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:	Firstcare Beneavin House
Name of provider:	Firstcare Beneavin House Limited
Address of centre:	Beneavin House, Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	29 June 2022
Centre ID:	OSV-0000694
Fieldwork ID:	MON-0037213

About the designated centre

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

The designated centre is located in north County Dublin and is close to local shops and amenities. There is a car park situated at the front of the building and disabled parking is available. Beneavin House is a purpose built nursing home that provides accommodation for 150 residents over the age of 18 years. The nursing home offers 24 hour care to dependent residents with low. medium, high and maximum dependencies including people living with dementia. Accommodation is provided across four floors which are arranged around a central courtyard garden. Oakfield unit is situated on the ground floor and has 31 single bedrooms and four twin bedrooms. Willowbrook is situated on the first floor and has 35 single bedrooms and five twin rooms. Claremont is situated on the second floor and has 41 single rooms and one twin room. Claremont is divided into two units Claremont and Claremont Walk. Claremont Walk provides accommodation for 11 residents living with dementia and is designed specifically to meet their needs. Most of the bedrooms on Oakfield, Willowbrook and Claremont units have en-suite facilities.Cedars Unit is on the fourth floor and has 19 single and two twin bedrooms. All bedrooms on Cedars are en-suite. Each floor has additional communal bathrooms and wheelchair accessible toilets. There are communal lounges and dining rooms on each floor and Claremont has an additional lounge. There is also a hairdressing salon, an oratory and a family room with overnight facilities which can be organised through the Home manager. Activity rooms and a smoking room for residents are also available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	105

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 29 June 2022	08:00hrs to 18:40hrs	Niamh Moore	Lead
Wednesday 29 June 2022	08:00hrs to 18:40hrs	Jennifer Smyth	Support
Wednesday 29 June 2022	08:00hrs to 18:40hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Inspectors observed interventions between staff and residents and spoke at length with nine residents and four visitors to gain an insight into life in the centre. The general feedback from residents was one of satisfaction with the care and services provided in the centre. They said it was a safe and pleasant place to live and that they were warm and comfortable, with one resident reporting "everything is very good, I have no complaints".

On entering the building, the inspectors were guided through the centre's infection prevention and control procedures, by a staff member. The systems in place was comprehensive, and included a signing in process, hand hygiene and a temperature check. There were alcohol-based hand rub located throughout the building. There was signage displayed throughout the designated centre, which informed staff, residents and visitors of procedures to follow to reduce the risk of infection, such as the wearing of personal protective equipment (PPE), hand hygiene and cough etiquette. Residents who spoke with inspectors said that they saw staff wash their hands regularly when they were assisting them.

Firstcare Beneavin House is situated on a campus with two other nursing homes. The centre is a five storey purpose built building and is registered to accommodate 150 residents, with access to each floor by the stairs or a lift. Two of the inspectors were guided on a tour of the premises, with the assistant director of nursing (ADON). Each floor had day and dining facilities available for residents use. In addition, there were several communal rooms such as the hairdressing room, the oratory and an activity room. Overall, the inspectors observed that the premises was clean throughout and generally well-maintained. However, inspectors noted that some flooring and items of equipment required repair and replacement.

Residents were accommodated in mostly single rooms with 12 twin bedded rooms. Residents had access to an en-suite or to shared bathrooms. Residents' bedrooms were observed to be personalised with photographs, flowers, plants and ornaments. Residents spoken with said that they were happy with their bedrooms. They said they were very happy with the level of cleanliness in the centre and were complimentary about the cleaning staff and said they were "always cleaning and their room was cleaned every day". However, inspectors found that for some residents in shared bedrooms, they did not have sufficient privacy as some rooms did not have privacy screens to protect residents' personal areas.

Residents had easy access to a secure internal courtyard, which was paved, had ample seating areas for residents and their visitors to use and enjoy and was well-maintained with beautiful flower beds. Inspectors were told that the internal smoking room had recently been changed to a storage area and as a result the only smoking area available to residents was within the internal courtyard. Inspectors saw this area was uncovered and in times of bad weather, residents would have no shelter. In addition, this area did not have accessible emergency call alarms or

sufficient fire safety measures in place.

Many residents spent a significant part of their day watching television or sitting without occupation and minimal meaningful engagement in the communal areas. Despite inspectors observing sufficient staffing levels and while staff were observed chatting with residents at times, staff interaction was observed to be predominantly task oriented.

There was an activity schedule to detail the activities on offer seven days per week. On the day of the inspection, activities were predominantly based on religious practice. However, these activities were focused on those who practiced one religion. Inspectors found that residents who practiced other religious faiths or who did not practice any religion did not have sufficient opportunities to participate in activities in accordance with their interests and capacities.

Inspectors observed a meal-time on two floors and found it to be a pleasant and enjoyable experience. Menus were displayed on most floors and there was a choice of three hot meals and a dessert at lunchtime, and two options for the evening meal. Inspectors observed that food presented looked appetising. Staff offered discreet assistance and encouragement to residents and staff were observed moving at the residents' pace. Some residents choose to take their lunch in their bedrooms and this was facilitated. Overall, residents spoken with were complimentary of the food with comments such as "the food is fabulous".

Residents were seen to receive visitors throughout the day of the inspection. Inspectors spoke with visitors and most provided positive feedback about the care their loved one received. Visiting was seen to occur in resident bedrooms including in the twin bedrooms. Two residents told inspectors that they would prefer access to a private communal space to receive their visitors.

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 delivered.

Capacity and capability

While sufficient staff and resources were in place, the registered provider had not ensured that the governance systems were effective in overseeing that a safe service was continuously provided for residents living in the designated centre. Gaps were found in access to mandatory training, oversight and auditing systems, records and contracts for the provision of services. Further findings relating to the quality and safety of the service are detailed below within this report.

Firstcare Beneavin House Limited is the registered provider for Firstcare Beneavin House. The senior management team consisted of a Chief Operating Officer, a Regional Director, Associate Regional Director and the person in charge. The person

in charge works full-time in the centre and reports directly to the regional director. They are supported in their role by three assistant directors of nursing and three clinical nurse managers (CNM). In addition, staff teams included nursing staff, team leaders, healthcare assistants, activity staff, household, catering and maintenance staff.

Inspectors reviewed the worked and planned staffing roster and were assured that there were sufficient staff on duty to meet the needs of the residents living in the centre on the day of inspection. Staffing was allocated per floor and each floor had a minimum of one qualified staff nurse scheduled on duty at all times. Inspectors were informed of a number of staff vacancies within the clinical and non-clinical teams. Some of these roles had been filled and were awaiting a start date, recruitment was in progress for others.

The registered provider had a policy on staff education and training which had been recently reviewed in May 2022. According to the timeframes of the centre's mandatory training within this policy, records reviewed showed that there was good attendance at training on safeguarding of vulnerable adults and manual handling. However, the records showed that a significant number of staff required training in fire safety and infection control.

Records showed that staff were appropriately supervised and supported through an induction programme signed off by a team leader and annual appraisals. Night time supervision included rostering a CNM every two to three weeks and unannounced visits from a Director of Nursing from the registered provider group. Records of these visits showed that they observed staff and residents, and reviewed the restraints register, infection control and staff knowledge.

During the inspection, inspectors observed that resident records were unsecured on six occasions. This included two medicine rooms which were unlocked, a filing cabinet unlocked, a handover sheet and medicine prescription left in a communal area without a staff member and a laptop open with an electronic care plan visible.

There were regular management meetings held in the centre that were attended by the person in charge and members of each relevant department such as household, catering, maintenance and activities. Minutes of the monthly management team meetings attended by the person in charge and members of the senior and regional team were reviewed by inspectors and these did not demonstrate sufficient oversight of clinical and some non-clinical matters, such as infection control. Inspectors were told that the management team had plans in place to strengthen oversight with the implementation of a new clinical and corporate monthly governance meeting due to commence shortly after the inspection.

Overall accountability, responsibility and authority for infection prevention and control within the centre rested with the person in charge, who was also the designated COVID-19 lead. In their absence, senior nurses became the lead should an outbreak occur. The centre had access to Public Health for outbreak support. However, there was no ongoing support from a qualified infection control practitioner as per the *National Standards for Infection Prevention and Control in*

Community Services.

The centre had experienced a parainfluenza outbreak in August 2021 and from records reviewed by inspectors, the outbreak was seen to be managed well. A recent COVID-19 outbreak started in January 2022 and finished in April 2022. It affected approximately a third of residents and a high number of staff. A formal review of the management of the outbreaks had been completed. It identified areas of good practice and areas for further development. Examples of this were, the engagement of agency staff to fill vacant shifts, with an enhanced induction for those staff, on the registered provider's policies. It also identified the need for comprehensive environmental audit tools to monitor the quality and safety of care. The inspectors saw samples of audit tools in development by the provider to include all aspects of standard and transmission based precautions. However, inspectors found gaps in the current audit tools in use on the day of the inspection. Further gaps in auditing systems will be discussed under Regulation 23 Governance and Management.

An annual review of the quality and safety of care delivered to residents in the designated centre had been completed for 2021, which included feedback from the residents and their families. An improvement plan for 2022 had been developed.

While contracts of care were in place for each resident and had been appropriately signed, inspectors found that action was required to ensure they detailed the requirements set out in the regulations in relation to the terms on which a resident shall reside in that centre and the fees charged. This is further discussed under Regulation 24: Contract for the Provision of Services below.

Regulation 15: Staffing

On the day of inspection, inspectors found that the number and skill-mix of staff was appropriate with regard to the assessed needs of the 105 residents in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Approximately 26% of staff required training in fire safety and 21% of staff required training in infection control.

As per the staff induction, orientation and supervision policy, evidence was seen by inspectors that staff are appropriately supervised.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors reviewed a sample of three staff records required under schedule 2. Inspectors found that one staff nurse file did not contain the following information:

- A record of the current registration details
- A full employment history

In addition, inspectors observed that resident records were not stored safely on six occasions during the inspection. This included, medicine records which were left on top of the medicine trolley for prolonged periods unattended during the morning medicine round.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured effective governance arrangements were in place to ensure that the service provided is safe and effectively monitored. For example:

- Oversight systems failed to identify trends and areas for improvement. For example:
    - Monthly audits on wound care, care plans and restraints did not have trending or recorded findings. Findings of this inspection relating to care plans and restraints were not identified within these audits.
    - Environmental audits had failed to identify the absence of call bells in several areas.
    - There was inadequate clinical oversight and clinical data was not discussed within management meetings.
    - There was insufficient managerial oversight of the day-to-day operation of the centre. Managers were unaware of which new nursing staff on induction had active nursing registration on the day of the inspection.
- There was insufficient oversight for the effective infection prevention and control and antimicrobial stewardship. For example:
    - Regular environmental cleanliness, hand hygiene and donning and doffing of PPE practice audits were carried out and recommended actions with a responsible person identified. These audit tools used did not identify findings on the inspection day. Gaps in examples seen were safe management of clinical waste such as used sharps, medical device management, linen management and hand hygiene facilities.

- Surveillance of infections and colonisation was not used to inform antimicrobial stewardship measures.

- There was insufficient oversight of the designated centre's risk register. For example, the smoking risk register referred to appropriate measures in place to manage the risk of fire within the designated centre's smoking room. This room was no longer in operation and the risk register had not been updated to assess the risk to residents smoking in the garden.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of two contracts between the resident and the registered provider, and found that that they did not clearly set out the terms and fees on which a resident shall reside in the centre. For example:

- The room number and occupancy of the residents' bedroom was not accurately recorded.
- The contract was unclear about residents access to general medical services (GMS) and the choice to avail of private services.
- The weekly fees for the additional services charge required review as the contract indicated that residents were being charged for services such as incontinence wear which was available to them through the Health Service Executive.

Judgment: Substantially compliant

Quality and safety

Overall, the quality and safety of care provided to residents was of a good standard. Residents were consulted about the organisation of the designated centre. However, some areas including care planning, healthcare, residents' rights, end-of-life-care, premises, infection control and medicines management required action to ensure they complied with the relevant regulations.

Care plans examined were seen to be prepared within 48 hours of admission to the designated centre. However, gaps were identified within accurate records for residents, for example, where specialist recommendations were sought and received, this was not recorded in the care plan. This and further gaps identified by inspectors are discussed under Regulation 5: Individual assessment and care plan. In addition, action was required to ensure residents assessed needs for end-of-life

care was recorded which is further outlined under Regulation 13: End of Life Care.

Residents' had access to their General Practitioner (GP) who visited the centre a number of times each week. Residents had a medical and medicine review completed on a four monthly basis. There was evidence that residents had access to health and social care professionals including physiotherapy, occupational therapy (OT), dietetic, speech and language, tissue viability, dental, ophthalmology and chiropody services as required. However, not all residents had timely referrals made to healthcare staff.

Assessments and care plans were seen to be in place for the use of bed rails within the designated centre, however there was no evidence that all restrictions had been risk assessed for safety and that the approach was the least restrictive solution to manage the risk. In addition, inspectors found that this was not in line with the registered provider's policy on the use of restraints.

Inspectors were assured all reasonable measures were taken to protect residents. Staff had access to the appropriate training in relation to the detection, prevention of and responses to abuse.

Residents were offered choices in most aspects of their day-to-day life and their choices were being respected. Residents had access to radio, television, and newspapers both local and national, together with access to the internet. However, action was required to ensure that all residents had the ability to exercise their religious rights. In addition, the layout of the multi-occupancy bedrooms also impacted on some residents' right to privacy. This is further discussed under Regulation 9: Residents' Rights.

Inspectors observed many visitors throughout the day of the inspection, visiting in bedrooms. Three visitors spoken with were happy with the arrangements in place, however some residents said they would like access to a private space to meet their visitors. The person in charge told inspectors that children aged under 12 could not visit within the designated centre. Inspectors reviewed the standard operating procedure on visiting for the designated centre and this restriction was not clear and had not been risk assessed to provide the rationale of the restriction.

While communal spaces, such as dining and lounge areas, were spacious and bright, the maintenance of the premises required improvement. Flooring in communal and some bedroom areas was in disrepair, residents did not have access to a suitable smoking area and the storage of oxygen was unsafe.

Notwithstanding the positive findings of infection control during this inspection, there was a limited number of clinical hand wash sinks for staff use within the centre. Inspectors were told that the sinks in communal bathrooms and in the residents' rooms were dual purpose, they were used by residents and staff. This practice increased the risk of cross infection. Inspectors were informed of plans to install additional clinical hand wash sinks in the corridors and upgrade current clinical sinks to align with national recommendations.

Inspectors found that action was required by the registered provider to ensure they

had sufficient oversight of all areas of medicine management within the centre, in particular relating to the safe storage, administration and reconciliation of medicines. For example, two residents had consented with their GP to self-administer their medicine, while there was a consent form, this process was not included in the designated centre's medicine policy.

Regulation 11: Visits

Visiting for children aged under 12 was restricted with no documentation to evidence the rationale.

There was no private space available for residents of the multi-occupancy bedrooms to receive visitors. Two residents told inspectors that they would like a communal space to receive their visitors in private.

Judgment: Not compliant

Regulation 13: End of life

From a sample of care plans reviewed, inspectors were not assured that these plans addressed the physical, emotional, social, psychological and spiritual needs of the resident concerned. For example:

The resuscitation status of a resident was recently discussed, however this was not reflected in their care plan.
The emotional, social, psychosocial and spiritual needs were not evident in three care plans, which was a repeat finding of the previous inspection.

Judgment: Not compliant

Regulation 17: Premises

Inspectors viewed a sample of the multi-occupancy bedrooms within the designated centre and found that they did not comply with the requirements of 7.4m2 of floor space for each resident of that bedroom, which area shall include the space occupied by a bed, a chair and personal storage space. For example:

- Inspectors observed that eight individual bed spaces measured under 7.4m2 of floor space.
- Some twin bedrooms did not have privacy curtains in place to ensure that they had adequate privacy arrangements in place. Inspectors were told that

for staff to assist residents with personal care in these rooms, out of sight of the other room occupant, residents had to be assisted in the bathroom.
- The configuration of some multi-occupancy bedrooms did not allow the residents to access their personal belongings in private. For example, four residents their wardrobe, bedside locker and chair were outside their personal floor space.

Issues were observed in the designated centre which did not conform with Schedule 6 of the regulations:

- There was inappropriate storage of oxygen cylinders seen where these were not secured safely.
- There was no call bell in one toilet and in the garden which was used as the designated smoking area. This smoking area also had no fire safety equipment in place.
- Equipment and areas of poor repair were observed. For example:
    - the floor in the staff dining area, in some communal bathrooms and in some residents' bedrooms were badly worn and marked
    - a fire door in an electrical room was damaged
    - paint work on shelves in a cleaner's room was not intact
    - a wall was damaged in a shared bathroom and a storage room.

Judgment: Not compliant

Regulation 27: Infection control

There was evidence of inappropriate storage seen in areas around the centre which could lead to contamination or cross infection respectively, in addition to reducing access to these areas for cleaning. This was evidenced by:

- Continence wear was stored out of their packets or in open bags on shelves in store rooms, on uncovered trollies, and in communal bathrooms and toilets. Medical supplies were seen on floors. Hoist slings were seen to be stored draped over hoists with no resident identifying labels on them. This meant that these slings may be used for multiple residents. These practices posed a cross-infection risk.
- Safety engineered sharp management devices were used; however, six sharps bins did not have the temporary closure mechanism engaged when they were not in use to ensure they were stored safely. Blood glucose monitoring needles required a risk assessment to ensure they do not pose a risk of cross contamination. These practices could pose a risk of exposure of blood-borne viruses to individuals.
- Sterile dressings were not used in accordance with single use instructions, they were stored with un-opened dressings and could result in them being re-used.

The inspectors were not assured that equipment was decontaminated and maintained to minimise the risk of transmitting a healthcare–associated infection. For example:

- Four hoists were seen to be dusty. One had red residue on it for the duration of the inspection. This meant that they were not properly cleaned and safe for further use.
- Disinfectant wipes were used for general cleaning of equipment, this meant that equipment or surfaces were not cleaned before disinfection, if required.
- Cleaning chemicals and shower gels were topped up which could result in products becoming contaminated and not safe for further use.

Staff did not consistently adhere to standard infection control precautions. This was evidenced by:

- Staff were not bare below the elbow as recommended in local hand hygiene guidelines. For example, five staff wore wrist jewellery and three staff members wore nail varnish when providing direct care to residents.
- Disposable aprons were inappropriately used during medication rounds. For example, aprons not changed following possible contact with residents who had multi-drug resistant organisms (MDROs).
- Domestic waste was inappropriately disposed of in the clinical waste bins. For example, supplies used for catheter care were disposed of as clinical waste.
- There was outdated guidance in the infection control policy to guide staff how to clean and store nebulizer masks and chambers. There was ambiguity amongst staff who spoke with inspectors with regard to the safe cleaning, storage and replacement of nebulizer delivery systems. Staff said that nebulizer delivery sets were changed every month or when they looked dirty. Two masks were seen to be stored with fluid in them and in unlidded boxes which did not align with good practice.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that all medicinal products were stored securely in the designated centre. For example:

- One medication room was propped open and the lock of another medication room was broken, both of these examples were rectified on the day of inspection.
- Inappropriate storage was observed within the control medicines press. For example, resident jewellery and monies.

Inspectors observed the medicine administration round and found that not all medicinal products were administered in accordance with the directions of the

prescriber. For example:

- Tippex was on the medicine administration record.
- Medication gel was held and applied by a resident, however nursing staff were signing the administration record.

Action was required to ensure that all medicinal products no longer required by a resident shall be disposed of in accordance with national legislation. Inspectors found that drug reconciliation was not complete. On checking the controlled medicines register, medication no longer in use was seen to be returned to the pharmacy. However, there was no record of the return.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

There were gaps in providing evidence that residents assessed needs were recorded and detailed. For example:

- When seeking to review care plans for residents with urinary catheters, there was none for one resident and no direction for staff with regard to daily care of the catheter site in three care plans seen. This may result in inappropriate precautions being used when delivering direct care to residents.
- There was no repositioning record maintained for a resident who had a pressure ulcer.

The care plan of each resident was not reviewed on every occasion following a recommendation or review by a health care specialist, for example:

- There was no record of a telephone consultation with a tissue viability nurse (TVN) in relation to a resident's pressure ulcer or their recommendations as reported by staff.
- There was no record of the outcome or recommendations for a resident who had attended a falls syncope clinic four weeks previously.

Judgment: Substantially compliant

Regulation 6: Health care

Action was required to ensure that timely referrals were made available for all residents. For example:

- A resident who had a pressure ulcer was not referred to the dietitian, which did not follow the designated centre's own nutritional status and

management policy.

- A resident who had sustained a fall and had been re-admitted back to the designated centre following hospitalisation, had been seen by the physiotherapist, however had not been reviewed by the OT, despite guidance from the OT who had requested to be informed of their return to the centre.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Assessments were not completed on all environmental restraints to evidence their use. For example, sensor alarms in use on the day of the inspection had no risk assessments. This was not in line with the designated centre's policy on the management of restrictive practice or the national guidance on promoting a care environment that is free from restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

A sample of safeguarding incidents notified to the Chief Inspector were reviewed, these were seen to be investigated and measures put in place within a timely manner.

Judgment: Compliant

Regulation 9: Residents' rights

Residents in some of the multi-occupancy bedrooms could not undertake personal activities in private as there was no privacy curtains in place around their bed spaces.

Not all residents had the opportunity to exercise their religious rights, there was no access to religious services or ministers for all religious denominations for residents living in the designated centre.

Judgment: Substantially 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	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Firstcare Beneavin House OSV-0000694

Inspection ID: MON-0037213

Date of inspection: 29/06/2022

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: S: Further update training was completed in Fire Safety on 5th July; now there is 95% staff trained, and continuous training is scheduled to ensure 100% by 31/08/2022 S: Weekly update training in IPC continues and will encompass all staff by 31/08/2022. M: Through monthly compliance audit and review by the PIC. Training matrix is updated as training is completed A: By PIC and Regional Management Team. R: Overview by the PIC & Regional Director in conjunction with RPR T: End of August 2022.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: S: Training is scheduled for all staff for GDPR purposes to ensure touchscreen is logged off after each use. S: Staff meetings held to advise staff on GDPR concerns when dealing with Medication Kardex, residents files and electronic systems. S: A full audit of staff records has been completed identifying omissions of required documents in line with legislation requirements. M: Through audit and review by the Senior management team A: By CNM, ADON, PIC, HR Compliance manager and Data Protection Officer. R: Overview by the PIC & Regional Director in conjunction with RPR T: End of October 2022.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
S: The new clinical and corporate monthly governance meeting has now commenced to ensure that the management teams have oversight of clinical and nonclinical matters
S: Weekly head of department meetings are held by the person in charge
S: Governance meetings are held by the Regional Director once a month where all non-clinical & clinical data is discussed, analysed and trended to identify learnings and action plans will be put in place to make changes to improve practices within the home. Audits will include: pressure area/wound care; weight management; donning and doffing of PPE; hand hygiene; use of restrictive practices; medication management; environmental; anti-microbial usage; resident record keeping; staff compliance.
S: PIC will link with IPC practitioner in CHO 9 for ongoing support
S: Call bells have been installed in the areas that was identified during this inspection.
S: PIC has commenced IPC Committee and will be identifying areas for improvement within IPC including AMRIC and data collected on antibiotic use for surveillance and analysed to improve use to appropriate antimicrobial use in the Centre.
S: PIC to ensure Centre's risk register is reviewed and updated at a minimum of 3 monthly.
M: Through audit and review by the Senior management team. Identifying trends and implementing action plans in discussion with heads of department and nursing and healthcare staff
A: By CNM, ADON, PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of September 2022.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
S: All room numbers of residents are now accurately recorded on contracts of care.
S: Contracts of Care have been updated to state details of access to general medical services, private services, and additional services. The details of ASC charges have been reviewed and now reflect the totality of services provided within the Centre.
S: Contracts of Care have been amended to include resident's room number and the type of room the resident is occupying i.e., shared, single, ensuite

M: Contracts of Care to be reviewed monthly by the administration team and presented at the monthly Clinical Governance Meeting. A: By PIC and Regional Management Team. R: Overview by the PIC & Regional Director in conjunction with RPR T: End of September 2022.

Regulation 11: Visits	Not Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: S: Standard Operating Policy on visiting will be reviewed in line with Public Health Guidance at the time. This has been changed to reflect visiting for those under 12 years. S: Communal rooms are available in each floor, and this has now been clearly marked as a visiting area. M: PIC will ensure SOP is in line with National Standards A: By PIC and Regional Management Team. R: Overview by the PIC & Regional Director in conjunction with RPR T: End of September 2022.	

Regulation 13: End of life	Not Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: S: PIC and the management team reviewed and updated all end-of-life care plans to ensure they clearly reference physical, emotional, social and psychological and spiritual needs. M: CNM will be auditing care plans monthly and this includes end of life care plans. Outcome of this audits will be discussed at Clinical Governance Meetings M: Through audit and review by the Senior management team A: By PIC and Regional Management Team. R: Overview by the PIC & Regional Director in conjunction with RPR T: End of September 2022	

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

S: All shared rooms have been reviewed to ensure compliance with requirements of 7.4m2 of floor space of each resident of that bedroom. This also ensures residents can access their personal belongings within their private space.
S: Privacy curtains rails will be installed in the rooms that were identified to ensure adequate privacy arrangement are in place.
S: Oxygen cylinders are securely stored in the designated areas.
S: Call bell in the toilet has been installed
S: Smoking room will be reopened, and residents will be advised to use this room for smoking. This room has call bell and fire safety equipment.
S: The fire door to the electrical room was resolved on the same day
of inspection
S: The plant room door has been repaired and meets fire regulations
S: The wall for room 315 has been repaired
M: Through audit and review by the Senior management team, maintenance and Household manager.
A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of October 2022

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
S: Household team have been advised to store the continence wear in their original packaging.
S: Shelves have been installed in the storeroom to prevent supplies stored on the floor.
S: Staff have been instructed to leave hoist slings with each resident as they are specific to them. Additional slings have a designated store area.
S: staff awareness on sharps bins closure was promoted. CNM check compliance with this during daily spot checks and through audits.
S: All reusable liquid soap and shower gel bottles will be changed to single use bottles
S: Blood glucose monitoring needle holders are resident specific.
S: Staff meeting were held to create awareness among staff on single-use dressings.
S: Cleaning schedule in place for all hoist and update training provide to staff
S: Centre is currently reviewing use of cleaning products to source one that has both cleaning and disinfectant properties
S: Staff are advised on on-going basis to ensure bare below elbow or nail Varnish. Hand Hygiene Audit completed by CNMs weekly which check staff compliance with this.
S: Disposable aprons worn in accordance with best practice
S: Staff have also been educated on waste segregation
S: Infection Control Policy has been updated to guide staff how to clean and store nebulizer and mask. Staff knowledge on same will be checked during handovers and staff meetings.
S: Infection Prevention and Control training includes education regarding the use of anti-

microbials. Monthly auditing on use of anti-microbials are completed to identify trends which will improve and measure the appropriate use of anti-microbials
M: Through audit and review by the Senior management team, IPC lead and Household manager.
A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of September 2022

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
S: Audits will be carried out to ensure appropriate storage of items i.e., jewellery in the controlled drug press. Staff have been given instruction to deposit any items of value in the Centre's safe-deposit box.
S: staff education on correct administration of medicinal products was completed including use of correction fluid and medications that are self-administered. Regular audits will be conducted by CNM to monitor practice is in accordance with best practice. Staff to complete HSEland training in medication management online which includes education of self-administration of medications and procedure for safely returning and disposing of medications
S: Quality team and Regional Manager will develop Self-administration of medications policy for the Centre.
M: Through audit and review by the Senior management team, Pharmacy CNM.
A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of September 2022

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:
S: All residents who are at risk of developing pressure ulcers and need assistance to reposition have a repositioning chart in place. Staff Nurse now notifies all grades of pressure ulcer through incident reporting system in EPIC which will be reviewed by the PIC and ADON. CNM will complete monthly wound care audit and check all the above measures are in place.

S: Care plans for all residents will be reviewed on admission and 4 monthly as per auditing schedule. Care plans will be in place for all residents where risk has been identified for catheter care management and continence management
S: Continence management training will continue
S: Localised training at handover will educate staff on the policy and procedure for catheter care
M: Through audit and review by the Senior management team, Pharmacy CNM.
A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of September 2022

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
S: On return from hospital all residents will have a check list in place to ensure they are reviewed by MDT services i.e., dietitian, speech and language therapist, tissue viability nurse, physio, occupational therapist, GP and community medicine for the elderly where required following risk assessments.
S: All residents who have sustained a fall will be reviewed at The Monthly Falls Clinic
S: Assessment and Care plans for all residents must be updated as resident's condition changes and following review by MDT/clinic.
S: All residents who are at risk of developing pressure ulcers and need assistance to reposition should have a repositioning chart in place. Staff Nurse will be requested to notify all grades of pressure ulcer through incident reporting system in EPIC and CNM and ADON will ensure all necessary steps are taken. CNM will complete monthly wound care audit and check all the above measures are in place.
M: Through audit and review by the Senior management team, Pharmacy CNM.
A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of September 2022

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
S: Risk Assessments for all environmental restraints to evidence their use are now in place.
M: Through audit and review by the Senior management team, Pharmacy CNM.

A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of September 2022

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
S: All shared rooms will be reviewed to ensure to comply with requirements of 7.4m2 of floor space of each resident of that bedroom. This also to ensure residents are able to access their personal belongings within their private space.
S: Privacy curtains rails will be installed in the rooms that were identified to ensure adequate privacy arrangement are in place.
S: All residents will be given the opportunity to attend religious services outside the home or have their religious organization visit the home. Social Care Leaders will organize the same and company residents to the service. Same will be documented in residents' care plans
M: Through audit and review by the Senior management team, maintenance and Household manager.
A: By PIC and Regional Management Team.
R: Overview by the PIC & Regional Director in conjunction with RPR
T: End of October 2022

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 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Not Compliant	Orange	30/09/2022
Regulation 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	30/09/2022
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall	Not Compliant	Orange	30/09/2022

	ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/08/2022
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	31/10/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/10/2022
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/10/2022
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/09/2022

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/09/2022
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any	Substantially Compliant	Yellow	30/09/2022

	other health entitlement.			
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.	Substantially Compliant	Yellow	30/09/2022
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	30/09/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30/09/2022
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of	Substantially Compliant	Yellow	30/09/2022

	date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/09/2022
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	Substantially Compliant	Yellow	30/09/2022

	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.	Substantially Compliant	Yellow	30/09/2022
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.	Substantially Compliant	Yellow	30/09/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/10/2022
Regulation 9(3)(e)	A registered provider shall, in so far as is	Substantially Compliant	Yellow	31/10/2022

	reasonably practical, ensure that a resident may exercise their civil, political and religious rights.			