Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

# Issued by the Chief Inspector

| | |
|---|---|
| Name of designated centre: | Beechwood Nursing Home |
| Name of provider: | Maisonbeech Limited |
| Address of centre: | Rathvindon, Leighlinbridge, Carlow |
| Type of inspection: | Unannounced |
| Date of inspection: | 02 July 2024 |
| Centre ID: | OSV-0000199 |
| Fieldwork ID: | MON-0040286 |

## About the designated centre

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

Beechwood Nursing Home is a purpose-built, single-storey residential service for male and female persons over 18 years of age and is located within close proximity to the town of Leighlinbridge and across the road from a busy arboretum. The designated centre provides accommodation for 57 residents in 57 single bedrooms. Full ensuite facilities were provided in 30 single bedrooms. Sufficient toilet and shower facilities were conveniently located throughout the centre to meet residents' needs. Accommodation for residents is provided at ground floor level throughout. The centre has a number of communal facilities, including two dining rooms and three sitting rooms, one of which could be subdivided to meet residents' activity needs. The centre provides long-term, respite, and convalescence care for residents with chronic illness, dementia and palliative care needs. The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 50 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Tuesday 2 July 2024 | 08:00hrs to 15:50hrs | Sinead Lynch | Lead |
| Tuesday 2 July 2024 | 08:00hrs to 15:50hrs | Helena Budzicz | Support |

## What residents told us and what inspectors observed

This inspection took place over one day and was unannounced. Beechwood Nursing Home is a designated centre for older people, registered to provide care to 57 residents. There were 49 residents living in the centre on the day of this inspection with one resident in the hospital. Throughout the inspection, the inspectors spoke with residents and staff and spent time observing practice throughout the different areas of the centre. Residents who spoke with the inspectors said that they were mostly satisfied with the quality of care they received. However, inspectors observed a number staff practices which were not in line with evidenced based practice or with person-centred care.

The inspectors arrived after 8 am and saw that many residents were being assisted in getting up and having their breakfast prepared and served. During the walk-around the centre, the inspectors observed that bedroom doors were open while residents were receiving personal care and not all call-bells were answered in a timely manner, and some call-bells were not available to residents in their bedrooms. The inspectors saw a number residents that required assistance and were at risk of falling or trying but unable to reach the bedside table. Call bells were found under residents beds or behind their locker. On numerous occasions the inspectors had to access the bell and press for attention of staff.

Residents were not being supported at meal times, in particular at breakfast. There were many residents observed sleeping while their breakfast was left on their bed side table, out of reach and getting cold. Inspectors had to highlight the need of staff assistance to the person in charge, as many of the residents did not have the ability to feed themselves without the assistance of staff.

Inspectors also observed instances where the call-bell rang, and staff proceeded to walk around without answering the ringing call-bells. Inspectors also saw residents in distress on several occasions and had to alert the person in charge to meet these residents needs.

In communal bathrooms and shared facilities, inspectors observed unlabelled toiletries, such as, hair brushes and shaving gel. This practiced posed a potential risk of cross infection.

Many rooms were found unclean and found to not have the cleaning check list completed for up to four days which could not clarify if these rooms had been cleaned in the previous four days.

Inspectors observed one resident had a yellow clinical waste bin in their room. The person in charge and two other staff members on this corridor could not identify the type of infection the residents had or the required precautions required to mitigate the risk of cross-infection.

A review of records of the residents' meetings showed that delays in answering calls for assistance had been a long standing issue. Although these concerns were reported by residents at the residents' meetings and internal audits of call-bell response showed significant delays in response times, no meaningful action plan had been developed or implemented and this issue continued to negatively impact the quality of care delivered to residents.

The centre had a complaints procedure in place. However, these complaints were not always acknowledged or appropriately investigated. There was no learning or quality improvement plans identified following the receipt of a complaint.

As the day progressed, the inspectors observed that staff interacted with residents in a kind manner and provided social activities and support to residents. Residents sat together in the communal areas watching TV, reading newspapers and chatting with one another and staff. Residents were provided with opportunities to participate in recreational activities of their choice and ability, either in the communal areas or their own bedrooms, seven days a week.

The inspectors observed the lunchtime experience and saw that although there were staff available to assist residents, there was an-absence of appropriate managerial supervision. For example, the inspectors observed inappropriate communication from a staff member to a resident living with dementia, where the only communication used during mealtime was a command style word to 'swallow'. This communication does not support residents' rights to dignity.

Inspectors saw that in the sitting room residents tables were not set in the same homely manner as in the dining room. The residents' cutlery was placed directly on a table and they were served their meals without access to condiments or serviettes provided. The choice of drinks served with the lunch was limited to milk only. The meals were pre-plated and the choice of sauce was offered to the residents after 15 minutes of serving and eating the meals. The food of pureed consistency was all mixed together, and as a result, the residents could not enjoy the different types of tastes from the meal served.

Inspectors also observed that residents cutlery was being stored in an empty water jug, the internal base of which appeared to be heavily stained.

Inspectors observed that draw sheets were used on the residents' beds, and staff members told inspectors that this was to prevent bodily fluids from getting on the bed sheets. This is an institutionalised practice that was not in line with the latest evidence-based guidelines and which did not promote skin intergrity and support resident's dignity.

Inspectors observed that visitors were coming and going throughout the inspection. Arrangements were in place to support residents to meet visitors in their bedrooms or in a variety of communal rooms.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being provided.

## Capacity and capability

While there were management systems in the centre to ensure oversight of care and service provided to the residents, they were not effective at ensuring the quality and safety of the service was maintained at all times and improvements were required to ensure compliance with the regulations.

Progress in relation to actions from the previous inspection was evident on this inspection. For example inspectors found that there was a completed directory of residents in place. This included all the required information as set out in the Regulations. The registered provider had also made improvements in relation to the review of policies and procedures as set out in Schedule 5. However, other regulations such as Regulation 23: Governance and Management, Regulation 16: Training and staff development, Regulation 31: Notification of incidents, Regulation 34: Complaints procedure, Regulation 18: Food and nutrition and Regulation 9: Residents rights required improvements to come into compliance with the regulations.

Beechwood Nursing Home is owned and operated by Maisonbeech Limited, which is the registered provider and part of the Beechfield Care Group. The company is comprised of two directors. From a clinical and operational perspective, care in the centre was directed by the person in charge. They were supported by one clinical nurse manager (CNM) who was responsible for overseeing the work of a team of nurses, health care assistants, an activity coordinator, maintenance, housekeeping and catering staff.

Staff training records were maintained to assist the person in charge with monitoring and tracking status of mandatory and other training completed by staff. A review of these records confirmed that mandatory staff training in manual handling and fire safety had been completed. However, further face-to-face training was required in relation to infection prevention and control, as gaps in practice were observed. There were audits completed on a routine basis across all areas of care but they had not identified the concerns found by the inspectors on the day of the inspection.

Further clinical supervision was required to ensure residents were provided with a high standard of quality of care.

The centre had an outbreak of COVID-19 the previous month in which 12 residents were affected. There was no review completed to identify learning post the

outbreak. This outbreak was declared over by public health on the 15th June 2024, (17 days prior to the inspection).

The Chief Inspector had not been notified of incidents that had occurred in the centre, specifically in respect of restrictive practices such as the use of reclining chairs which restricted residents' movement.

Inspectors reviewed minutes of resident meetings and were not assured that concerns raised by residents had been addressed and reviewed to ensure that all residents were meaningfully consulted with and listened to. This is further discussed under Regulation 23:Governance and management.

There was a complaints procedure in place, however, it was not followed when managing individual complaints. The complaints were up-loaded to the electronic system, however, for the majority of complaints there was no acknowledgement sent to the complainant and no investigation completed, in line with policy. All the complaints received remained open with no outcome or learning identified.

## Regulation 16: Training and staff development

The person in charge had ensured that staff had access to training. However, this training continued to be online and the supervision of staff practices was not sufficient to ensure the principles of training were implemented in practice. Further face-to-face training in relation to infection prevention and control was required to ensure staff and management knew and understood the requirements and recommendations in relation to contact precautions.

The person in charge did not ensure that staff were appropriately supervised at all times and that local policies were implemented in practice. For example, inspectors observed a number of task-oriented practices that did not promote residents' dignity, as further described under Regulations 18: Food and Nutrition and Regulation 9: Residents' Rights. Further training in human rights-based approaches to care and enhanced supervision of staff practice was required.

Judgment: Not compliant

## Regulation 19: Directory of residents

The registered provider had established a directory of residents which was made available when requested.

Judgment: Compliant

## Regulation 23: Governance and management

Management systems in place had failed to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23. This was evidenced by:

- Although residents' surveys had been completed eight months prior to this inspection, the responses had not been analysed, there were no actions developed and no further consultation with the residents or feedback provided on the findings of the surveys. The findings were not included in the annual review for 2023.
- Infection prevention and controls audits had not identified the issues highlighted on this inspection. Such as the cleaning checklists not being completed and the inappropriate storage in the shared bathrooms.
- Audits did not meaningfully inform practice or identify areas for improvement. For example, a call-bell audit was completed by the person in charge showing that a call-bell was not answered for over 17 minutes. There was no learning identified following this audit and no action plan to address delays in the provision of care.
- Inspectors reviewed records of two residents' meetings and saw that residents' concerns were not appropriately actioned or followed up on since January 2024. For example, a number of residents raised the issue with respect to the prolonged times taken by staff to respond to call-bells in two meetings; however, while an action was put down in writing, the action was not completed, reviewed or signed off as completed/addressed.
- The registered provider had given assurances that a new annual review template would be completed to include the residents' survey and all consultation with the residents and their advocates by 30th June; this was not completed.
- Staff supervision to ensure person-centred care was provided to residents at all times, as per the statement of purpose, was not sufficient. The systems in place regarding staff practices to support and uphold residents' rights and dignity at all times and mealtime experience required review, as evidenced under Regulation 9: Residents' rights and Regulation 18: Food and nutrition.

Judgment: Not compliant

## Regulation 3: Statement of purpose

There was a statement of purpose available in the centre. However, the arrangements for dealing with complaints was not reflective of the regulatory requirements and therefore not up-to-date. For example; the review officer was no longer available to the centre.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The person in charge had not notified the Chief Inspector of Social Services at the end of each quarter in relation to the occurrence of an incident set out in Schedule 4. For example;

- Seven residents were in a reclined position in comfort chairs which restricted their movement.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The complaints procedure in place was not followed when a complaint was received. For example complaints were found to be recorded but in many cases;

- They were not acknowledged
- Complaints were not investigated appropriately
- Written responses were only identified for one complaint out of 14 received
- All complaints were not closed with the outcome defined
- There was no review officer available to the complainant as the person mentioned in the policy no longer worked for the provider.

Judgment: Not compliant

## Regulation 4: Written policies and procedures

The registered provider had prepared in writing policies and procedures on the matters set out in Schedule 5. However, these policies were not implemented in practice as detailed under Regulation 27: Infection prevention and control and Regulation 34: Complaints.

Judgment: Substantially compliant

## Quality and safety

Overall, the systems in place overseeing the quality and safety of the service delivered to the residents did not consistently ensure that the residents' rights for privacy, dignity, choice, and safe practices were adhered to. Notwithstanding good practices in respect of access to healthcare and the management of residents' transfers, significant improvements were required to ensure that the rights of all residents were upheld and to ensure that all residents received care in line with their assessed needs.

Residents had access to appropriate medical and social care professionals. Referrals were made to professionals such as General Practitioners (GPs), palliative care, psychiatry, speech and language (SALT), dietitians, and tissue viability nursing (TVN).

The inspectors reviewed a sample of residents' care plans and daily care records. While care plans for residents who were exhibiting responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were detailed and comprehensive. Inspectors found that residents who had been assessed as having mobility needs, an infection, requiring crushed medication and having incontinence issues did not have an updated care plan setting out their needs and assessment with appropriate therapeutic interventions.

The premises were designed and laid out to meet the needs of residents. However, some improvements were required with respect to the cleanliness of the centre.

The inspectors observed that the food served during the day appeared to be wholesome and nutritious. While the dining experience in the two dining rooms was of a good standard, the serving of breakfast and the dining experience in the sitting room required review. These issues are further detailed under Regulation 18: Food and Nutrition.

Residents had access to local and national newspapers, television and radio, along with access to an independent advocacy service. There was a programme of activity scheduled daily and inspectors observed residents who were active and socially engaged throughout the day of the inspection. However, inspectors observed some institutionalised practices where residents' rights were not supported as discussed under Regulation 9: Residents' rights.

## Regulation 17: Premises

The inspectors saw that one of the communal bathrooms had no toilet seat; the high-rise seat was on the floor. In addition, a call-bell cord was missing in one of the communal bathrooms beside the toilet.

Judgment: Substantially compliant

## Regulation 18: Food and nutrition

The inspectors observed that the serving of food and the mealtime experience for residents required action with regard to the following;

- Inspectors were not assured that there were adequate numbers of staff to assist residents with breakfast. The breakfast meals for three residents were served, and they were left to go cold while the residents waited for the staff to be available to help them as the bedside table with the breakfast tray was not within residents' reach. In addition, the resident could not use the call-bell as it was not within the resident's reach.
- The service provided was not conducive to promoting a relaxed and dignified mealtime experience that encouraged residents' independence. For example; condiments, sauce bowls and a variety of drinks were not available for residents whose food was served to them in the sitting room.
- The storage arrangements for cutlery required review.

Judgment: Not compliant

## Regulation 25: Temporary absence or discharge of residents

The inspectors saw that a copy of all transfer letters when a resident was recently temporarily transferred to the hospital was kept in the resident's file in the electronic system. This letter included information such as the resident's weight, infections and vaccination status, and food and fluid consistency status. The nursing staff also ensured that upon residents' return to the designated centre, all relevant information was obtained from the discharge service and saved in residents' files.

Judgment: Compliant

## Regulation 27: Infection control

Improvements were required in order to ensure procedures are consistent with the National standards for infection control in community services (2018). For example,

- The cleaning checklists had not been completed for many rooms since 28 June 2024. This did not provide assurances that the rooms had been cleaned regularly.

- The floor in the storage room where the dressing material and other nursing equipment were stored was visibly stained and dirty, with rubbish lying on the floor.
- Inappropriate storage was observed in the cabinets in the communal bathrooms, such as hair brushes, combs, and shaving gels. This posed a risk of cross-contamination when equipment is shared.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' care documentation and found that assessment and care planning required improvement to ensure safe care delivery for residents. For example:

- Only two out of five mobility care plans were reviewed following a resident's fall or updated to reflect current mobility needs and accurately described fall risk assessment scores. In addition, a manual handling assessment for a resident who experienced several recurrent falls was completed in August 2023 and April 2024, and not on a four-monthly basis or when the resident's condition changed.
- The infection control and prevention care plan for residents infected with COVID-19 was generic and did not detail information on self-isolation, correct infection control precautions in place, observation of symptoms, or a date for recovery.
- The medication management care plan was not updated for crushing medication administration. This posed a risk that staff would not be aware of the specific requirements of a resident.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had access to a general practitioner (GP) who attended the centre as required or requested. There was evidence that following a nursing assessment for pressure ulcers and weight loss, appropriate referrals were sent to the tissue viability nurse (TVN) and to the dietitian, requesting a resident review.

Judgment: Compliant

## Regulation 9: Residents' rights

Inspectors identified that residents' rights to dignity and choice were not being fully protected and embraced in the centre and task-orientated practices were observed. For example:

- Draw sheets were observed on the residents' beds, and staff members told the inspectors that this was to prevent bodily fluids from getting on the bed sheets. This is an institutionalised practice that was not in line with the latest evidence-based guidelines and which did not promote skin integrity and support resident's dignity.
- The inspectors observed inappropriate communication from a staff member to a resident living with dementia.
- The emergency call-bell chords were not easily accessible to residents in several bedrooms, making it difficult for residents to call for help.
- Staff did not answer call-bells in a timely manner.
- Residents' privacy rights were not respected. Some bedroom doors were left open during personal hygiene.
- Although there were attempts to consult with residents, their views were not always considered and meaningfully responded to for effective participation in the running and organising of the service.

Judgment: Not 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 16: Training and staff development | Not compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Not compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 18: Food and nutrition | Not compliant |
| Regulation 25: Temporary absence or discharge of residents | Compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Beechwood Nursing Home OSV-0000199

## Inspection ID: MON-0040286

## Date of inspection: 02/07/2024

**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 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>A training needs analysis is currently being undertaken by the PIC and HR department. Based on this analysis staff training and refresher training has been planned and will be implemented via in person training. As a result, both IPC and adult safeguarding training has been completed. Staff and management now understand the requirements and recommendations in relation to contact precautions.<br>In person training will continue along with online training.<br><br>The PIC will ensure that staff have the competencies, training and support to enable safe and effective practices. This will be achieved through monitoring of staff on a regular basis. Staff have also been re issued with the homes policies.<br><br>A review of the training Matrix will form part of the monthly Ops meetings going forward. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>Post inspection all surveys were analysed by the PIC. Any required actions were discussed with the individual residents who raised the concerns and these are now closed.<br><br>Following the inspection the IPC audit was redone. All cleaning checklists have been | |

signed and inappropriate items have been removed from the shard bathrooms. This is being monitored by management daily to ensure that items are not stored inappropriately.

Following the inspection the home has purchased software for the call bell system. This produces real time actual reports of call bell times. Beechwood Nursing Home has a Clinical and Governance Plan which audits compliance to the regulation. This includes a monthly audit of call bell responses, which the PIC/DON has oversight. The above will form part of the monthly KPI which is submitted to the senior management team every first Friday of the month. A feedback system via unit review meeting is done every 2nd week of the month to ensure that staff are informed of the audit findings as well as the necessary improvements that is required on foot of the results. The CNM on shift together with the DON monitors the responses to the call bells daily to ensure that staff are attending promptly to any calls.

The PIC has reviewed all actions from previous residents' meetings. These have been actioned and completed. Going forward all actions will be completed with an agreed time frame and reviewed by the Ops team.

The annual review has now been completed to include the residents survey.

The PIC and HR department has carried out a full review of the centre to assess and ensure appropriate staffing levels and skill-mix are in place so each residents needs are met. A new staff allocation has been implemented in the home to ensure person cantered care is provided to all the residents at all times.

| Regulation 3: Statement of purpose | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose was amended to reflect the change of the review officer.

| Regulation 31: Notification of incidents | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

| |
|---|
| The chief inspector has now been informed via the quarterly notifications of the residents who in are a reclined position in a comfort chair and this will be in place for future notifications. |

| | |
|---|---|
| Regulation 34: Complaints procedure | Not Compliant |

| |
|---|
| Outline how you are going to come into compliance with Regulation 34: Complaints procedure:<br>All complaints have now been acknowledged and investigated appropriately. Written responses have been sent and all complaints have now been closed. The PIC is now only using the Care Monitor system to document all complaints going forward<br><br>The complaints procedure has been updated to reflect the new review officer. |

| | |
|---|---|
| Regulation 4: Written policies and procedures | Substantially Compliant |

| |
|---|
| Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:<br>A training needs analysis is currently being undertaken by the PIC and HR department. Based on this analysis staff training and refresher training has been planned and will be implemented via in person training. As a result, IPC training has been completed.<br><br>All complaints have now been acknowledged and investigated appropriately. Written responses have been sent and all complaints have now been closed. The PIC is now only using the Care Monitor system to document all complaints going forward. The complaints procedure has been updated to reflect the new review officer. |

| | |
|---|---|
| Regulation 17: Premises | Substantially Compliant |

| |
|---|
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>The toilet seat was put back on the toilet at the time it was discovered and the call bell cord was placed in the bathroom to ensure that the resident could call for assistance when in the bathroom. |

| | |
|---|---|
| Regulation 18: Food and nutrition | Not Compliant |

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The home has completed a full review of the breakfast service. Following the inspection, the kitchen roster has been reviewed and amended (complete). Kitchen staff now starts at 7am to ensure that breakfast is prepared and is made available to residents who are up early and wanting food. This also ensures that healthcare staff are available on the floors to attend to the care needs of residents. As part of the review all HCA's need to go to the resident's rooms to ensure they are awake and ready for breakfast prior to the food being served. A new breakfast ordering sheet has been developed to highlight dependency levels to ensure any residents who require assistance of feeding will receive same.

Following the inspection a clear standard procedure for lunch service in the lounge was completed by the PIC and Household manager. This system details how to set up the lounge area for lunch. This will ensure all condiments, sauces, drinks are available for residents who choose to dine in this area. All relevant staff have been trained in this procedure. The PIC along with the Household manager and CNM will monitor to ensure compliance.

New cutlery trays have been purchased for the trolleys and are in use to ensure that there is adequate access to cutlery.

Monthly audits are in place to ensure standard of practice are adhered to in the catering department. The PIC with the assistance of the CNM and Household manager maintains oversight of same, spot checks are also carried out by management to ensure compliance and address any issues in a timely manner.

| | |
|---|---|
| Regulation 27: Infection control | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
A schedule of regular deep cleaning was put in place and the DON/PIC with the assistance of the CNM and the Housekeeping Manager maintains oversight of same. Daily spot checks are being carried out to ensure compliance.

A deep clean of the storage room was completed following the inspection.

Post inspection all communal bathrooms were inspected, and all areas were clear of hair brushes and shaving gels.

Daily spot checks are carried out along with weekly inspections to ensure compliance within the home.

| | |
|---|---|
| Regulation 5: Individual assessment and care plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The three residents identified in the inspection report had their assessments and care plans reviewed (complete). A system of monitoring has been introduced and a Keyworker is allocated to ensure that care plans and assessments are kept up to date and reviewed every four months as discussed above.

Care plan review and audit is part of the centre's monthly KPI's which the PIC/DON has oversight. On top of this, the PIC reviews assessments and care plans on a weekly basis and communicates any overdue actions to the clinical team for completion.

By the end of September 2024, a review of each resident's care plan will be completed to ensure they reflect each individual's needs and guide staff appropriately to meet those needs. This will specifically review individual risks, i.e. falls, challenging behaviours, medication management, etc. to ensure appropriate supervision and safety measures are in place and evidence of care and checks are documented.

| | |
|---|---|
| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Draw sheets have been removed from the nursing home and these are no longer in use.

Through the toolbox talks and auditing, staff are aware that call bells must be within reach of the residents while they are in their rooms. Staff have also been made aware that the bedroom door must be closed over for the residents during personal care procedures and this is being monitored by the Staff Nurses and DON.

A residents meeting has been conducted since the inspection and the residents reported that previous issues raised were rectified satisfactorily. The resident survey that was

completed was reviewed again and resident feedback was sought to ensure that the residents were happy that their issues had been resolved.

Beechwood nursing home has sourced software that can monitor call bell reaction times. This will allow for the effective monitoring of the call bells at all times and allow prompt action to be taken with the staff on duty if there is an issue with a delay in answering the bells. Staff have again been reminded of the importance of answering the call bells as quickly as possible.

Actions from the resident's meetings have be completed and closed off.

Beechwood Nursing Home has a set Clinical Governance Plan in place to audit compliance with the regulations. A further review of the management system in place includes quarterly Clinical Governance Meeting, Falls meeting, restrictive practices, and care plan audits. The PIC/DON maintains oversight of these audits and submits a weekly report to the Senior Management/Operations team as a complete oversight of the home. This weekly report also ensures that assessments and care plans are kept up to date. Any issues identified in the above are communicated to the relevant teams and is monitored for compliance by the SMT.

## 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 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Substantially Compliant | Yellow | 30/09/2024 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 30/09/2024 |
| 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 | 31/08/2024 |
| Regulation 18(1)(b) | The person in charge shall ensure that each resident is offered choice at mealtimes. | Not Compliant | Orange | 30/09/2024 |
| Regulation 18(1)(c)(i) | The person in charge shall ensure that each resident is | Not Compliant | Orange | 31/08/2024 |

| | | | | |
|---|---|---|---|---|
| | provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served. | | | |
| Regulation 18(3) | A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served. | Not Compliant | Orange | 31/08/2024 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 30/09/2024 |
| Regulation 23(e) | The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families. | Not Compliant | Orange | 31/10/2024 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections | Substantially Compliant | Yellow | 31/08/2024 |

| | | | | |
|---|---|---|---|---|
| | published by the Authority are implemented by staff. | | | |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 31/08/2024 |
| Regulation 31(3) | The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4. | Not Compliant | Orange | 31/08/2024 |
| Regulation 34(1)(a) | The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned. | Not Compliant | Orange | 31/08/2024 |
| Regulation 34(2)(d) | The registered provider shall ensure that the complaints procedure provides | Not Compliant | Orange | 31/08/2024 |

| | | | | |
|---|---|---|---|---|
| | for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c). | | | |
| Regulation 04(1) | The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5. | Substantially Compliant | Yellow | 31/10/2024 |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Substantially Compliant | Yellow | 31/08/2024 |
| Regulation 9(3)(a) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents. | Not Compliant | Orange | 31/08/2024 |
| Regulation 9(3)(d) | A registered provider shall, in so far as is reasonably | Not Compliant | Orange | 31/10/2024 |

| | | | | |
|---|---|---|---|---|
| | practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned. | | | |