maintained to a good standard and that supported monitoring of the wound progression.

Systems of referral were in place to ensure that residents had timely, unrestricted, access to GP services and allied health and social care professionals as required or requested. Three GPs visited the centre and residents were supported to retain their own GP on admission to the centre if they wished.

Centre-specific and up-to-date policy documents were available to inform the management of residents' responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and use of restrictive procedures in the centre. The centre accommodated a small number of residents with health conditions that predisposed them to episodes of responsive behaviours. Through observations and discussions with staff, the inspector was assured that staff supported residents with their responsive behaviours in a manner that was kind, respectful and non-restrictive. The use of 'as required' psychotropic medication was minimal. An ABC (antecedent, behaviour, consequence) chart was maintained for each resident to identify triggers of responsive behaviour and effective methods of meeting the resident's needs. This is an observational tool used to inform positive behaviour support plans.

Mealtimes were observed to be a relaxed experience for residents and staff were seen to be available to provide discreet support to residents when required. Residents confirmed that they were offered a choice for their meals daily and could choose something different off the menu if they wished. The inspector spoke with catering staff who detailed the system in place to ensure they were informed of up-to-date information in regard to resident's specific dietary needs.

Residents were facilitated to receive visitors in the centre in line with current guidelines. Residents told the inspector that during restrictions they were provided with alternative methods of communication with their family and friends, such as video calls, social media and window visits.

Residents' health and wellbeing was protected through effective health and safety management that was guided through a centre-specific risk management policy.

The centre provided a homely environment for residents and was maintained to a good standard. Residents enjoyed access to ample private and communal space and to secure gardens. The inspector found that areas identified as requiring improvement since the previous inspection had been addressed. This included replacement of worn fabric chairs and repairs to surfaces in the office area. However, there were further aspects of the premises that required improvements as it had the potential to impacted on effective infection prevention and control measures. This is discussed further under Regulation 17: Premises.

The inspector observed many good practices in regard to the prevention and control of infection. This included:

- Symptom monitoring of staff and visitors prior to entering the centre.

- Twice daily symptom monitoring of all residents.
- Alcohol hand sanitisers placed throughout the centre. An automated hand hygiene station.
- Staff uniforms were laundered and supplied on site.
- Appropriate signage was placed throughout the centre to prompt staff, residents and visitors to perform hand hygiene.
- Individual residents slings for manual handling purposes.
- Outbreak control team meetings were held with a leader from each department in the centre.

Arrangements were in place to respond to an outbreak of COVID-19 and an up-to-date contingency plan was in place that detailed the isolation and staffing arrangements to support the implementation of contingency plan. Staff whom the inspector spoke with were aware of the details of the plan and confirmed that the person in charge kept them informed of any changes that occurred to guidance documents in regard to COVID-19. The housekeeping team had a colour-coded cloth system in place for cleaning and a system to segregate clean and unclean items during the cleaning process. There were specific days where bedrooms were deep cleaned and supporting documentation was available for review. Household staff were knowledgeable in regards to the cleaning agents used and the correct dilution of such cleaning agents.

The fire procedures and evacuation plans were prominently displayed in the centre and provided guidance on the nearest exit to use in the event of a fire. The inspector reviewed the testing and maintenance records of the fire alarm system and emergency lighting and all records were up to date. Daily checks to ensure means of escape were unobstructed were completed by the nurse on duty. Simulated fire evacuation drills of the largest compartment were completed with staff but some improvement was required to ensure the safe and timely evacuation of residents from the largest compartment. Assurances were received following the inspection. Further findings are discussed further under Regulation 28: Fire Safety.

Through a review of records and conversations with staff and residents, the inspector was assured that residents were protected from the risk of abuse in the centre. Residents reported that they felt safe in the care of the staff.

Residents told the inspector that they would not hesitate to raise a concern with a member of staff or the person in charge and were confident that their concerns would be acted upon. Residents reported a good quality of life in the centre where they could exercise choice in how to spend their day and were supported by staff to continue doing the things they enjoyed in life.

Regulation 11: Visits

Residents were supported to maintain personal relationships with families and friends. The centre was facilitating visits in line with the current Health Protection

Surveillance Centre (HPSC) COVID-19 visiting guidelines.

Visitors were guided through the centres infection prevention and control procedures prior to entering the centre and systems were in place to ensure residents, visitors and staff were protected.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were provided with appropriate storage in their bedrooms for personal possessions and were encouraged to personalise their private space with items of significance to each resident.

Residents clothing was laundered onsite and the laundry system in place minimised the risk of items of clothing becoming damaged or misplaced. Residents were satisfied with the service provided.

Judgment: Compliant

Regulation 17: Premises

The premises was maintained to a good standard and residents enjoyed access to ample private and communal space and access to secure gardens. However, there were areas of the premises that required further attention in regard to maintenance, and repair.

- A number of bedroom doors had scuff marks and paint chipped that required painting.
- There were gaps between some floor and skirting board where exposed concrete was visible and a build-up of debris in store rooms.
- There were several surfaces and finishes on residents' furniture and wooden covers over some toilets that were damaged.
- Extractor fans in bathrooms and the smoking room were not clean on inspection.
- Some store rooms had not been finished in regard to painting and plaster, concrete and pipes were exposed.
- The ceiling in the dementia care unit required re-painting following repair of a leak from a skylight.
- Mobility equipment such as hoists were inappropriately stored in corridors when not in use.
- Clinical equipment and medication was stored in a small store room in the dementia care unit that has not been finished in terms of painting or

appropriate flooring.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a choice for their meals daily and resident reported their satisfaction with the quality of the meals provided.

Where residents were prescribed a specific dietary requirement, modified texture diet or fluids, this was communicated to the catering staff in addition to the resident's individual likes and dislikes in terms of food preferences.

Residents identified as nutritionally at risk were monitored in regard to the daily food intake and weights were monitored weekly for some residents. This information was made available for the general practitioner and dietitian to review and make adjustments to the resident's nutritional plan of care.

Judgment: Compliant

Regulation 26: Risk management

The centre had a risk management policy that was within the required time frame for review. The policy contained the specific risks and controls in place to mitigate the risk as required by the regulation.

A risk register was maintained that detailed identified risk specific to the centre and the controls in place to mitigate the risk.

Judgment: Compliant

Regulation 27: Infection control

Staff confirmed they had training in infection control and that this was updated regularly. Infection prevention and control audits were completed and actions arising from same were followed up and communicate to staff. Staff had access to the guidance published by the Health Protection Surveillance Centre and the Health Information and Quality Authority (HIQA).

Judgment: Compliant

Regulation 28: Fire precautions

Overall, the inspector was satisfied with the centre's fire safety procedures and fire equipment was services and maintained as required. The inspector observed some fire risks that required further review. For example:

- A fire blanket was not available in an outdoor designated smoking area.
- There were gaps in the ceiling where some smoke sensors had been installed and this required review by a competent person to ensure they were appropriately fire stopped.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were developed upon admission and formally reviewed at intervals not exceeding four months.

Care plans were informed through assessment using validated assessment tools that assessed, for example, residents dependency, risk of falls, risk of malnutrition and skin integrity. A social assessment gathered information on the resident's hobbies, likes and dislikes.

Each resident's care plan had been updated to reflect COVID-19 guidelines that included restrictions of visiting and how each resident maintained contact with their relatives and friends. These were reviewed each time there was a change in guidelines.

The detail contained within residents' care plans confirmed that residents were actively involved in the care planning process. However, while care plans and assessments were reviewed in consultation with the residents, this process was not captured in the residents' records and is actioned under Regulation 21: Records.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a physiotherapist on site three days per week and could avail of individual and small group exercises. Where residents would benefit from

supportive equipment, such as specialise seating or mobility aids, there was evidence of referral to occupational therapy services for assessment. A small number of residents had sustained pressure wounds in the centre. Residents were seen to be provided with evidence-based nursing care in the management of wounds. The advice of tissue viability experts was seen to be implemented in terms of dressing regime and the providing residents with pressure relieving equipment to aid wound healing.

There was evidence of timely referral to, and review by, allied health and social care professionals where residents required additional expertise in the areas of, for example, dietetics, speech and language and occupational therapy.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector reviewed the files of residents that exhibited responsive behaviours and found that residents received care that supported their physical, psychological and social care needs. The inspector observed an episode of responsive behaviour during the inspection and staff responded to the residents' needs through implementing the actions detailed in the residents' person-centred positive behaviour support plan which were effective. Records of the actions taken and their effectiveness were recorded in the resident's ABC chart and used to inform and update the residents care plan.

Records reviewed evidence an ongoing initiative in the centre to promote a restraint-free environment and the management team worked towards reducing the use of bedrails in the centre which was evident from the previous inspection. Residents that required the use of bedrails had consented to their use and the appropriate risk assessment and supporting documentation was in place. Some risk assessments required updating and review in addition to documenting the least restrictive alternatives trialled and this is actioned under Regulation 21: records.

Judgment: Compliant

Regulation 8: Protection

Residents told the inspector that they felt safe in the centre and that staff treated them with dignity and respect. Staff detailed the training they had received in regard to safeguarding of vulnerable people and told the inspector that they would report any concerns to the management team in line with the centre's policy and procedure.

Residents felt able and supported to voice any concerns they may have to the management team in private or at resident committee meetings and were confident in the management's ability to take action on any concerns raised. Residents had access to advocacy services at their request.

Judgment: Compliant

Regulation 9: Residents' rights

Interactions between residents and staff were observed to be kind, dignified and respectful. Residents were encouraged to exercise choice and had control over how they spend their day and their right to privacy was upheld. The inspector saw that residents were consulted and could actively participate in the organisation of the centre. The records of residents' meetings conveyed that residents were consulted about the menu, activities, COVID-19 restrictions, visiting how the centre was organised.

A small number of residents under the age of 65 were accommodated in the centre with complex health and social care needs. The inspector reviewed the support plans for these residents and found that person-centred social plans were in place that incorporated their individual activities outside of the centre, such as attendance at local day centre services. The plans detailed the daily activities in place for each resident during suspension of these service as a result of the COVID-19 pandemic. Each resident had access to advocacy services.

The inspector observed that residents' choice in regard to their day-to-day routine, as per their care plan, was respected. Residents confirmed that they could get up from bed when they wished, spend time in their bedroom or in the communal room and their choice was respected.

There were two activity staff employed in the centre who developed activity schedules based on the resident's requests. One member of staff facilitated a range of sensory and meaningful activities to residents living with dementia in the dementia specific care unit while the other member of staff organised group and individual activities for residents in the main centre. Overall, residents reported that they looked forward to activities each day and the schedule was constantly reviewed and updated.

The inspector observed that there were newspaper and magazine stands in the communal areas available for residents to access. Residents had a choice to watch television or listen to the radio in the communal area or in the privacy of their bedroom. Mass was streamed daily on the television and was held once a week in the centre.

Judgment: Compliant



Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Beech Lodge Care Facility OSV-0000408

Inspection ID: MON-0034109

Date of inspection: 12/01/2022

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

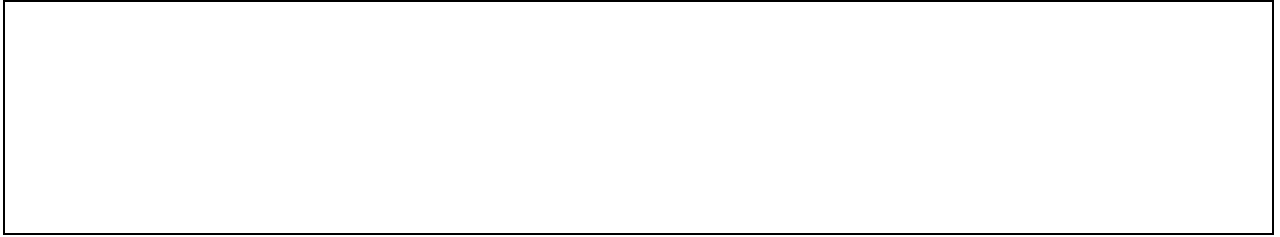
Section 1

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

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <ol style="list-style-type: none"> 1. Post inspection all bedrail risk assessments on the restraints risk register have been reviewed and updated - complete. Going forward these risk assessments will be reviewed and documented on a three-monthly interval and be subject to ongoing review and audit. - Date completed: 21/01/2022 2. Three monthly care plan reviews now include a summary of the review that has taken place and includes both resident and relative signatures where possible. 3. The staff training matrix has been reviewed and updated to ensure that the correct dates of training completed and the dates when training updates falls due, have been adequately recorded. PIC will oversee the training matrix on a monthly basis to ensure full compliance. 	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ol style="list-style-type: none"> 1. Three new Health Care Assistants have been recruited. The staffing levels will be reviewed monthly using a validated assessment tool (The Modified Barthel Index) to ensure the care hours provided meets or exceeds the care hours required by residents’ assessed needs. 2. Housekeeping weekend hours had been under review prior to inspection and preliminary plans were in place for the additional cleaning hours to commence from that 	

subsequent weekend. Extended rostered hours are now in place at weekends to allow for a more robust cleaning schedule	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>1. As outlined in Regulation 27, An environmental audit of the areas identified on inspection to be addressed was undertaken by the management and maintenance team. A programme of works has been drawn up to set out target dates for completion of the required upgrades. The management team will monitor the completion of action plans from the audits, to ensure identified issues found have an effective and timely action plan in place and these are addressed in the agreed timeframe. The audit management systems will continue to be reviewed, and the action plans discussed at the weekly departmental meeting attended by representatives from each department in the care facility.</p> <p>The anticipated completion date for these planned scheduled works is 31/05/2022</p> <p>2. Extractor fans were being cleaned on a frequency of two monthly. This has now been increased too monthly.</p> <p>3. Management have communicated to care staff the importance of storing hoists in the assigned equipment storeroom to prevent cross contamination when not in use. Management will monitor the ongoing compliance by daily walk around and spot checks.</p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>1. Fire blanket installed to the outdoor designated smoking area since 20/01/2022</p> <p>2. A fire stopping audit was undertaken by our inhouse fire officer and the gaps around smoke sensors have now been appropriately fire stopped . Completed 24/01/2022</p> <p>3. Post inspection a specific risk assessment for delayed evacuation was completed, added to the risk register, and submitted to the Chief inspector on 19/01/2022.</p> <p>4. The frequency of fire drills, simulating night-time staffing levels in the two largest compartments, has now been increased to bimonthly with the overall aim to reduce the time taken for evacuation. These drills will be subject to trending and analysis and corrective action planning, overseen by the PIC and management team.</p>	



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2022
Regulation 21(1)	The registered provider shall 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.	Substantially Compliant	Yellow	28/02/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Substantially Compliant	Yellow	28/02/2022

	the statement of purpose.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	20/01/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	24/01/2022