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:	Beechlawn House Nursing Home
Name of provider:	Congregation of Our Lady of Charity of the Good Shepherd
Address of centre:	Beechlawn House Nursing Home, High Park, Grace Park Road, Drumcondra, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	17 September 2024
Centre ID:	OSV-0000115
Fieldwork ID:	MON-0044784

About the designated centre

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

Beechlawn House Nursing Home can accommodate up to 56 residents and provides care in the ethos of the Congregation of Our Lady of Charity of the Good Shepard. The centre is primarily for religious sisters and females over 65 years old, however women under 65 can be accommodated also. The home comprises of 41 single ensuite bedrooms and 8 twin rooms and is divided into 3 wings. Each wing has its own lounge room, dining area and activity space. Medical and nursing care is provided on a 24-hour basis for residents with low to maximum dependency needs. There is an oratory and a large, secure garden area in addition to internal courtyards available for residents use. Physiotherapy, chiropody, optician and dental services are available and can be arranged for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

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 17 September 2024	08:50hrs to 18:05hrs	Karen McMahon	Lead
Tuesday 17 September 2024	08:50hrs to 18:05hrs	Niamh Moore	Support

What residents told us and what inspectors observed

This inspection took place in Beechlawn House Nursing Home, Drumcondra, Dublin 9. During this inspection, the inspectors spent time observing and speaking to residents, visitors and staff. From what inspectors observed and from what the residents told them, residents were happy residing in the centre. The overall feedback was that the premises was lovely, the food was tasty and that the staff were very friendly and caring. While residents spoken with were happy within the designated centre, the inspectors found that significant improvements were required in the oversight and provision of care for some residents which will be further discussed within this report.

Shortly after arrival to the centre the inspectors went on a tour of the premises. A staff nurse accompanied the inspectors on the tour, while awaiting the arrival of the person in charge.The centre was divided into three units and can provide accommodation for a maximum of 56 residents in a mix of single and twin occupancy bedrooms. All bedrooms had en-suite facilities.The centre was observed to be clean and well-maintained.

Many residents were seen up and mobilising around the centre. Residents were well-presented and neatly-dressed. Eight residents were observed sitting in an open corridor space on the Grafton wing. The residents were not interacting with each other or with staff and appeared to be waiting in this area. Inspectors were informed by staff that residents were brought to this area so that they could be observed more easily as staff went about their morning duties and that residents would be taken from here to the dining room for breakfast once staff were available to take them. Staff were unsure, when asked by the inspectors, why residents couldn't go straight to the dining room for breakfast once their morning care needs had been attended too.

Inspectors observed that residents had personalised their rooms with pictures, flowers, plants and other personal items. There was a variety of small and large communal areas for use, including dining facilities and sitting rooms. These communal areas were seen to be clean, bright, comfortable and tastefully decorated, and suited to the purpose of their use.

There was a dining room on each unit, which were both spacious and well laid out. Tables were seen to be neatly laid. The daily menu was displayed on each table. The inspectors observed that mealtimes in the centre’s dining rooms were relaxed and social occasions for residents, who sat together in small groups at the dining tables. Residents were observed to chat with other residents and staff. There was a choice of hot meals at lunchtime, and a choice of a hot or cold option for the evening meal. The lunch was observed to be well-presented, warm and with ample amounts on the plate. Resident's who chose to eat meals in their rooms were facilitated to do so. The meals were home cooked on-site.

However, one resident reported to inspectors that due to a change in staffing arrangements in the dining room they felt they were left longer waiting for assistance. This was because health care attendants were now required to serve up the food to residents who could eat independently before they assisted those residents who needed support to eat their meals. Previously the meals were served by the catering staff while the health care attendants provided assistance and supervision to those residents who needed additional support.Two staff spoken with confirmed this was a change of practice within the weeks prior to the inspection and required review to ensure the new arrangement was meeting the needs of all residents.

Mass was held daily in the centre in the large oratory and many residents were observed to sit here throughout the day for silent prayer and reflection. Group exercise was held after mass each day except Sundays. Other activities included sing alongs, board games, arts and crafts bingo and ladies club.

There were a number of enclosed garden and outdoor spaces available to residents in the centre. One outdoor space was recently renovated. The outdoor spaces available to residents were well maintained with appropriate paving and outdoor seating. On the day of the inspection afternoon activities took place outdoors due to the warm sunny weather that day. Residents were observed to enjoy sitting outdoors, wearing sunhats to protect them in the warm weather and participating in social activity.

The inspectors spoke with many residents, over the day of inspection, all of whom were positive and complimentary about the care they received, including response times from staff. One resident told the inspectors "I have a place to lay my head stay in from the cold and get great food and company what more could I want". Another resident told inspectors that they enjoyed the company and being able to attend mass daily which was very important for them.

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

This inspection found that although, the provider aimed to provide a good service and support residents living in the designated centre to receive a good standard of care significant focus and effort were now required to improve the management and oversight of care and services provided for the residents. There had been a significant decline in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), since the previous inspection in January 2024 and this was impacting on the quality and safety of care for residents.

This was an unannounced risk inspection carried out to follow up on recent unsolicited information submitted to the office of the Chief Inspector. The registered provider of Beechlawn House Nursing home is The Congregation of Our Lady of the Charity of the Good Sheppard. The inspectors found that although there were clear lines of accountability and responsibility in relation to governance and management arrangements for the centre the high number of absences by senior clinical staff was impacting on the efficacy of these arrangements. The person in charge was supported by a named provider representative, an assistant director of nursing and two clinical nurse managers (CNMs). However, there were multiple gaps identified in this structure throughout the year due to unplanned extended leave by members of this management team. The provider had failed to ensure these absences were appropriately covered and this had impacted on the oversight of care and services provided for residents.

On the day of the inspection, inspectors found that there was sufficient staffing levels and skill mix in place. A review of rosters and staff leavers and beginners identified that 50 percent of staff had been working in the centre for less than a year but this was offset by the other 50 percent many of whom had worked in the centre for over ten years, with some having almost 20 years of service in the centre. There were no staff vacancies on the day of inspection. A review of documentation, of both worked rosters and management meeting minutes, identified a high level of sick leave in the centre which, for the most part, was covered by the centre's own staff.

The person in charge had been newly appointed to the role in August 2023. The person in charge was a registered nurse who was full time in post and had the necessary experience and qualifications, as required by the regulations. However, the required documents for the person in charge as set out under Schedule 2 of the regulations were not available in the centre for review by the inspectors.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

The complaints log was made available to the inspectors for review. There were no current open complaints. Inspectors noted that one complaint had been made from January to August 2024 and eight complaints were received since August 2024. One complaint required a significant investigation to be carried out. A review of the records of one recent complaint found that the complaint had not been adequately investigated to ensure all lines of enquiry were followed up. This is further discussed under Regulation 34; Complaints Procedure.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to meet the assessed needs of the residents in the designated centre, on the day of inspection.

Judgment: Compliant

Regulation 21: Records

The registered provider had not ensured that the records set out in Schedule 2 were kept in the designated centre and available for inspection by the chief inspector. For example as set out under Regulation 14 the required documentation for the person in charge was not kept in the centre and was not available for review. Furthermore, the supervision records for one member of staff were not available on the day of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management and oversight systems in place were not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). This is evidenced by the number of non-compliance's found on inspection.

The management systems that were in place did not ensure that the service provided for residents was safe ,appropriate,consistent and effectively monitored. This was evident in the oversight of key areas of clinical care including assessment and care planning, the management of restrictive practices and the care of residents with nutritional needs and was impacting on the quality and safety of care provided for residents. Furthermore the oversight of safeguarding processes failed to ensure that all potential allegations or incidents of abuse were identified and reported promptly by staff.

The provider had not ensured that there were adequate resources available to cover extended periods of absence by senior clinical staff. As a result the clinical management team set out in the provider's statement of purpose had been depleted since February 2024 which had impacted on the support and supervision of staff in their day to day work.

Judgment: Not compliant

Regulation 31: Notification of incidents

Two safe-guarding incidents identified in care records on the day of inspection had not been notified to the Chief Inspector. Furthermore, not all restraints in use in the centre were reported in the quarterly notifications to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

Records showed that a recent complaint had not been managed in line with the provider's own complaints policy. Inspectors were not assured that the complaint had been appropriately investigated as some lines of enquiry had not been followed up. Furthermore inspectors were not assured that the issues raised by the complainant had been adequately considered in the investigation. As a result the complainant was not satisfied with the outcome or how their complaint had been followed up.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Records showed that there had been a number of unplanned absences of senior nursing staff some of which had been for extended periods of time. This had impacted on the the support and supervision available to nursing and care staff. These absences also correlated with a significant rise in resident falls in the centre and a rise in complaints about care provided for residents.

Judgment: Substantially compliant

Quality and safety

Residents in Beechlawn House Nursing Home appeared content living in the centre and many spoken with said they were happy with the care they received. However, inspectors identified that significant improvements were required to ensure a safe and good quality service was consistently provided for residents. This was a,

particular concern in relation to care planning, healthcare, the management of restrictive practices and safeguarding residents.

Care documentation was electronic. Inspectors reviewed a number of assessments and care plans on the day of inspection and found that while all regulatory time frames had been met and documentation was in date, there were significant gaps seen in a number of records and this was impacting on the quality of care provided for residents. For example, inspectors saw that where changes had occurred in the resident's condition particularly in their mobility status, the corresponding assessments and care plans had not been updated to guide staff on how to manage the resident's changing needs. In addition, a high number of care plans were generic and did not provide details of each resident's specific care needs. This created a risk that temporary or new staff would not have sufficient information from reading care plans to provide appropriate care for residents. This is further discussed under Regulation 5: Individualised Assessment and Care Plan.

Residents' had access to medical care. Two general practitioners (GPs) attended the designated centre on a weekly basis. Outside of this an out of hour's service was contacted. There was evidence from a review of residents' records that residents were reviewed by health and social care professionals, for example by GP, physiotherapy and chiropody. However, inspectors identified that two residents with significant nutritional needs had not been referred to dietician services in a timely manner and that this failure had had a negative impact on their health and well-being. This is discussed further under Regulation 6: Healthcare.

Inspectors saw that residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had appropriate assessments and care plans in place. 81 percent of staff had completed dementia awareness training and 32 percent of staff had training on the management of anger, agitation and aggression. Overall, observations on the day of the inspection were that staff supported residents in a person-centred manner. The registered provider had a policy on the use of restraint dated November 2023, however, the inspectors found that the policy was not being consistently implemented in practice. As a result restraints were not being managed in line with national guidance.

Training records for safeguarding had a compliance level of 100 percent, however this training was provided online and staff attended remotely. The registered provider had recently facilitated further in-person safeguarding training. Records showed that 43 percent of staff had received this additional training. Although this was a welcome improvement in safeguarding training the inspectors found that some staff did not demonstrate appropriate safeguarding knowledge, in relation to identifying and reporting potential safeguarding incidents to senior staff and in developing appropriate safeguarding care plans.

Visitors were observed to be welcomed to the centre throughout the day of inspection. There was a sign-in and sign-out system in place at the reception desk. There was suitable space for residents to receive visitors with many smaller private

communal areas available, however many residents chose to receive their visitors within their bedrooms.

Where a resident had been transferred to hospital, a transfer letter was used to capture relevant detail. Inspectors were told that copies of current medicine prescriptions were also sent with the resident. Hospital discharge letters were also available for review and inspectors saw that GPs reviewed this documentation upon the residents return to the designated centre.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors, which was unrestricted.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Inspectors saw evidence that relevant information accompanied residents who were temporarily transferred out of the centre to another service. On return to the centre following the temporary absence, medical and nursing transfer letters were available for any changes to the resident's care.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to ensure care plans were reflective of the resident's current care needs. For example:

- Two residents with significant weight loss, did not have their assessment score recorded and as a result the residents did not have up to date nutritional care plans in place to inform nursing and care staff of the actions they needed to take to support the resident with their nutritional needs.This created a risk that these residents' nutritional needs would not be met.
- Inspectors reviewed documentation for three residents following serious injuries. The following gaps were evident in the care records:
    - One resident's manual handling assessment was incomplete, as the detail relating to their mobility status was blank. This resident was a

wheelchair user and this had not been recorded. Furthermore, this resident's falls care plan reflected an incorrect mobility aid, and not the current aid used by the resident.
    - A resident's Personal Emergency Evacuation Plan (a personalised evacuation plan to detail the level of support a person may require during the evacuation of a building) and mobility care plan had not been updated following changes to their mobility status following a recent injury. For example, this documentation referred to the resident walking with supervision, while the resident required a wheelchair.
    - A falls care plan had not been updated for one resident to reflect their current mobility aid and their current Canard falls risk assessment.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that improvements were required to ensure all residents' received a high standard of evidenced based nursing care. For example:

- Two residents experiencing significant weight loss were not weighed weekly in line with their clinical risk according to their MUST score (a tool used to identify individuals who are at risk of malnutrition).
- There was an error in the completion of the malnutrition assessment tool which resulted in the MUST score being miscalculated for one resident. As a result this detailed that the resident had gained weight which was not accurate. This prevented the appropriate action from being taken such as increased monitoring and appropriate referrals such as to a dietitian.
- There was a delay in making a referral to a dietitian for assessment and follow-up for two residents with significant nutritional risk. For example, one of the residents was identified as a MUST score of 2 which is high risk four months prior to the inspection. This risk had increased and the resident was a MUST of 4 on the day of the inspection. They had not been referred to the dietitian. The referral was made when this was pointed out to the person in charge on the day of the inspection.
- There was no evidence that staff were monitoring residents using bed rails when in bed. This was validated by the person in charge who confirmed that these checks to ensure the equipment was being used safely and for the least possible time were not taking place.
- There was no documented pain assessments available to review for one resident who had received two doses of as required pain medication. As a result the inspectors were not assured that the resident's pain was being monitored and that analgesia was administered appropriately.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

While the centre had an up-to-date restraint register which was reviewed on a monthly basis, the monthly reviews did not ensure that restraint was used in accordance with national policy "*Towards a Restraint Free Environment in Nursing Homes*" and in line with the registered provider's own policy on the use of restraint. For example:

- There was no assessment available in the records of three residents who had restraints in place to evidence the reason for using the restraints. This related to two residents who had floor and bed alarms, in place and one resident who was using bed rails.
- Records showed that there was no evidence that alternative less restrictive practices were trialled prior to the implementation of restraint for three out of four records reviewed.
- There was no signed consent by either the resident or their representative available to review for three out of four records reviewed.

Judgment: Not compliant

Regulation 8: Protection

All reasonable measures to protect residents from abuse had not been taken. For example:

- Staff had failed to recognise two incidents of abuse, and had not completed incident reports or reported these incidents to the relevant manager.
- Two safeguarding plans were not updated to reference the update or outcomes of safeguarding investigations. For example, as part of a safeguarding investigation, a recommendation made from the safeguarding team was that a resident required assistance and support with care needs from two staff. This assessed need was not reflected in the resident's safeguarding care plan to ensure staff were aware of the current care needs.
- Safeguarding care plans were generic and referred to the overall safeguarding policy within the centre instead of specific measures in place to safeguard the individual resident.
- One resident had no safeguarding plan in place when there was an assessed safeguarding need identified. As a result staff may not be aware of the actions they needed to take to safeguard the resident.

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 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Beechlawn House Nursing Home OSV-0000115

Inspection ID: MON-0044784

Date of inspection: 17/09/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff records are now accessible on our HR electronic system. These include the relevant information for the PiC and all staff members. This information includes onboarding, references, education, reviews and disciplinary (including open investigations). In line with regulation requirements the PiC HR file (hardcopy) has now been relocated to Beechlawn House Nursing Home and available for viewing at any time.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There has been a re-appointment of an additional CNM on a full-time basis. This appointment allows 7 day per week management cover. This ensures the PiC is supported by a member of the clinical management team to guarantee consistent oversight of the Nursing Home. Each Clinical manager is allocated oversight of one of our three care areas and this will allow for safe, consistent and effective nursing care, monitoring in care planning, assessments, nutrition, falls and management of restrictive practices. There are now clinical key component areas assigned to each of to the Clinical Managers which are reviewed at weekly clinical management meetings and discussed at weekly PPIM meetings to ensure quality care is delivered. There is a clear clinical operational management structure within the Nursing Home. In the absence of the PiC the ADON will be in place supported closely with the PPIM and	

Clinical Nurse Managers. There has also been a further plan put in place, whereby a Senior Staff Nurse working in the Nursing Home for 16 years and who is currently completing a healthcare management course, will act up in any future absences. Additional training on safeguarding has been arranged (in person). An open reporting culture is promoted, this is echoed at handovers and safeguarding tool box talks are used to assess recall and escalation pathways.

All leave will be planned, and no 2 members of the clinical management team will be on leave at any one time. In the event of unforeseen circumstances, a member of the senior staff nurse team will be appointed in a supernumerary role to fulfil the deficit. Management rosters are completed one month in advance and reviewed by the PiC and PPIM.

The statement of purpose is currently being updated to reflect these changes.

Regulation 31: Notification of incidents	Not Compliant

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

A full review of all incidents, use of bed rails, floor alarms, pose alarms and all other objects used as safety mechanisms has been completed and updated to ensure that any potential gaps in care are identified, this will be repeated on a monthly basis. All notifications will be submitted in the allocated time frames and in line with regulatory requirements.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Beechlawn House Nursing Home engaged with an external investigator to review the incident and complaint. This has now concluded and the findings presented and discussed with the Management Committee of Beechlawn House Nursing Home including the RPR,PPIM & PiC. Learning identified from this complaint and investigation process whereby the investigator will broaden lines of enquiry and explore all aspects of concern. This report is filed in the complaint folder at DCOP.

Our aim is that all complaints are dealt with in line with our complaints policy. These are overseen by Senior Management, reviewed by a complaint officer and independently reviewed. Where necessary, external specialists' services to investigate complaints will be used. Our aim is to achieve positive outcomes with learning were possible. Should the complainant not be happy a review meeting is held, we review the complaint and

feedback if additional finding or recommendations are made. Throughout the investigation external supporting agencies information is offered.

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Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

There is now a member of management or a Senior Staff Nursing present in the Nursing Home 24 hours a day 7 days per week. This level of clinical supervision aids the oversight and direction to ensure resident safety and wellbeing is being achieved at all times.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Our care plans are developed with The Roper, Logan, and Tierney (2000) Model of Nursing based on Activities of Living, considering knowledge from the natural sciences, the social sciences and the humanities. The care plans are initiated, following an assessment of needs which supports the residents to live a supported life. Each member of the nursing staff has been named as a link for a small cohort of residents to provide personalized individualized care plans and ensure assessments are up to date. The Clinical management team (ADON/CMN) oversee this action and conduct monthly audits on their peer's working area. Importance of accurate auditing and follow up and actioning of outcomes is now emphasized at weekly Clinical Meetings, spot checking of time in motion audit across all areas will now be conducted by the PiC. Upon a review of audit and outcome actions it has been identified that additional care plan training for all nursing staff is needed with nursing staff given planned adequate time to complete same. Care plan training has been sourced and date of confirmation is pending.

Following on from recent inspection:

A full nutritional review has taken place by the newly appointed link nurse at CNM level with support from a CORU registered dietitian. The CNM is also enrolled and currently undertaking a Healthcare in nutrition course QQI Level 6 to support her in this role. All MUST's score and weights have been reviewed. All residents with a MUST score of 2 or above have been referred or reviewed by the dietician.

A plan is currently in plan to ensure all nutritional care plans have been reviewed and for updates to be maintained thereafter.

A member of the clinical management team has now taken on oversight to ensure all residents' manual handling assessments have been reviewed and are being updated regularly and as required.

All residents PEEP's have now been updated and displayed in the residents bedroom and can also be located in the fire book at main reception. A member of the clinical management team now ensure that these assessment are completed every three months or sooner if needed.

All falls' assessments and care plans have been reviewed and updated to reflect the resident current needs. A continuous plan is in place to minimize residents risk by hourly meaningful checks.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

AA full review of all MUST assessments has been conducted. Relevant actions have now been put in place to prevent shortcomings in assessments, referrals and decreased monitoring re-occurring. A CNM now holds the responsibility to oversee and coordinate all components of Nutrition, this is supported by their enrollment on a QQI course on nutrition in healthcare.

The two residents who are using bed rails are checked on hourly for meaningful wellbeing. This is common practice in Beechlawn House Nursing Home, these checks are and have been logged on our live recording system. There will now be specific checks conducted for bed rail safety. There are information leaflets readily available across the home. Updated consent forms for items classed as a restraint have been completed and signed by all stakeholders.

All staff nursing staff have been reminded of the importance of pain assessments before administering and of the need to reassess in order to monitor effectiveness.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

All residents with a restraint in place were reviewed, this includes those residents using bed alarms, floor alarms (Fall prevention) and bed rails. All relevant assessment has been carried out and consent gained and consent forms completed. This information is reflected in the restraint register and resident care plan.

Beechlawn House Nursing Home remains working towards a restraint free environment within the nursing home. Trials have taken place to offer alternative ways to live less restrictively within the Nursing Home and now reflected in the residents individual care plans. Information, education and support has also been provided and will continue to be given by nursing staff.

Following same, all required assessments and consent forms have been completed for residents who require or choose to use a practice of a restrictive nature. These adaptations will be reviewed on a 4-month basis or earlier if needed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

While our safeguarding training completion is at 100% we remain committed to the further education of our staff members. We are doing this with in person (Classroom based) training. We also have put together toolbox talks for safeguarding which will be run by CNMs to assess the staff knowledge and recall of vital information and reporting pathways. We have also scheduled a full review of all safeguarding practices, premises and policies.

Safeguarding care plans are now in place for all residents who require them. They include detailed personal information on how to directly protect as needs be it from a family member, peer or staff member.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	25/10/2024
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	25/10/2024
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.	Substantially Compliant	Yellow	08/11/2024
Regulation 23(c)	The registered provider shall	Not Compliant	Orange	25/10/2024

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	25/10/2024
Regulation 31(4)	Where no report is required under paragraphs (1) or (3), the registered provider concerned shall report that to the Chief Inspector at the end of each 6 month period.	Not Compliant	Orange	25/10/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	08/11/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not	Not Compliant	Orange	08/11/2024

	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.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	25/10/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	15/11/2024
Regulation 8(1)	The registered provider shall take	Not Compliant	Orange	25/10/2024

	all reasonable measures to protect residents from abuse.			