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 Manor
Name of provider:	Firstcare Beneavin Manor Limited
Address of centre:	Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	18 November 2021
Centre ID:	OSV-0005756
Fieldwork ID:	MON-0034874

About the designated centre

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

Beneavin Manor is a purpose-built centre in a suburban area of north Dublin providing full-time care for up to 115 adults of all levels of dependency, including people with a diagnosis of dementia. The centre is divided into three units, Ferndale, Elms and Tolka, across three storeys. Each unit consists of single bedrooms with accessible en-suite facilities, with communal living and dining areas. There is an enclosed outdoor courtyard accessible from the ground floor. The centre is in close proximity to local amenities and public transport routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	70

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
Thursday 18 November 2021	07:00hrs to 18:25hrs	Niamh Moore	Lead
Thursday 18 November 2021	07:55hrs to 18:25hrs	Deirdre O'Hara	Support
Thursday 18 November 2021	07:55hrs to 18:25hrs	Jennifer Smyth	Support

What residents told us and what inspectors observed

From what residents told us and from what the inspectors observed, residents were seen to be comfortable in the company of staff, with many positive interactions between staff and residents observed. While many residents told inspectors that they were content with the care they received within Firstcare Beneavin Manor, not all were. In addition, inspectors found that management systems required improvements to ensure that the provider had sufficient oversight of the service provided, which will be discussed further within this report.

On arrival at the centre, staff checked the inspectors' ID and guided two of the three inspectors through the infection prevention and control measures necessary on entering the designated centre. These processes included temperature check, hand hygiene, the wearing of personal protective equipment (PPE) such as a face mask and checking for signs of COVID-19. While this was in place for visitors, inspectors observed occasions of inappropriate wearing of PPE and poor hand hygiene practices by some staff.

The centre is laid out over three floors referred to as Tolka, Elms and Ferndale. Each floor was divided into two areas, referred to as the Park and Green areas. Each area was set up as a separate unit with day and or dining rooms and separate staffing allocations. During the walk around of the centre, inspectors saw that one of these areas was closed on the day of the inspection. All bedrooms are single occupancy with en-suite facilities. Residents spoken with said that they found their bedrooms warm and comfortable. They confirmed they had the opportunity to bring in personal belongings from home and had adequate space to store their possessions. Bedrooms seen were decorated with personal items, such as pictures, family photographs, ornaments and bedspreads.

There were two secure internal gardens which were well-maintained. A memorial garden had recently opened on the campus grounds. Inspectors were told this was constructed in remembrance of one of the staff members who had died. This garden had plants in raised beds and seating for residents, visitors and staff use. There is also a summer house within this area which inspectors were told could also be used for visiting.

The cleaning on the ground floor needed to improve. For example, dust was seen on surfaces and the floor of one vacant en-suite bathroom was heavily stained where there appeared to be a water leak, and the toilet was also dirty. Inspectors were told that there had been issues with sourcing household staff since October. There was adequate cleaning staff on the day of inspection.

Inspectors found that the oversight of maintenance required review as inspectors saw that equipment that required repair had not been reported or had not been addressed. This included a hoist and equipment to allow for the safe storage of medicines. This will be further discussed under Regulation 17: Premises within this

report.

Inspectors spoke with nine residents. Most residents told inspectors that staff were very nice and if they were unwell that they would act quickly to help them. However, some residents told inspectors that there was a lot of agency staff used within the centre and at times, this resulted in staff not being familiar with their likes and preferences. One resident told inspectors that "you are never sure who is in charge, they are here one week and gone the next". Some residents spoke about how unfamiliar staff had impacted their care at times detailing a recent incident where a resident missed a medical appointment.

Inspectors observed a mealtime service on the day of the inspection. Residents were offered a choice of meals. Soft background music played which helped to provide a calm and relaxed atmosphere. Staff were seen to support residents at a pace that suited resident's needs. Satisfaction levels regarding the food differed between residents. Some residents reported that they enjoyed the food on offer. However, inspectors found that the overall satisfaction with the lunch provided was poor, two residents reported they hadn't received what they had ordered. A number of residents said that they found the food provided "poor" and gave examples of over use of oil and salt within meals provided. Inspectors observed that on the Ferndale unit, when residents had finished their lunch, a lot of returned plates still had quite a lot of uneaten food on them. Some residents expressed concern to inspectors that there is a high level of food wastage within the centre. Inspectors were told that residents had completed questionnaires on the food provided, and had had a meeting with the chef, but no improvements had occurred. Inspectors found that improvements were required in how managers sought and learnt from feedback within the centre to improve the food on offer for residents.

Residents' life stories were sought in a document called 'key to me' to enable staff to formulate activity programmes. Inspectors found there was good access to activity provision on the day of the inspection, each floor had a dedicated activity staff member. The activity room in the Elms unit was partially laid out to simulate a train carriage, with a TV monitor displaying simulated views seen from a train window. Residents could also purchase a train ticket from the reception for their journey. The other part of this room was set up as a library, with a selection of paper and audio books for resident use. Inspectors observed there was an interactive 'magic table' and residents were seen to be positively engaged and enjoying themselves while using it.

There was a weekly activity planner which included activities such as the magic table, massage therapy and nail painting. Mass was celebrated on Sundays by a visiting priest. Inspectors were also told external providers attended the centre regularly for activities such as dog therapy and music sessions. Inspectors observed staff to support residents preferences as inspectors observed that for some residents who chose to not take part in group activities, they were supported to take part in colouring with arts and crafts.

During the course of the day, inspectors observed many visitors arriving to the centre. They were received by residents in a number of comfortable and private

designated visitors' areas. One visitor spoken with stated that they were delighted that visiting arrangements were now less limited. They reported that the home had communicated with the family during times of no indoor visits and that they were very grateful for this.

Inspectors were told that the provider had sent families a satisfaction survey and the results were due for distribution in January 2022. Following the receipt of some initial feedback from this, the provider had implemented a family communication schedule so that families could choose when and how often they would like to be updated about their loved one. In addition, the person in charge said that they were planning to develop a newsletter for families to include activities, occasions and events that took place in the centre on a monthly basis.

Residents' privacy and dignity was respected. Staff were observed to knock on residents' bedroom doors and await an invitation before entering and they ensured bedroom doors were closed or curtains were drawn when giving personal care.

Residents had access to television, radio and magazines, with newspapers delivered daily. The staff worked to maintain the links with the local community.

The next two sections of the report will describe in more detail the specific findings of this inspection in relation to the governance and management of the centre, and how this impacts on the quality and safety of the service provided to residents.

Capacity and capability

Inspectors found that the governance and management systems within the centre required improvements. The centre was previously inspected in June 2021. Inspectors found that while some improvements had been made since the last inspection, further improvements were required, particularly regarding the providers oversight of the designated centre. Inspectors found evidence that there were insufficient management systems to ensure the safe delivery of care, particularly in the areas of staff supervision, complaints management, restrictive practices, the premises and infection control. In addition, inspectors were not assured that the provider had sufficient oversight of medicine management within the centre which resulted in an urgent action plan being issued to the provider following the inspection. The registered provider provided the Chief Inspector with the necessary assurances within the requested timeframe.

Firstcare Beneavin Manor is operated by Firstcare Beneavin Manor Limited. The provider group is part of Orpea Ireland and this designated centre is one of a number of nursing homes managed by the registered provider. The registered provider was restructuring the management of the designated centre at the time of the inspection and the centres statement of purpose had not been updated to reflect this. Inspectors were told the management structure consisted of the registered provider representative, a regional director, an associate regional director and the

person in charge.

The person in charge was responsible for the day to day operations of the centre and was supported in their role by an assistant director of nursing and three clinical nurse managers. Other staff members included nurses, team leaders, healthcare assistants, social care leaders, household, maintenance, administration and catering staff.

This unannounced inspection was prompted by the receipt of unsolicited information. The majority of this information related to staffing levels, residents' care and dissatisfaction with communication within the centre. During the inspection, inspectors found that there was sufficient staffing levels for the 70 residents. However, the previous weeks' worked rosters did not provide assurances that all shifts had been covered. The registered provider had informed the inspectors that the centre had voluntarily ceased new admissions and inspectors requested to be updated prior to any new admissions into the centre.

Inspectors were told that there were a number of healthcare assistant vacancies within the centre, and as a result, there was a high usage of agency staff. Inspectors were informed that there had been a recent issue with retention of staff, however the provider was implementing new strategies to encourage recruitment of staff.

A review of senior management meeting minutes outlined that the management team were meeting regularly and were discussing key performance indicators and topics relevant to service delivery. These topics included staffing, complaints management, communication, incidents and accidents, residents, the action plan from the previous HIQA inspection, COVID-19 and audits.

Inspectors found there had been some improvements since the last inspection, for example in care planning and safeguarding risk assessments. However, inspectors found that overall management systems in place required review to ensure there was adequate oversight and monitoring for all areas of care. For example, in a senior management meeting from August 2021, medication was discussed and in particular ensuring all medication had been reviewed, however this discussion did not result in action as medication issues had not been resolved on the day of inspection.

Accessibility of records within the centre required improvement. On the previous inspection, the provider committed to addressing the issue. However, inspectors found that there were long delays in response to information requests. For example, inspectors requested access to and were not given, confirmation of agency cover on worked rosters, the complaints register, the minutes of resident meetings and flushing schedule for water outlets.

The complaints register was unavailable on the day of the inspection. As a result, inspectors did not have access to all complaints within the centre. Inspectors did follow up on a sample of three closed complaints recorded on the centres computer system and found that they were well managed. In addition, learning was displayed from one of these complaints where the centre had made improvements to

resident's oral care. Inspectors found that the management of verbal complaints had not been addressed, which had also been raised on the previous inspection. Residents told inspectors that they had made verbal complaints which had not been addressed by the registered provider.

Inspectors reviewed a sample of contracts for the provision of care within the centre, and found there were written and signed contracts of care in place. Contracts seen outlined the fees and costs involved in the service, and the occupancy of the bedrooms being offered.

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 70 residents' in the centre. There were three or more qualified nursing staff scheduled on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that oversight and supervision of staff required review. For example:

- Inspectors were told that new staff completed seven supernumery shifts where they shadowed a more experienced staff member as part of their induction. However, inspectors found this was not occurring for one newly-appointed staff member on the day of the inspection.
- An agency staff member spoken with was not aware of the fire evacuation procedure within the centre.
- Inspectors were informed of one occasion where an agency staff member was involved in a near miss medication incident and where a resident missed a medical appointment.
- There was no evidence of follow up in the annual appraisal of a staff member relating to an area of improvement identified.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the overall current governance and management systems

within the designated centre were inadequate. For example:

- Records were incomplete and did not provide sufficient assurances that residents were able to choose to remain in communal areas and could retire to bed at their preferred time in the evening. This was a finding from the previous inspection.
- While an improvement was seen in the recording of senior management meetings, there was not sufficient evidence that these discussions resulted in quality improvements for the centre. For example, a discussion was seen regarding verbal complaints which were being recorded in care notes but did not follow the complaints process. As previously mentioned within this report, verbal complaints had not been recorded or adequately addressed.
- The management systems in place did not give assurances that the service was safe, consistent and effectively monitored. Records were not readily available on the day of the inspection for review. This remained a finding from the previous inspection in June 2021. For example, the person in charge gave inspectors assurances that an action plan following a recent environmental audit and records of flushing of water outlets would be submitted to the Chief Inspector two working days after inspection. This was not received.
- An anti-psychotic and anxiolytic medicines audit had been carried out in August 2021, which had identified no evidence of general practitioner (GP) reviews, but no follow up action has occurred to address this short fall. These findings remained on the day of the inspection and indicated a serious concern that the system was not appropriate or safe, particularly in relation to prescriptions, storage and administration of medicines.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The contracts for provision of services contained all the required information.

Judgment: Compliant

Regulation 3: Statement of purpose

Inspectors were given access to a statement of purpose dated in June 2021. This document required updating as it did not reflect the current governance and management systems within the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors were not assured that the management and oversight of complaints within the designated centre was robust. Inspectors were aware that some verbal complaints reported to the person in charge were not accurately recorded. This meant inspectors were not assured that all complaints were followed up, investigated and where appropriate the issues remedied.

Judgment: Not compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their choices in how they spent their time. Residents' needs were mostly being met through good access to healthcare services and opportunities for social engagement. However, there were a number of immediate improvements needed to ensure residents' safety while living in the centre, which included oversight of maintenance and in medicines and pharmaceutical services. Other areas that required improvement were in the areas of residents' rights, managing behaviour that is challenging and infection control.

There were systems in place for the assessment, planning, implementation and review of health and social care needs of residents. Inspectors found that the nursing and medical care needs of residents were assessed and appropriate interventions and treatment were given. Care plans detailing residents preferences regarding their social, cultural, religious and psychological needs were in place and written in a sensitive manner.

Inspectors spoke with two visitors. One visitor stated they were very happy with the care provided and they had no concerns. Another visitor was concerned in relation to their family member's weight loss. On reviewing care plans, residents with identified weight loss were seen to be appropriately referred to the dietitian. Recommendations such as prescribed nutritional supplements, high calorie diets and weekly weights were evident in the care plans.

Improvements were seen in the development of person centred activity care plans for all residents, which was due for completion by the end of this year. In three activity care plans, two had been completed in a person centred manner, detailing preferences and how residents liked to spend their day, one was still to be completed. The participation and enjoyment levels for each resident during activities or events were recorded daily and were kept under review.

Efforts were made to identify and alleviate the underlying causes of responsive

behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Care plans in relation to responsive behaviours showed techniques that would help to distract and reassure the resident at the time. Residents with responsive behaviours were seen to be redirected by staff and were seen to respond well to this.

A register of restrictive practice used was maintained. However, the use of restrictive practices was not reviewed by the multidisciplinary team every three months. There were gaps seen in consent practices for the use of some alarms, bed rails and specialised chairs. In behaviour support plans, it did not always direct staff when to use PRN medicines (medicines to be taken when required) to ensure that it was used as a last resort when other measures had been exhausted. However, there had been a reduction in the use of bedrails where other methods to support residents were seen, such as the use of bed wedges.

Inspectors found improvements had occurred in residents' access to meaningful activities in line with their choices and preferences. There were dedicated activity staff, who were supported by healthcare staff to provide residents with a range of activities. Residents were seen to be supported to join activities in communal areas. Where residents didn't want to join the activities their choice was respected and some residents were supported with one-to-one sessions.

Residents were able to exercise choice in relation to how they spent their time and how they personalised their bedrooms. Residents spoke positively about the healthcare staff in the centre. The person in charge informed inspectors that resident meetings were taking place but there were no records to show they had taken place or any actions taken following feedback at these meetings. The residents' committee had not met this year to consult residents with regard to the service provided. As a result, inspectors found that improvements were required to ensure that the voice of the residents was being heard and to show that feedback being used to improve services for residents within the centre.

Visiting was still being booked in the centre to assist in the control of movement through the centre in efforts to prevent transmission of COVID-19.

The centre was suitably decorated and was generally well maintained, however some items of equipment were seen to require maintenance which had not been reported. While the premises was of sound construction, improvements were required which impacted on cleanliness, comfort and the safety of residents. For example the provision of appropriate alert signage for oxygen storage, accessible call-bells, cleaning, temperature and odour control. In addition, there was open in-use containers of personal hygiene products seen stored in baskets on linen trollies and were not labelled with resident names. This practice could result in cross infection.

There was evidence of some good infection prevention and control practice and ample supplies of PPE available. Inspectors were told that the provider had set aside one unit, Elm Park which had 16 beds, in the event that it would be needed for

isolation purposes. However there were gaps seen in records to monitor staff for signs of COVID-19 infection on all floors. Inspectors found that refresher training was required to ensure staff used the correct cleaning processes so that equipment was safe for further use. Measures needed to be put in place to ensure that clinical waste was stored safely while awaiting collection. This is further detailed under Regulation 27: Infection Control.

Inspectors found some good examples of medicines practice within the centre, for example the safe storage of controlled medicines and there was evidence of medicines reconciliation. However, a number of serious concerns were found in relation to medicine management. For example, safe administration, and the storage and security of medicines were not sufficiently robust. As a result, this practice could potentially create a risk to the health and safety of residents. This resulted in an urgent compliance plan issued to the registered provider and is further discussed in Regulation 29 Medicines and pharmaceutical services.

Regulation 17: Premises

The following improvements were required to ensure the needs and safety of the residents conformed to Schedule 6 of the regulations:

- While oxygen was seen to be stored safely, there was no appropriate hazard signage on the doors where they were stored.
- There was no call-bell in one resident's toilet and call bells were not readily accessible in two other toilets, should residents need to call for assistance.
- The floor in the hairdresser room had rust stains from the base of hairdresser's chair.
- The surface of desks at the nurses stations were damaged and could not be effectively cleaned.
- There was excessive heat on the Ferndale unit with temperatures recorded at 27 degrees Celsius.

Judgment: Substantially compliant

Regulation 27: Infection control

There were issues important to good infection prevention and control practices which required improvement. For example, the COVID-19 staff symptom monitoring logs were incomplete.

Hand hygiene practices required review:

- Some staff were seen to wear watches and stoned rings.
- Some staff were not seen to perform appropriate hand hygiene when

assisting residents with meals.
- Alcohol based hand rub was required in communal rooms and the oratory.
- Clinical hand-wash basins did not meet the national standards.

Waste management required review:

- There was no bin seen in one cleaner's room and no hand towel dispenser in another cleaner's room.
- Two clinical waste bins were not lidded, where one was seen on a corridor that residents use.
- The external waste holding area was open to public access and one of the clinical skips was not locked.

Cleaning schedules and procedures required review:

- Inappropriate cleaning solutions were used to clean and or decontaminate equipment between uses.
- Cleaning on the ground floor was inadequate as dust and debris were seen on surfaces in the unit.
- Chairs in the reception area and one sitting room were cloth covered and could not be effectively cleaned. There were a small number of stains seen on chairs in reception.
- Spray bottles containing cleaning solution were made up daily, however the bottles were not washed out and dried between uses.

Furthermore, inspectors had concerns about the storage of four individual residents medicated cream seen stored together in a container with a watery residue.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that immediate improvements were required to ensure that medicines were stored and administered in a safe manner, such as:

- A sample of thirteen prescriptions were reviewed. Seven of these prescriptions were out of date, with one dating back to the 9th November 2020.
- There was evidence of unsafe storage of medicines in a cupboard. The cupboard lock was broken and the key was left in it. Staff reported that the key was usually left in a wooden box on the wall which is not safe practice.
- Inspectors viewed the records of two fridges used to store medicines. Numerous entries of temperatures showed that medicines had been stored outside of the recommended temperature range.
- Inspectors observed medicines being administered in a crushed format to a resident where this was not prescribed on the prescription.

- Blood sugar monitoring equipment seen was not labelled.
- Of two insulin pens seen, one was not labelled and the other pen label was faded and difficult to read.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' records on the day of the inspection. A comprehensive pre-admission assessment was carried out on residents and care plans were seen to be prepared within 48 hours of admission.

Care plans were found to be person centred and reflective of practice observed by inspectors on the day of inspection. There was consultation with both residents and where appropriate, family members through health updates, care plan reviews and the key to me document. This document was seen to provide a personal insight into the residents past history, hobbies, likes and dislikes.

Judgment: Compliant

Regulation 6: Health care

Residents had regular access to their GP and to specialist health and social care professionals. Inspectors saw evidence within one resident's care plan where a recent review by a Geriatrician had occurred which resulted in a medicine review.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Improvements were required with regard to the following:

- Provision of clear direction for staff when to use PRN medicine to support residents with responsive behaviours.
- Clear evidence to show that the use of restrictive practice is reviewed and subsequently consented for, such as bed wedges and sensor alarms.

Judgment: Substantially compliant

Regulation 8: Protection

The centre had a policy and procedure on safeguarding which was reviewed in March 2021.

Inspectors reviewed a sample of safeguarding documentation and found that all reasonable measures to protect residents were in place. Inspectors saw risk assessments and safeguarding plans were in place for residents. Staff demonstrated good knowledge of the residents, they were able to identify their preferences and issues that may upset them, and appropriate measures to take, which were also evidenced and reflected in the individual care plans.

Judgment: Compliant

Regulation 9: Residents' rights

Improvement was required with regard to residents being consulted with and participating in the organisation of the centre. For example, there was no documented evidence of any consultation with residents. In addition, feedback from some residents was that verbal complaints they had made to management remained unresolved.

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 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	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 Manor OSV-0005756

Inspection ID: MON-0034874

Date of inspection: 18/11/2021

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:
A system of staff supervision, appraisals and follow up is in place including a robust induction for new staff. Additional actions for oversight of the procedures and processes in place now include:

• A review and update of the 7-day supernumerary induction plan has been completed. This addressed clarity of roles, definition, supervision expectations and processes.
• Identified buddies/mentors have been reminded that new staff on induction must remain with them at all times whilst on induction shifts. CNMs will ensure that this is occurring through a series of spot checks throughout the induction period.
• All agency staff are provided with a comprehensive orientation to the building and on commencement of shift are briefed on all key policies and procedures including fire evacuation. A dedicated sign-off sheet for agency staff has been introduced and the senior nurse on duty is responsible for completing this. The CNM now checks that all sign off-sheets have been completed and carries out spot checks with agency staff on their knowledge. This process is also included in the monthly oversight review conducted by the PIC/ADON.
• Agency staff are supervised by the nurse on each floor and are provided with a handover sheet outlining the key care requirements of each resident including dietary needs, levels of assistance required for mobility etc. Where the nurse is an agency nurse, they receive an induction from the CNM in order to fully orientate them. This includes showing them the diary of appointments. The CNM then checks in with the agency nurse throughout the day to ensure that no appointments or other issues of note are missed in the care of the residents.
• An annual appraisal system including where relevant, follow-up actions from ongoing performance reviews is in place. The appraisal form has been amended so that the documentation of follow-up on performance improvements is within the one document and not filed separately.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• As noted at the inspection, there was evidence that residents exercised choice in relation to how they spent their time. Care plans reflect this choice including when a resident wishes to retire to bed. CNMs now complete a daily check and document who has retired before 7pm and the reason as outlined by the resident or those staff caring for the resident. The PIC/ADON review this list periodically throughout the month and audit the results at the end of the month. All care plan audits completed by CNMs and the ADON are also reported to the PIC and used to inform the PIC's understanding and awareness of the exercise of resident choice within the home.

• Clarity on the policy and procedure regarding recording and managing verbal complaints has been provided to all staff through staff communications – email reminders, staff meetings, and additional training. All senior management staff completed additional complaints management training in September & October 2021. The CNM, ADON and heads of departments monitor compliance with the complaint policy and procedure by including complaints and general responses from residents and families in their meetings. CNMs/ADON report weekly to the PIC through the management meeting on all actions taken and those planned in response to complaints management. Priority entries are reviewed also by the PIC/ADON to identify anything that might be a complaint but was not previously identified as such.

• Procedures such as environmental audits and flushing of water outlets are completed as per schedule. Each of these processes is now documented with a person responsible to sign off on their completion. An Action plan for the environmental audit has been completed. This now includes a flushing schedule with household staff which takes place on a Tuesday, Wednesday, and Thursday in Tolka, Elms and Ferndale respectively.

• A review of record management has concluded, and a process is now in place to centralise the filing of records in the housekeeping office in an agreed folder that is readily available, can be easily accessed and reviewed by others when required. These records and any arising actions are discussed at the weekly management meeting.

• The GP has reviewed antipsychotic and anxiolytic medications and a plan has been agreed with the GP that such reviews will be completed as required and at a minimum on a three-monthly basis. All cardex have been reviewed and updated. A schedule for 2022 will ensure that all medications are reviewed as appropriate with an email reminder sent to the GP's surgery the week prior to the date.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: An up-to-date Statement of Purpose (SOP) has been completed and is available in the home. A copy of the most recent SOP was emailed to HIQA on the 26th of November 2021. Any future changes to the SOP will be communicated to and agreed by the Authority and will then be shared with our residents and families.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: There is a robust complaints policy and procedure with a process of identified management of complaints and access to a nominated person for appeal should the complainant be unsatisfied with the outcome. As noted at the inspection, the complaints reviewed within the EpicCare (online record management system) were found to be well managed. The areas of improvement relative to record management and in particular the documentation and follow up of verbal complaints has been addressed by: • Updating all staff on the policy and procedure regarding recording and managing verbal complaints. This had been communicated to all staff through staff communications – email reminders, staff meetings, additional training etc. • All senior management staff completed additional complaints management training in September & October 2021. • The CNM, ADON and Heads of Departments monitor compliance with the complaint policy and procedure by including complaints and general responses from residents and families in their meetings. CNMs/ADON report weekly to the PIC through at the management team meeting on all actions taken and planned. • Priority entries are reviewed by the PIC/ADON to pick up anything that might be a complaint but was not formally identified as such.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Signage has been replaced to indicate and include a hazard warning on the doors where the oxygen is safely stored. • A call bell audit has been completed with all residents' toilets as well as all other toilets	

having call bells in place and readily accessible. Call bell reviews and daily checks have been included on the household cleaning schedule of all bathrooms which is located on the inside of bathroom doors.
• The stains on the floor at the base of the chair in the hairdresser room have been removed.
• New desks have been ordered for each nurse's station. Existing desks have been removed and temporary replacements have been sourced until the new desks arrive.
• Maintenance carried out an audit to review the temperature on the three floors. All were found to be within acceptable limits. Such reviews will be ongoing and any issues together with the remedial actions will be agreed with the PIC.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• A review of the current training, which addressed IPC best practices, wearing of PPE, hand hygiene and uniform policy has been completed. In addition, IPC training with an external provider was delivered to senior staff during our recent outbreak. The PIC and team will continue to be supported by the Training Coordinator who arranges all required training, including IPC. The coordinator also updates the training matrix regularly. This will be monitored monthly by the ADON/PIC thereby ensuring all staff receive mandatory and other training as required.
• The hand hygiene audit tool has been amended to include nailcare, nail varnish & jewellery, with regular reviews by the CNM. Any issues/breaches are addressed immediately with the staff member. Regular checks of staff uniforms and general appearance has been included on the daily hand over sheet and reviewed by the PIC/ADON to ensure appropriate actions have been taken. An audit of compliance with this process and documentation is carried out by the PIC/ADON monthly and any non-conformances/breaches identified are addressed immediately. These findings are discussed at monthly team governance meetings.
• The daily handover sheet is included at staff handovers to ensure all staff are reminded about IPC measures, including the COVID-19 staff symptom monitoring logs which are reviewed by the CNMs.
• The installation of clinical handwashing sinks on corridors will commence in Q1, 2022 so as to ensure the home is in full compliance with the national standards.

Waste management:

• The PIC, housekeeper and maintenance staff completed an environmental review on the placement of bins and an action plan is in place to address the findings and thereby ensure the most appropriate placement of bins and towel dispensers in each room.
• All clinical bins have been reviewed and only rigid, foot-operated lidded bins are in use; all other bins have been removed from the building to ensure they are not used.
• The one clinical skip within the external waste holding area belonging to Beneavin

Manor has had a sign affixed to identify it as the Beneavin Manor Clinical Skip and it is locked. Housekeeping staff have the key and open it as required, ensuring to close and lock it after use.
• The external waste holding area is locked by the maintenance staff every evening and the key is left with the night staff.

Cleaning:

• A risk assessment was completed regarding the shortfall in cleaning staff and as per the risk assessment an external company attended the home and carried out a deep clean. The risk assessment remains live, and the situation is being monitored by the PIC.
• The fabric chairs have all been removed there only remains a fabric couch in reception. The covers on the couch cushions have been laundered are now included on the cleaning schedule. A replacement couch will be delivered in Q1 2022.
• Spray bottles are dried daily.
• There is a cleaning schedule present for the medication room including the fridge. The medication trolley and room audit includes a review of the fridge. These are conducted monthly by the CNM and reviewed by the PIC/ADON. Any issues identified are addressed immediately.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All issues raised were immediately addressed by the PIC, senior management team and GP.

• All prescriptions have been reviewed by GPs and updated as required.
• A schedule for 2022 will ensure that all cardex are kept updated in the future.
• The broken lock has been replaced and all keys are in working order.
• All nurses have been advised that keys are to be carried on their person at all times and the allocated nurse for each unit has the keys for their drug trolley and it is carried on their person for the duration of the shift.
• The two fridges have been replaced and the temperatures are recorded by the Staff Nurses daily. All nurses are aware of the actions to take in the event that fridge temperatures are recorded outside the normal range. The CNMs are monitoring daily temperature checks to ensure that they are completed, that they are within normal range or where they are not, that suitable action has been taken.
• All residents requiring crushed medication have this charted. Staff Nurses have been informed of the importance of following the prescription as stated. Those residents who require crushed medication have this also added to their care plans.
• There is an audit of the drug trolley and medication room which CNMs are completing monthly, included in this is a review of the blood sugar monitoring equipment and all

medications to ensure that they are correctly labeled.

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:
GPs have reviewed all PRN medication and provided clear directions as to when they should be administered. They have also ensured that where there is more than one medication, first and second-line medication is clearly indicated.
Consent forms have been completed by the resident and/or NOK in consultation with the OT, Physio, Staff Nurse and GP as appropriate for restrictive practices where these may be in place.

A review will be completed as required and at a minimum three monthly.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• There are a number of methods employed in the home to consult with and facilitate residents' participation in the organisation of the centre.
• Regular satisfaction surveys are carried out to ascertain residents' and family's opinions as to the overall quality of care provided in the home. Feedback from the most recent survey (due in January) will be incorporated into the annual review.
• In addition to the above, satisfaction surveys regarding meals are completed by the catering team who meet with any resident whose feedback is neutral or not positive. A report of these surveys is sent from the catering team to the PIC.
• Following a recent review, residents' meetings now take place on the first Monday of each month. This meeting is chaired by a member of the administration staff. These meetings can be attended by any resident who so wishes, with the Social Care Leaders visiting each resident prior to the meeting to discuss the meeting with them, provide assistance in preparing for the meeting, escorting them to the meeting or to bring an issue or concern forward to the meeting on their behalf. Post the meeting, minutes are sent to the PIC who will action all items raised, with feedback provided to the residents formally at the next month's meeting as well as in person/verbal updates provided to individual residents as items are actioned.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/12/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	20/12/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	20/12/2021
Regulation 27	The registered provider shall ensure that procedures,	Not Compliant	Orange	30/04/2022

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
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.	Not Compliant	Red	22/11/2021
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.	Not Compliant	Red	22/11/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	26/11/2021
Regulation	The registered	Substantially	Yellow	31/01/2022

34(1)(d)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Compliant		
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/01/2022
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	31/01/2022

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	20/12/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	06/12/2021