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:	Belmont House Private Nursing Home
Name of provider:	Belmont Care Limited
Address of centre:	Galloping Green, Stillorgan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	12 April 2023
Centre ID:	OSV-0000014
Fieldwork ID:	MON-0039617

About the designated centre

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

Belmont House is a 157 bed centre providing residential, respite and short stay convalescent care services to male and female residents over the age of 18 years. The centre was originally a Georgian country house and was owned by a religious order. The building has been extended and completely refurbished while retaining some of its older features. It is located on the Stillorgan dual carriageway, close to the village of Stillorgan, with access to local amenities including shopping centres, restaurants, libraries, public parks and coffee shops and good access to public transport. Accommodation for residents is across six floors. There are also areas for residents to socialise and relax, including activity rooms, a coffee dock and quiet areas. The majority of bedrooms are single rooms and there are 26 twin rooms. There is 24 hour nursing care with access to both in-house and specialist healthcare as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	135

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
Wednesday 12 April 2023	09:40hrs to 18:30hrs	Mary Veale	Lead
Thursday 13 April 2023	08:30hrs to 17:30hrs	Mary Veale	Lead
Wednesday 12 April 2023	09:40hrs to 18:30hrs	Kathryn Hanly	Support
Thursday 13 April 2023	08:30hrs to 17:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Residents enjoyed a good quality of life and were positive about their experience of living in Belmont Private Nursing Home. There was a welcoming and homely atmosphere in the centre. Residents' rights and dignity was supported and promoted by kind and competent staff. Care was led by the needs and preferences of the residents who were happy and well cared for in the centre. The inspectors observed many examples of person-centred and respectful care throughout the days of inspection. Inspectors spoke with 19 residents. Residents reported their satisfaction with the quality and safety of care they received. Two residents said they were looking forward to upcoming changes in mask use for staff and visitors as they found masks were a barrier to effective communication.

The inspectors spent time observing residents' daily life and care practices in the centre in order to gain insight into the experience of those living in the centre. Residents looked well cared for and had their hair and clothing done in accordance to their own preferences. Residents' stated that the staff were kind and caring, that they were well looked after and they were happy in the centre. Residents' said they felt safe and trusted staff. Residents' told the inspectors that staff were always available to assist with their personal care.

On arrival the inspectors were met by a member of the administration team and guided through the centre's infection control procedures before entering the building. Following an introductory meeting with the person in charge, the inspectors were accompanied on a tour of the premises. The inspectors spoke with and observed residents' in communal areas and their bedrooms.

The centre provided accommodation for up to 157 residents. The centre was laid out over seven floors and was maintained to a high standard.

The centre was laid out over seven floors and was maintained to a high standard. The centre comprised of six units, Beech unit 1; Beech 3 unit; Cedar unit; Evergreen unit; Maple 1 & 2 units; and Oak unit.There were 106 single bedrooms with 26 twin bedrooms. Bedrooms had floor to ceiling windows and residents bedrooms on the third, forth and fifth floors had panoramic views of the Dublin mountains, Dublin bay and Dublin city and county. Bedrooms were personal to the resident's containing family photographs, paintings and personal belongings. Residents were supported to bring their preferred or sentimental items from home. The inspectors observed that many residents had brought their own furniture for example tables, side boards and antique memorabilia which enhanced their feeling of being at home. Bedrooms had sufficient storage space, and some residents had small refrigerators in their rooms to keep their drinks and snacks cool. Pressure reliving specialist mattresses, falls prevention alert devices, and cushions were seen in residents' bedrooms. However the majority of resident bedrooms were carpeted. One resident said they felt the carpet in their room was unclean. This is discussed further in the report under

Regulation 27.

The centre was warm and there was a relaxed atmosphere. The design and layout of the centre promoted a good quality of life for residents. Despite the infrastructural issues identified, overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared appeared visibly clean with few exceptions. Finishes, materials, and fittings in the communal areas struck a balance between being homely and being accessible, whilst taking infection prevention and control into consideration. There was suitable furniture in communal rooms. Corridors were free from clutter with appropriate hand rails. Residents had access to a number of comfortable and well decorated communal spaces, including sitting rooms, dining rooms, a visitor's room and a library with residents' art and craft works displayed throughout these areas. There was access to outdoor spaces via communal spaces on the ground floor, first floor and fifth floor. Residents from the second, third and forth floors accessed the outdoor areas using two of the passenger lifts in the centre.There was a specialised dementia care floor in the centre with its own sitting area, dining area, quiet room and family room. Residents in this area had access to a safe enclosed garden with seating and planting.

Residents had access to a café in the lobby of the centre, which greatly enhanced the social and welcoming atmosphere in the centre. All residents spoken with said that they highly valued this facility. This area was observed to be very busy with visitors and residents over the two days of inspection. The inspectors were informed by the person in charge that a phased removal of face covering would begin in the café area so as residents and staff could begin implementation of the change in the national guidance on the introduction of the removal of face coverings in designated centre.

Residents' spoken with said they were happy with the activities programme in the centre. Group activities were observed taking place throughout the days of inspection. Over the two days the inspectors observed residents' attending a virtual tour of 1950's Ireland, movement to music, attending a happy hour event, jigsaw making, and partaking in a songs and stories activities. For residents who could not attend group activities, one to one activities were provided. The inspectors observed staff and residents having good humoured banter during the activities. The inspectors observed the staff chatting with residents about their personal interests and family members.

Residents' enjoyed home cooked meals and stated that there was always a choice of meals and the quality of food was very good. Residents' told the inspectors that they could have their breakfast in bed and were not rushed at meal times. The inspectors observed the lunch time experience for residents in the Cedar unit on the first day. The meal time experience was relaxed and staff were observed to be respectful and discreetly assisted the residents during the meal times. Most residents said that snacks were available at any time. Residents had access to cold water dispensers and jugs of water were observed in residents' bedrooms over the days of inspection.

Improvements were noted in hand washing facilities throughout the centre. Clinical

hand wash basins that complied with the recommended specifications for hand hygiene sinks had been installed in the majority of units since the last inspection. Staff also carried personal bottles of alcohol hand rub. Equipment viewed was generally clean with some exceptions. For example the underside of several commode chairs covers were unclean and used laundry skip bags were not routinely washed. In contrast the ancillary facilities including sluice rooms and housekeeping facilities did not support effective infection prevention and control. On the day of the inspection sluice rooms on each floor were being used by housekeeping staff. This posed a risk of cross contamination. The provider was aware that aspects of the premises required to be upgraded and a new central housekeeping facilities were under construction on the day of the inspection.

The location of the sluice rooms in some areas did not minimise travel distances for staff from resident rooms to reduce the risk of spillages and cross contamination, and to increase working efficiencies. For example on one unit, staff had to pass through up to seven doors to access the sluice room. Barriers to effective hand hygiene practice were also observed within some sluice rooms during the course of this inspection. Findings in this regard are presented under regulation 27.

The centre provided a laundry service for residents. Residents' whom the inspectors spoke with on the days of inspection were happy with the laundry service and there were no reports of items of clothing missing. A small number of residents preferred to have their clothes laundered by a family member. The infrastructure of the onsite laundry supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and tidy. However part of one unit was used as a thoroughfare for staff transporting dirty and clean laundry to and from other units within the centre. This arrangement posed a risk of cross contamination.

There was no clean utility or treatment room for the storage and preparation of medications, clean and sterile supplies and dressing trolleys. Clean and sterile supplies and medications were stored in the nurse's office on each floor.

There was a lack of appropriate storage space in the centre resulting in the inappropriate storage of supplies in some areas. For example a store room viewed on the first floor was inaccessible due to the large amount of equipment and supplies in the room. Inspectors also observed a storage of large stocks of incontinence wear within a resident's bedroom. Clean linen was stored on open shelving on the second floor.

The inspector observed that visiting was facilitated. The inspectors spoke with two family members who were visiting. The visitors told the inspectors that there was no telephone booking system in place. Visitors spoken to were very complementary of the staff and the care that their family members received.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection carried out to monitor ongoing compliance with the regulations and standards. The inspectors follow up on the compliance plans for the previous inspections carried out in November 2021 and February 2022. The inspection in February 2022 was an infection prevention control focused inspection. The provider had progressed the compliance plan following the inspections in 2021 and 2022. The inspectors followed up on the centres infection prevention and control procedures following notifications of a COVID-19 outbreak in February 2023 and a gastroenteritis outbreak in March 2023.

On this inspection, inspectors found that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control governance, environmental management and the application of standard infection control precautions. Details of issues identified are set out under Regulation 27. The provider did not comply with Regulation 28: fire precautions and further oversight was required of issues pertinent to fire safety as set out under Regulation 28. Areas of improvement were required in Regulation 5: individual assessment and care planning, Regulation 12: personal possessions, Regulation 17: premises and Regulation 23: governance and management.

The inspectors followed up on a restrictive condition which was applied to the centre in June 2022. This restrictive condition required twin rooms 2, 3, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 111, 115, 120, 312, 313, 316, 317, 421 and 423 to be reconfigured to include personal storage space and a chair in each residents bedroom floor space. These twin rooms are discussed further in the report.

Belmont Care Limited is the registered provider for Belmont Private Nursing Home. The company is part of the Orpea Ireland group, which has a number of nursing homes nationally. The company had three directors, one of whom was the registered provider representative. The person in charge worked full time and was supported by two assistant directors of nursing, five clinical nurse managers, a team of nurses and healthcare assistants, a social programme co-ordinator, housekeeping, catering, administration and maintenance staff. The person in charge was also supported by a regional director and a general manager. The person in charge was also supported by shared group departments, for example, human resources. Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the Director of Nursing. Infection prevention control advice and support was also provided by an infection prevention and control specialist nurse as required. Inspectors saw evidence of infection prevention and control specialist nurse on site visits and comprehensive reviews.

The management structure within the centre was clear and staff were all aware of their roles and responsibilities. There were sufficient staff on duty to meet the needs

of residents living in the centre on the days of inspection. However the provider had not nominated a staff member with the required training and protected hours allocated, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.

There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and the majority of staff were up to date with training. Staff were supported and facilitated to attend training and there was a high level of staff attendance at training in areas such as fire safety, safe guarding, cardio-pulmonary- resuscitation (CPR), dementia awareness, and infection prevention and control. All nursing staff had completed medication management training and the inspectors were informed that medication management competencies were completed annually. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. The inspectors noted that fire training and CPR training took place in the centre over the inspection days and fire safety training was scheduled to take place in the weeks following the inspection.

Management systems in place to monitor the centre's quality and safety required review. The centre had an extensive suite of meetings such as healthcare governance management meetings, local management meetings, staff meetings, falls reduction group meetings, infection prevention and control, and supervisor meetings. Meetings took place monthly in the centre. Minutes of meetings detailed items discussed, actions and persons responsible. There was evidence of operational monthly reports to the governance meeting. These reports were aligned with the regulations and discussed items and actions from previous meetings and key areas arising from discussion at meeting. The annual review of the quality and safety of care to residents in 2022 was completed, and a summarised easy to read version of the review was compiled for residents. In addition to the annual review the provider had completed quarterly reviews of the service with improvement plans. The person in charge monitored key performance indicators (KPI's) on a weekly basis such as falls, skin tears, weights, pressure sores, and restrictive practice. There were detailed analysis of resident's wounds and falls completed monthly which outlined interventions for improvement and action plans. Records of audits reviewed required improvement as audits some audits for example; care planning and infection prevention control were not scored, tracked and trended to monitor progress. This is discussed further under Regulation 23; governance and management.

All paper based and electronic records and documentation were well presented, organised and supported effective care and management systems in the centre. All requested documents were readily available to the inspectors throughout the days of inspection. Surveillance of healthcare associated infection (HCAI) was routinely undertaken and recorded. However a review of acute hospital discharge letters and laboratory reports found that staff had failed to identify residents colonised with multi drug resistant bacteria. As a result documented plans to guide the care of residents colonised with multi drug resistant organisms (MDROs) were unavailable

for these residents. Details of issues identified are set out under Regulation 27.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies. However, the centres falls management policy required improvement, this is detailed under regulation 23.

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, dementia awareness, and infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspectors. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- The system for assessment of residents post a fall required review as a number of fall incidents involving residents were not managed in accordance with the centre's policies. The centres post fall procedure did not include an update of the residents evidence based fall assessment or update of the residents care plan.
- Nursing documentation audits were not scored, tracked and trended to monitor progress and action plans were not comprehensive enough to drive quality improvement.
- Further oversight was required of issues pertinent to fire safety as outlined further under regulation 28.

Judgment: Substantially compliant

Regulation 30: Volunteers

Volunteer's attended the centre to enhance the quality of life of residents. Volunteers were supervised and had Garda vetting disclosures in place. Their roles and responsibilities were set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames.

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. There was a varied programme of activities that was facilitated by activity co-ordinators, nursing and care staff and was tailored on a daily basis to suit the expressed preferences of residents. There were good positive interactions between staff and residents observed during the inspection. Improvements were required in relation to Regulation 5: individual assessment and care planning, Regulation 12: personal possessions, Regulations17: premises, Regulation 27:

infection prevention and control and Regulation 28: fire precautions.

Improvements were found to the premises in the centre and the provider had reconfigured twin rooms 2, 3, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 111, 115, 120, 312, 313, 316, 317, 421 and 423 to include personal storage space and a chair in each residents bedroom floor space. Overall the premises supported the privacy and comfort of residents. However; improvements were required in relation to the centres premises this will be discussed further under Regulation 17.

There were no visiting restrictions in place and public health guidelines on visiting were being followed. Visits and social outings were encouraged with practical precautions were in place to manage any associated risks. Inspectors observed a high level of visitor activity over both days of the inspection.

Oversight of fire safety required review. All bedrooms and compartments had automated door closures. All fire doors were checked over the days of inspection were found to close properly to form a seal to contain smoke and fire. Fire training was completed annually by staff. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents. Not all fire safety equipment service records were up to date, this is discussed further in the report. There were fire evacuation maps displayed throughout the centre, in each compartment. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire drills took place monthly in 2023. Fire drills records contained details of the number of residents evacuated and how long the evacuation took. There was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors. There was evidence that fire safety was an agenda item on the health and safety meetings in the centre. There was a smoking area available for residents. On the days of inspection there were no residents who smoked. A fire extinguisher and fire blanket were in place in the centre's smoking area. Oversight of fire drills and fire safety procedures required improvement, this is discussed further in the report under Regulation 28.

Residents were supported to access appropriate health care services in accordance with their assessed need and preference. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents had access to a consultant geriatrician, a psychiatric team, nurse specialists and palliative home care services who all attended the centre and residents attended follow up appointments in hospital. A range of allied health professionals were accessible to residents as required an in accordance with their assessed needs, for example, physiotherapist, speech and language therapist, dietician and chiropodist. The centre had access to a mobile x-ray service in the home. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The centre did not act as a pension agent for the residents. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. Residents who were

unable to manage their finances were assisted by a care representative or family member. Laundry was provided on-site however some residents chose to have their clothing laundered at home

The layout of the building over seven separately staffed floors lent itself to effective outbreak management. This meant that each area could operated as distinct cohort area with minimal movement of staff between zones to minimised the spread of infection should an outbreak develop in one area of the centre. The centre had effectively managed several outbreaks and isolated cases of COVID-19.

However a gastroenteritis outbreak from 4th – 26th January 2023 had spread extensively over all floors. A total of 62 residents and 19 staff developed symptoms consistent with norovirus infection. A formal review of the management of the outbreak of had been completed. The review did not highlight issues identified on the day of the inspection that may have contributed to the outbreak, such as poor laundry management, inadequate hand washing facilities, insufficient housekeeping facilities, management of carpets in resident rooms and the manual reprocessing of commodes and urinals.

Waste and used laundry was not observed to be segregated in line with local guidelines during the course of the inspection. For example laundry was not segregated at point of care into color coded bags as per local guidelines and staff were observed decanting used laundry into a central skip on two units. This posed a risk of cross-contamination. Waste was transported in the same skip as dirty laundry. Inspectors were informed that laundry and waste management processes were under review.

The carpet cleaning machine was visibly unclean and inspectors were informed that the waste water from the machine was disposed of in the in the sluice rooms. This posed a risk of cross-contamination. Furthermore inspectors were informed that all carpets had not been steam cleaned following the recent COVID-19 outbreak and a small number of carpets appeared visibly unclean.

The inspector saw that the resident's pre- admission assessments, nursing assessments and care plans were maintained on an electronic system. Resident care plans were accessible on a computer based system. Residents' needs were comprehensively assessed prior to admission, following admission and following recommendations by allied health professionals. Resident's assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspectors were generally personalised, and sufficiently detailed to direct care with some exceptions. For example there were no residents with confirmed or suspected respiratory or gasterenteritis infections in the centre on the day of the inspection. However infection prevention and control care plans for the majority of residents were generic and focused on COVID-19 and Norovirus (gasterenteritis). Further improvements were also required to residents care plans follow incidents of falling and a number of residents care plans were not consistently consulted with the resident or where appropriate a residents family. This is discussed further under

Regulation 5: individual assessment and care planning.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The centre's risk register contained information about active risks and control measures to mitigate these risks. The risk registered contained site specific risks such as risks associated with obsconding, medication management and infection prevention control risks.

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications; this was up to date and based on evidence based practice. Medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were stored securely in the centre and returned to pharmacy when no longer required as per the centres guidelines. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

There was a rights based approach to care in this centre. Residents' rights, and choices were respected. Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the organisation of the service. The centre promoted the residents independence and their rights. The residents had access to an independent advocate and SAGE advocacy services. The advocacy service details were displayed across the centre and activities planner were displayed near the café area in the centre. Residents has access to daily national newspapers, WI-FI, books, televisions, and radio's. Mass took place in the centre up to five times a week. Musicians attended the centre weekly. Group activities of quizzes, songs and storytelling, and a movement to music session took place throughout the days of inspection. Satisfaction surveys showed high rates of satisfaction with all aspects of the service.

Regulation 11: Visits

Indoor visiting had resumed in line with the most up to date guidance for residential centres. The centre had arrangements in place to ensure the ongoing safety of residents. Visitors continued to have their temperature checks and there was a checklist to ensure that visitors had appropriate PPE and had completed hand hygiene procedure on entry to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Actions were required to reconfigure the layout of some of the multi-occupancy twin rooms as some residents were unable to maintain control over their clothes. For example:

- A resident in rooms 6 and 312 did not have a wardrobe located in their floor space.

Judgment: Substantially compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Room 6 required reconfiguring as a resident in this room had to enter another residents personal space to access their clothes from a wardrobe.
- Also in room 6, staff had to enter a residents personal space to access a storage room and external access was through a residents personal space.
- Room 421 and one bed space in room 423 did not have lockable storage space for residents.
- Cabinets in the ensuite bathrooms in rooms 314, 315A and 422 were damaged with exposed medium density fibreboard (MDF) resulting in staff not being able to effectively clean the residents cabinet units.
- A storage room on Beech unit required review as it was cluttered with items such as resident assistive equipment, catering supplies, staff training equipment and PPE. This posed a safety risk to staff working in the centre.

Judgment: Not compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- The provider had not nominated an infection prevention and control link practitioner to increase awareness of infection prevention and control and antimicrobial stewardship issues locally.
- Standardised infection prevention and control audit tools were not used by clinical nurse managers. Audits were not scored, tracked and trended to monitor progress. This was a lost opportunity for learning. Disparities between the findings of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- Staff and management did not know which residents were colonised with MDROs. Accurate information was not recorded in resident care plans to effectively guide and direct the care residents colonised with MDROs. This meant that appropriate precautions may not have been in place when caring for these residents.
- Inspectors were informed that urine samples were routinely sent for analysis following completion of a course of antibiotics. Routinely sending samples to the laboratory in the absence of signs and symptoms of infection is a poor use of resources and can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including adverse effects, drug interactions and antimicrobial resistance.

Inspectors observed inconsistent application of standard precautions during the course of the inspection.This was evidenced by;

- The carpet cleaning machine was unclean. Effective cleaning and decontamination is compromised if cleaning equipment is unclean.
- Staff in one unit informed inspectors that commodes and urinals were manually emptied in en suite bathrooms and manually cleaned. Inadequate disinfection of commodes and urinals increases the risk of environmental contamination and cross infection.
- Laundry was not segregated at point of care. Reusable canvas laundry bags were not routinely washed after each use.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The majority of sluice rooms were small sized and did not facilitate effective infection prevention and control measures. For example, there was insufficient space for cleaning and disinfecting equipment within the majority of sluice rooms and the detergent in two bedpan washers had expired. Janitorial units used by housekeeping staff were observed within all sluice rooms.

- Assurances were not provided that carpets in resident rooms were cleaned in line with best practice guidance. Carpets in all resident's bedrooms were not on a cleaning schedule. Several carpets were visibly stained.
- Flooring within several en suite bathrooms was damaged and did not facilitate effective cleaning.
- The staff changing and staff locker facilities required review as staff belongings such as coats and bags were stored in cupboards in the dinning area on Cedar unit and in a cupboard in an open plan area on Oak unit adjacent to the sluice room. This posed a risk of cross-contamination to staff.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was not taking adequate precautions against the risk of fire. For example;

- Escape signage was not adequate; inspectors observed escape routes where adequate exit signage was not provided across all floors.
- While a service log demonstrated that the emergency lighting system was serviced, the frequency did not ensure that the system was serviced quarterly as required, and the service records were not available since April 2022.
- The process for quarterly walkaround fire safety audits by the provider required review as records of quarterly walkaround fire safety audits in quarter 4, 2022 and quarter 1, 2023 documented that the emergency lighting system had been serviced.
- Emergency lighting in the centre required review as a large number of bedrooms and toilet areas did not have emergency lighting to guide an evacuation for staff and residents in the event of a night time evacuation.
- The wall between the laundry room and a sluice room had a large gap between the bedpan washer and the centres washing machines; this would not provide effective fire containment to the laundry enclosure.
- Some rooms were not fitted with smoke detection, for example, sluice rooms.
- Evacuation plans required further details, for example: evacuation maps were directional but did not have sufficient detail to guide residents who could evacuate themselves to the nearest assembly point.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. Medicines were administered in accordance with

the prescriber's instructions in a timely manner.

Medicines were stored securely in the centre. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A number of residents care plans viewed did not include an update on their care following a fall.
- Infection prevention and control care plans for the majority of residents were generic and focused on COVID-19 and Norovirus (gasterenteritis).
- Some care plan reviews were not comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs.
- It was not always documented if the resident or their care representative were involved in the reviews in line with the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the

centre. Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.
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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Belmont House Private Nursing Home OSV-0000014

Inspection ID: MON-0039617

Date of inspection: 13/04/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The centre's Fall Policy was reviewed & updated. The post-falls procedure now includes an update of residents' evidence-based falls assessments and their care plan. CNMs now audit all post-falls assessments and care plans and discuss findings at monthly falls clinics. Viclarity audit tools are in place. Audit results are discussed at monthly governance meetings which enables the timely tracking and trending of progress and actions taken.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: An additional wardrobe has been provided in Room 312 and works are in progress in Room 6 to maximise the amount of storage available for resident's personal possessions.	
Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Cabinets have been replaced in en-suite bathrooms where applicable and works are well progressed to address storage issues identified in bedrooms and on the Beech Unit. These works will be complete by 30 June 2023.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: A comprehensive review of the IPC arrangements in place within the centre was carried out immediately following the inspection. In response to this review, a dedicated programme of training has been provided that includes Clean Pass training for housekeeping staff and training for care staff on the use of the bed pan washer. An ADON has recently completed a QQI Level 5 course in IPC, both ADONs are to participate in the next IPC Link Practitioner Course and an external IPC Nurse Specialist is to provide dedicated IPC training for all staff during June 2023. A revised system of audit has been introduced to inform IPC monitoring. This includes an updated approach to MDROs, updated cleaning and laundry arrangements (including the introduction of a revised flow), and revised use of staff rooms and the storage of personal property. An environmental review currently ongoing into sluice facilities will be complete by 30 June 2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A programme of works ongoing within the centre will be complete by 30 June 2023. The programme includes updated fire evacuation plans and escape signage; a review and where applicable, installation of additional emergency lighting and smoke detection, the sealing of the gap in the laundry room, a revised approach to quarterly fire safety audits and ensuring that records of servicing are available for inspection in the centre.

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 centre's Falls Policy has been reviewed and updated. Under the governance of the DON, post-falls reviews and actions taken in response are audited by a CNM to ensure that all assessments and care plans reflect the assessed level of risk and residents care needs.

Updated care plan training is ongoing for all registered nurses. This will be complete by 30 June 2023.

A robust schedule of care plan review meetings with the resident and where applicable his/her nominated care representative is now in place. Such reviews take place at least quarterly or more frequently in response to a change in the care needs or wishes of the residents.

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 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	30/06/2023
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.	Not Compliant	Orange	30/06/2023
Regulation 23(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	19/05/2023

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2023
Regulation 28(2)(i)	The registered provider shall make adequate	Not Compliant	Orange	31/05/2023

	arrangements for detecting, containing and extinguishing fires.			
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	30/06/2023