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:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Meelick, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	25 July 2022
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0037426

About the designated centre

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

Ennis Road Care Facility is a designated centre located on the outskirts of Limerick city on the old Ennis Road. It is registered to accommodate a maximum of 66 residents. It is a purpose-built single storey facility, where bedroom accommodation comprises 54 single and 15 twin rooms, all with en-suite facilities of shower, toilet and hand-wash basin. Additional toilet facilities are available throughout the centre. Communal areas comprise a spacious dining room, a large garden room (day room), activities room, smoking room, and oratory. Main reception is an expansive space with a grand piano, fire place, and lots of seating hubs; off the main reception is the hairdressers' salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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
Monday 25 July 2022	10:00hrs to 18:30hrs	Catherine Sweeney	Lead
Monday 25 July 2022	10:00hrs to 18:30hrs	Claire McGinley	Support

What residents told us and what inspectors observed

Overall, residents spoken with and observed on the day of the inspection enjoyed a good quality of life in the centre. At the start of the inspection, the inspectors met with the person in charge and the clinical nurse manager, who accompanied them on a walk around the centre.

The atmosphere in the centre was warm and relaxed. Residents told the inspectors that they enjoyed their life in the centre and that staff knew them well, and treated them with kindness.

Inspectors observed that the premises was clean and well-maintained. Residents were observed mobilising independently around the many communal spaces in the centre. Most residents were observed to be actively engaged in social activity throughout the day of the inspection. Others spent time alone in there bedrooms, as was their preference. All residents spoken with reported that there was 'plenty to do' and that 'they were able to decide how to send their day'. Residents were observed to have access to television, radio and newspapers. Residents bedrooms were observed to be decorated in a person-centred manner, using resident's family picture and furnishings. There were two spacious external courtyards which residents could access independently.

Inspectors observed a lunch-time service. Meals appeared to be relaxed, unhurried social occasions. Meals appeared appetising and nutritious. Residents reported that the quality of food was good and that there was always choice available. One resident explained that the kitchen staff would cook them 'anything they wanted if they didn't fancy what was on the menu'. Staff were observed to facilitate residents who required assistance with their meals in a kind and respectful manner.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

This was an unannounced risk inspection to review and assess the application made by the provider to vary the conditions of the centre's registration, returning the occupancy of the centre from 66 to 84 registered beds. As part of this inspection, inspectors monitored the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the actions committed to by the provider as part of a compliance plan submitted following an inspection of the centre in

August 2021. The Chief Inspector of Social Services had received unsolicited information in relation to the safeguarding of residents. A review of this information was found the issues of concern to be partially substantiated.

The centre had experienced a significant outbreak of COVID-19 in April 2020. Subsequent inspections of the centre in May, July, September 2020 and February 2021 found ineffective governance systems in place inspections of the centre. An inspection in August 2021 had found some improvements in the governance systems, however, the findings of this inspection were that these improvements had deteriorated and that the provider had failed to ensure that the governance systems in the centre were safe, and effectively monitored.

The registered provider of the centre was Beech Lodge Care Facility Ltd. One of the directors was the representative of the provider and was the person in charge. The person in charge was supported in the centre by two recently recruited clinical nurse managers. Two further clinical nurse managers named on the roster were on planned leave at the time of the inspection. The clinical nurse managers were rostered to work in both a supervisory and direct resident care capacity. The overall staffing levels in the centre, while adequate on the day of the inspection, would not support the provider's own proposed staffing structure, submitted with the application to vary the condition of the centre's registration.

This inspection was facilitated by the person in charge and a clinical nurse manager. Information requested for this inspection was not provided in a timely manner, was disorganised and difficult to review. Requested documents, such as policies and procedures, were filed and stored in a manner that made them difficult to retrieve. Inspectors made multiple requests for some documents, and waited extended periods of time for other documents to be produced. There was an electronic system of documentation in place. A review of this system found that multiple clinical records, such as details of safeguarding incidents, were incomplete. There was no system of oversight in place to ensure that clinical documentation was completed in line with professional guidelines. In addition, inspectors were not assured that the service provided could be effectively monitored due to the poor system of record keeping. A review of completed audits and staff meetings found that while issues of risk had been identified, there was no action plans in place to address these issues.

The risk management system failed to ensure that resident safety was effectively managed. The risk management policy was not reviewed and updated in line with regulatory requirements. A review of the accident and incident log within the electronic documentation system found that while incidents were recorded, no root cause analysis, investigation, or follow up interventions were documented. It was therefore difficult to establish if appropriate action had been taken, or if there was any learning identified from an incident that may have informed an quality improvement plan for all residents in the centre. As there was no root cause analysis completed for multiple injurious falls in the centre, inspectors were not assured that the staffing level at the time of the incidents had been considered as a possible contributing factor to the incident occurring.

Regulation 15: Staffing

Staffing in the centre, on the day of the inspection, was adequate to meet the day-to-day care needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the staff training records found that training was provided to staff, commensurate to their role.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that record management was not in line with the requirements of Regulation 21. This was evidenced by;

- Records were filed in a way that was not safe or easily accessible. Records were disjointed and difficult to review. New and old records were stored together, out of chronological order. Reviewed policies were stored with out-of-date policies.
- Records of incidents were not maintained in line with Schedule 3(4)(j) of the regulations. No detail in relation to any investigation or actions taken following an incident were recorded.
- Fire safety records were not stored in one location for safety and accessibility. This meant that the provider could not provide timely assurance that all the fire safety systems were in line with requirements.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not ensure that there was adequate resources, with particular regard to experienced senior nursing staff, to ensure the effective delivery of care. Two members of the senior nursing team were on extended planned leave. The

provider had failed to ensure that there was a system in place to replace staff on planned long term leave. This resulted in

- inadequate supervision of nursing documentation
- poor management of safeguarding incidents

The management systems in place were not effective to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example,

- Clinical and environmental audit systems did not have an appropriate plan in place to address issues identified.
- Ineffective oversight systems for the management of risk, records and complaints. This meant that areas of leaning and quality improvement were not identified, increasing the risk of incidents repeating.
- Records of staff meetings identified generic agenda items for discussion. Records of these meetings did not contain the detail of issues discussed, or any action plans in place to address issues.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints log found that complaints were not managed in line with the centre's own complaints policy or the requirements of regulation 34. While complaints were recorded, there was no record of the investigation of the complaint, the action taken to address any issues, or the satisfaction of the complainant.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A review of the policies and procedures in the centre found that policies given to the inspectors on the day of the inspection had not been reviewed in line with the requirements of regulation 4. For example, the risk management and safeguarding policy were out of date. The provider submitted updated policies following the inspection.

Judgment: Substantially compliant

Quality and safety

Residents were observed to enjoy a satisfactory quality of life in the centre. The day-to-day health and social care received by residents was delivered at an appropriate standard. However, the systems in place to ensure that this care standard could be sustained and that the residents were safe were not robust. The deficits in the governance and management of the centre were found to impact on the compliance of the regulations in place to ensure residents' safety. Action was required to ensure compliance in relation to risk management, fire precautions, and protection of the residents.

The risk management policy was out of date. A review of an incident and accident register identified that risks were not managed in line with the risk management policy in place at the time of the inspection. Incidents had not been appropriately risk assessed and no plan was put in place to ensure the incident was not repeated. Inspectors reviewed the records of three injurious falls and found that the documentation of these incidents was poor. There was no analysis of the possible causes of the fall and therefore no plan could be developed to reduce the risk of further falls.

A review of the fire safety in the centre found that the documentation to provide assurance in relation to the systems in place to maintain the fire safety precautions was disjointed and difficult to review. This issue is addressed under Regulation 21. Inspectors observed a number of gaps between some of the fire doors and the doors frames. This meant that in the event of a fire that it could spread due to inadequate containment. A review of the fire drills completed found that action was required to ensure residents could be safely evacuated in the event of an emergency.

There was an electronic nursing documentation system in place. Each resident had an assessment and care plan in place. Residents had access to medical and allied health care through an appropriate system of referral.

Inspectors were not assured that the system in place to ensure the protection and safeguarding of residents was robust and in line with the HSE (2014) National safeguarding guidelines. On the day of inspection, inspectors found two separate incidents of alleged abuse that had not been appropriately managed. A review of the resident's care records found that a potential safeguarding incident had not been identified as such and therefore, appropriate action had not been taken to assure the safety of the resident.

Social connections, including regular visiting, were observed to be facilitated. Activities were organised to meet the social care needs of the residents. Staff were observed to be kind and respectful in all interactions observed by the inspectors. Residents were observed to have their social care needs met.

Regulation 26: Risk management

An up-to-date risk management policy was not in place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A review of some of the fire doors in the centre found that there were gaps between the doors and the door frames, when the door was in a closed position. The bottom of one bedroom fire door appeared to be uneven and had a significant gap between the door and the floor. Gaps were also observed around the dining room doors. This poses a risk that the systems in place to contain fire and smoke in the event of an emergency were not effective.

A review of the documented fire drills in the centre found that the drills completed did not provide assurance that the largest compartment could be safely evacuated, in a timely manner, using night-time staffing levels. The drills reviewed provided assurance that one resident could be safely evacuated.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of the nursing documentation found that all residents had an assessment and care plan in place.

Judgment: Compliant

Regulation 6: Health care

Residents had unrestricted access to a General practitioner (GP) service. Residents were also supported by a team of allied health care professionals such as dietitans, speech and language therapists and palliative care supports. The centre also employed a full time physiotherapist.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that the management of safeguarding incidents in the centre was not in line with the HSE (2014) National guidelines for the safeguarding of vulnerable adults.

A safeguarding incident that was notified by the provider to the Chief Inspector was not managed in line with the national guidelines for the safeguarding of vulnerable adults. A review of the incident found that a preliminary review found that there was cause for concern, however, there was no safeguarding plan documented for the resident.

A further potential safeguarding incident was identified though a review of the residents care file. No action had been taken by staff to ensure the safety of this resident.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents told the inspectors that they enjoyed a good quality of life in the centre. Residents were supported and facilitated to be actively socially engaged through out the day of the inspection.

There was an appropriate schedule of activity which were observed to be attended by different groups of residents. Residents told inspectors that they chose how to spend their day.

Residents had access to an advocacy service.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0037426

Date of inspection: 25/07/2022

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	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All records are stored in an accessible manner in the CNM's office. These have now been organized in a chronological manner with an easy to navigate indexing system and there is only one current version of each record maintained. Fire records are now all stored together in an accessible manner in a fire-retardant file cabinet. All out of date records have been archived. – with immediate effect Incidents are reviewed on a monthly basis for closure at which time full details of the investigation, learning and actions are completed within the relevant file. Going forward this detail will be updated on a weekly basis with formal closure at the end of each month.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The person in charge has two recently recruited CNM's in place on rotation covering the full seven days a week, to ensure there is management present at all times. These additional staff are rostered to cover the clinical hours previously fulfilled by two other CNM's who are currently on planned leave with a clear date for return to work. This will bring the total senior nurse management complement to 5 nurse managers. Also, the person in charge has a senior staff nurse allocated to night duty. A newly recruited and appointed PIC will be in place to further enhance the management structure with a thorough knowledge of older person care, due several years of senior management experience in a large older person care facility from 03/10/2022. Previous CNM also	

returning from planned leave on 19/9/22.

All staff meetings have a clear agenda, minutes and action plan to follow in place. With immediate effect the minutes of these meetings will include more detail on the specifics discussed at each individual meeting.

A centralized corrective action plan has now been developed to ensure greater clinical oversight and status monitoring of the actions required to be implemented. This plan will be used as the basis for our weekly governance and management meetings with all heads of departments. – with immediate effect

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The gaps in complaints records have now been addressed. All complaints on review for closure, have learnings and an action plan in place prior to closure. Complaints are fully investigated and resolved before closure and are addressed and reviewed within one month of opening. – Completed with immediate effect

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Files have been reorganized and old policies have now been archived – complete.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The risk management policy is in date and contains all the requirements of regulation 26 - complete.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A fire drill of total evacuation of the largest compartment was carried out on 22/07/2022. Fire drills will continue to be carried out weekly using different compartments, different fire scenarios, take account of day-time and night-time staffing levels and will alternate between partial and total evacuation of the compartment. All fire documentation is now kept together in a fire-retardant cabinet. There continues to be yearly inspections by a fire safety consultant. Gaps on fire doors will be remedied – to be completed by 30 October 2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Safeguarding and Protection of Residents Policy and Recognising and Responding to Allegations of Abuse policy are in place. There is also Policies on Protected disclosures & Complaints in place.
All staff have completed the Safeguarding training vulnerable adults on induction and updates every 2 years thereafter.
The PIC has been appointed as the Safeguarding Officer. She will also act as a resource person to staff members, carers or volunteers who have protection concerns.
There is a CNM/Senior staff Nurse on duty at the weekends and evenings who are aware of the necessary steps to follow in the event of an allegation or incident of concern in line with policy.
All preliminary screening forms will now be reviewed immediately by the Person in Charge (as Safeguarding Officer) following any such incident to ensure there is a safeguarding plan in place and that residents and staff have the appropriate resources and support.
Resident's rights are discussed at the resident's meetings. Sage advocacy have and continues to support the residents' rights with talks for both residents and staff (With latest being 6 weeks ago). Their contact details are displayed in communal areas of the Nursing Home. The resident Guide, which is in each bedroom, contains information to access the Safeguarding officer, Sage Advocacy, and the safeguarding contact for CHO3.
Care plans are put in place for all residents to reduce the risk of harm, and to promote the resident6s Human rights. To formulate the care plans this information shall be sought at Preadmission and admission stage.
Safeguarding is regularly discussed and reviewed at the Clinical Governance meeting.

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 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.	Not Compliant	Orange	29/07/2022
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	29/07/2022
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 the statement of purpose.	Not Compliant	Orange	27/07/2022
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	28/07/2022

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	25/07/2022
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	25/07/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable,	Substantially Compliant	Yellow	27/07/2022

	residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	27/07/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	28/07/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	27/07/2022
Regulation 04(3)	The registered provider shall	Substantially Compliant	Yellow	27/07/2022

	review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	25/07/2022