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 July 2023
Centre ID:	OSV-0005756
Fieldwork ID:	MON-0040904

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:	71

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 18 July 2023	10:40hrs to 18:40hrs	Karen McMahon	Lead
Wednesday 26 July 2023	20:30hrs to 21:45hrs	Karen McMahon	Lead
Thursday 27 July 2023	08:45hrs to 11:40hrs	Karen McMahon	Lead
Tuesday 18 July 2023	10:40hrs to 18:40hrs	Helen Lindsey	Support
Wednesday 26 July 2023	20:30hrs to 21:45hrs	Helen Lindsey	Support
Thursday 27 July 2023	08:45hrs to 11:40hrs	Helen Lindsey	Support

What residents told us and what inspectors observed

Throughout the days of inspection, the inspectors spoke with a number of residents residing in the centre. Generally residents said they were mostly happy and content living in the centre. One recurrent area of feedback from residents was in relation to the poor quality of meals.

One resident said that the staff were lovely but that the dinner was often cold and could be hotter. Another resident stated to inspectors that " the food is terrible. I haven't had a decent meal since I came in here, it's always cold. But the staff are lovely and always come when I ring the bell for help." Many other residents the inspectors spoke with echoed the same sentiments on the cold food. Two residents said they chose salads as they were of a better quality.

The designated centre is located in Glasnevin, Dublin 11 and shares a campus with two other nursing homes. The centre can provide accommodation for a maximum of 115 residents in single occupancy en-suite rooms over three floors. Each floor has two units. On the days of the inspection, one unit on the second floor was closed.

Inspectors viewed a number of residents' bedrooms and found them to be bright and homely spaces, tastefully furnished. Many were personalised with possessions and photographs from home. The corridors were observed to have unique features to prevent a clinical look to the centre, and provided a comfortable space for residents. Some walls had printed wallpaper on them and there were hanging baskets with artificial flowers hanging along the corridor outside the doors of residents' rooms.

Overall the centre was observed to be clean, tidy and well-maintained. Corridors, bedrooms, communal rooms and bathrooms were all seen to be cleaned to a good standard. There were pantries on each floor for catering staff to work from. However, these were noted to be dirty and in need of a deep clean. This had not been addressed on the second day of the inspection.

There was an enclosed garden outside for residents to use. This was accessible through an unlocked door on the ground floor communal rooms. Residents on the first and second floor did not have access to outside areas from their units, but some were seen to be supported to go downstairs to smoke outside of the centre, or go for a walk.

Each unit had a large day room with dining and TV facilities and a small kitchenette. During the daytime hours of the inspection many residents were observed sleeping in chairs, while others watched TV and a small number were participating in activities such as jigsaw puzzles and ball throwing exercises with staff. There were two activity rooms, one on the first floor and one on the second floor, but they were not observed in use on the days of inspection. It was noted activities staff were supporting individual residents, for example to go for a cigarette. Overall there was

very little meaningful occupation available to residents, with a reliance on music videos on the television. This was in part due to the availability of staff, who were engaged in delivering individual care and support for significant periods of time.

Inspectors observed that in one unit, the needs of the residents were such that one member of staff could not meet them. On this unit, eight residents still remained up at around 9pm. Of these residents three were observed sleeping in chairs, one resident was displaying responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), another resident was walking around the room and surroundings and the rest were watching TV. All residents were in the dining room as the staff member reported it was easier to supervise them this way. The staff member predominantly was focusing on delivering care to the resident displaying responsive behaviour, who was becoming more agitated. One resident who was sleeping woke from the chair and requested to go to bed. The resident was unable to have their personal choice facilitated as they were informed that they had to wait until more help came. Another resident needed re-direction to the toilet and again the carer was unable to provide this as they were already providing care to another resident. No supervision was available on this unit to those who were in bed.

There was one unit out of the five, where residents had high levels of support requirements, and one-to-one staffing had been sourced for a number of them. This resulted in a more active environment where residents were seen to be taking part more in routines of their choosing, and supervision was in place to ensure a safe environment.

Menus were displayed outside the dining facilities. There were three meal choices available for dinner and a hot and cold meal option available for tea-time. Snacks were available throughout the day and a separate menu displayed all available snack options, clearly displaying all options suitable for all levels of swallowing ability. Residents were encourage to sit at large dining tables which led to a pleasant social experience. Overall, staff were supporting residents discreetly, and engaged in pleasant encouraging conversations. Tables were set with tablecloths, cutlery, crockery and condiments. There were also flowers. Mealtime was seen to be a pleasant and unhurried experience for residents. Those who chose not to eat in the dining area were supported to have their meals in their room. One resident told inspectors it was their choice to eat in their bedroom but some days they also liked to avail of the communal dining areas. They said it was their own personal choice and it is always respected by staff.

All residents spoke highly about the staff and the care that they delivered. Staff were observed to be gentle in their interactions with residents and appeared to know the residents well. All residents appeared well-groomed and well-presented.

Visitors were observed visiting residents throughout the inspection, without restriction.

The next two sections of the report present the findings of this inspection in relation

to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The oversight arrangements in the centre were not sufficient to identify and address significant issues in the centre, that were were impacting residents quality of life. Inspectors were not assured there were sufficient staff available to meet the needs of the residents, taking into account their individual needs, and the layout of the centre. Governance and management arrangements had not identified this issue, which was impacting on the quality of care delivered to residents.

This was a three-day inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to review information received by the Chief Inspector through notifications from the registered provider and other unsolicited information received about the centre.

On day one of inspection, inspectors were met by the regional director of operations, who guided them through the sign-in procedure. After a brief introductory meeting, the inspectors completed a tour of the premises with some members of the clinical management team.

There was a management team in place, all recently recruited to the centre. There was a person in charge and two new assistant directors of nursing had been appointed. Along with the person in charge they were all working in supernumerary capacity. The team had been working together in the centre for around a month ahead of the inspection. Other staff members included nurses, health care assistants, activity coordinators, domestic, laundry and maintenance staff. Catering staff were provided by an external company contracted by the provider. Nevertheless, the inspectors were not assured that there were adequate staffing resources to provide care in line with the provider's Statement of Purpose and to meet the needs of residents.

Examples were seen throughout the three days of the inspection where residents did not have adequate supervision, could not receive support with personal care as staff were busy with other tasks, and were not engaged in regular social activities due to staff supporting other residents.

A number of peer-to peer-incidents had been notified to the Office of the Chief Inspector in the previous months of inspection. Many of these incidents had taken place in residents' own bedrooms. Appropriate investigation had taken place into these incidents and the registered provider had identified a need for staff with specialist experience and training in responsive behaviours, but had not identified inadequate supervision, as a result of low staffing levels, as an issue. A new clinical nurse manager (CNM) with relevant experience had recently been recruited for one

unit and staff training was on-going. However, inspectors observed that there was a significant reduction in staffing numbers on nights consistent with the timing of many of these incidents. Inspectors were not assured that there was adequate supervision during the hours of 8pm -8am as set out in Regulation 15; Staffing.

There were clear and structured systems around auditing and review in the centre. There were regular management meetings held between management and staff in the centre and the registered provider. However it was found that findings from audits and feedback from residents, visitors and staff were not always fed back into the management meetings for further discussion. Feedback had been gathered from residents in an annual review in 2022, but it was not evident that improvements had been made in line with the feedback received.

A sample of contracts were viewed over the course of inspection. The contracts included services provided, any relevant fees, room number and occupancy. However, it was found that they were not in line with regulation as the named person in the contract was not the registered provider of the centre. The registered provider is Firstcare Beneavin Manor Ltd, however a third party was documented on the contracts.

Examination of rosters demonstrated that staff retention had improved in the months previous to the inspection, but there was still a high use of agency staff in place. Recorded worked rosters were not reflective of actual worked shifts as the agency record of worked shifts was kept separate to this.

Staff training records indicated that the majority of staff were up-to-date with both mandatory and non-mandatory training.

On day one of the inspection, inspectors requested individual records for residents who the registered provider acted as pension-agent for. It was found that not all records relating to residents' finances, were kept on site. Further financial documents had to be requested from a financial department that was off-site. Regulatory requirements require all documents relating to residents finances to be available in the designated centre.

Regulation 15: Staffing

There were insufficient numbers of staff in four out of five units to meet the needs of the residents and to manage the layout of the centre. For example:

- after 8pm, the staffing levels on the ground and first floor went to three staff to cover two units, of around 30 residents per each floor. One staff member was a nurse who was completing a medication round, lasting up to two hours. Inspectors observed that the two remaining staff, one located in each unit, could not supervise residents who were still up, support residents to

retire to bed, or answer call bells.

- some residents remained in bed for prolonged periods of time, as they went to bed before 8pm and were still waiting for staff to support them to get up at 10.30am the next day
- in four of the five units there was little meaningful activity taking place for residents to engage in, with staff mostly engaged in care duties as they needed to meet the needs of residents for personal care, and to provide drinks and snacks.
- staff who were employed to carry out activities, were supporting residents displaying responsive behaviours, on a one-to-one basis, which meant other residents did not have staff around them to engage them in meaningful group activities

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider had a range of training programmes for staff to complete. This included fire safety, safeguarding of vulnerable adults, manual handling and infection, prevention and control training.

Most staff had completed fire safety training and refresher training, with further update sessions planned in the coming weeks.

There was a detailed induction programme for new staff to complete. Agency staff also confirmed they had received key information about working in the centre ahead of their first shift.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of Residents was available to view and information was in compliance with paragraph 3 of Schedule 3.

Judgment: Compliant

Regulation 21: Records

All documents relating to residents' finances were not kept on site, as required by the regulation.

Staff were not able to provide financial records requested on the day, as they were held in another place, which was not part of the designated centre. Of the records reviewed, it was not possible to consolidate the internal and bank records due to the manner in which they were recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place to ensure the service provided was safe, consistent and well-monitored were not adequate to ensure effective oversight. For example.

- While there were regular management meetings carried out, minutes did not evidence that the provider had identified, nor had a plan in place in respect of staffing resources. This included following a number of safeguarding incidents where staff had not been present to redirect residents from confrontation with other residents.
- Provider's audits had failed to identify the issues found during the inspection in respect of staffing levels and activities, and the impact they had on resident's quality of care and quality of life. The levels of staffing especially in the evening time resulted in task-driven care being delivered, and not person centred care, that respected the rights of residents to make choices about how they spend their time.
- Where audits identified areas for improvement, actions plan to address these issues were not in place or effective. For example, audits of the kitchenettes had identified issues, but they had not been addressed at the time of the inspection, and a deep clean was required.
- Feedback from residents' meetings and surveys was not acted on in a timely manner. The resident survey in 2022 showed 33% of the residents taking part had said they were 'not very' or 'not at all satisfied' with the meals. 37% were not satisfied with activities. It was not evident from management meetings, or any updates following the survey that this feedback was being responded to. The findings on this inspection found issues with meals persisted, and that there was limited meaningful engagement for residents.
- Oversight of staffing arrangements was impacted by ineffective record-keeping, as the roster did not provide assurances in respect of shifts covered. Agency staff hours were recorded separately, which made it difficult to confirm if agreed staffing levels had been maintained.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

While contracts of care were in place, it was noted that the more recent contracts did not name the registered provider as being part of the contract, but a third party organisation

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a policy in place that had been updated following the change to the regulations at the beginning of 2023. The policy set out who was responsible for managing complaints, and also the oversight arrangements in place to ensure the policy was followed.

Three complaints were reviewed, and two had been responded to in the time line set out in the policy. The third complaint was being progressed at the time of inspection. It had been acknowledged and the registered provider was responding to additional information that had been supplied.

There was information about the complaints process displayed on the walls in the centre, and also in the residents handbook which was given to residents.

Judgment: Compliant

Quality and safety

While there were some positive aspects of the service being delivered, arrangements in relation to upholding residents rights were not adequate, including safeguarding arrangements. Gaps in oversight and weak governance and management arrangements impacted on residents' quality of care and quality of life.

The premises provided a well- maintained and homely environment for residents, and many relatives were visiting throughout the inspection. Inspectors reviewed a sample of residents' care plans and pre-admission assessments. Comprehensive assessments, prior to admission, were used to develop relevant person-centred care

plans relating to individual needs and preferences. Care-plans were reviewed at least four monthly. However some gaps were identified. These are discussed further under Regulation 9 & 13.

The registered provider was monitoring the use of restrictive practice in the centre. They had a comprehensive restraints register in place that was used to monitor the number of restraints and their appropriateness. There was also a comprehensive restraint policy in place, that was accessible to all staff members. Responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) care plans, that inspectors reviewed, gave a clear description of resident responsive behaviours and the interventions required to support the individual concerned. The registered provider had sought additional resources to meet the needs of some residents, where their needs assessments identified that this was necessary.

The registered provider was a pension-agent for one resident. There was a separate bank account for residents' finances. Records available on the first day of inspection were not clear. Administration staff available on the day were unable to provide an explanation for this and were unable to contact the finance department for explanation. Further documents were examined on day three of the inspection and after much review of several documents inspectors eventually were able to establish the correct information. Inspectors were not assured that the system in place to monitor residents' finances, for whom they acted as pension- agent, was robust enough to provide adequate safeguarding of residents monies.

There was an activities schedule in place over the three days of inspection. However there was no robust and socially simulating activities seen over the dates of the inspection, to reflect this schedule. On day one of inspection, on one floor a small number of residents were seen participating in activities with the care staff, including jigsaws and ball throwing exercise. On day three, a small number of residents were seen to be going on an outing. This is further described under Regulation 9; Residents' rights.

The inspectors also observed that the quality of the documentation on the recording and identification of a resident’s activity and social care care plan varied. One care plan provided a detailed overview of the resident's life and their hobbies and interests. While the other care plans examined by inspectors lacked detail and identification of the resident's personal interests and hobbies. Many appeared to be a repetition of care plans with personal details changed. Activity participation records were also not consistent and varied over two technology platforms. One platform logged a lot of TV watching as the resident's daily activity and the other platform appeared a bit more detailed and included photos where relevant. However, activities and the residents engagement with them were still not recorded on daily basis to provide reassurance that the residents’ rights around choice and activities were being met.

Similarly, gaps in end-of-life care planning arrangements were observed as further described under Regulation 13; End of life. Residents did have access to local

palliative care services and general practitioner (GP) services for end-of-life care.

Improvements in overall maintenance of the centre had been noted since the previous inspection. However some further improvements were required regarding the oversight of fire safety. Examples were seen where fire doors throughout the centre had gaps in the fire seals and two external doors leading out to the enclosed garden were observed to have the fire seals coming off. Fire emergency lights were also observed flickering on and off in some bedrooms and corridors.

Regulation 11: Visits

Visiting was in line with regulation and no restrictions were in place. A room with toileting facilities, was available to family members who wished to stay overnight. Residents reported they were pleased to see their visitors at times that suited them.

Judgment: Compliant

Regulation 13: End of life

The person in charge had not ensured that all residents had an appropriate end-of-life care plan that reflected their individual physical, emotional, social, psychological and spiritual needs and ensured that their needs were met.There were inconsistent care planning arrangements and the quality of the documentation differed from unit to unit.

Two care plans viewed clearly outlined the residents' personal wishes for end-of-life care and were very detailed. However, two other residents had a generic care plan in place that had the individual names changed on it relevant to the resident, while two other residents had no personalised or detailed care plan for end-of-life care in place at all.

Judgment: Substantially compliant

Regulation 17: Premises

The premises of the Designated centre was appropriate to meet the number and needs of residents and was in accordance with their statement of purpose. The

centre was well maintained, with a programme in place for ongoing maintenance.

Judgment: Compliant

Regulation 28: Fire precautions

While there were policies and procedures in place to manage fire safety in the centre, inspectors noted some areas that required action by the provider:

- there were some large gaps identified between fire doors; this did not ensure effective smoke containment in the event of fire.
- fire seals on two external doors were in need of replacement or repair as they were falling off.
- there was a large hole in the ceiling of a comms room, preventing appropriate compartmentation of a high-risk area.
- one fire exit area was used for storage of multiple boxes, which were seen on all three days of the inspection. Fire exit doors should be maintained clear of any obstruction at all times.
- there was a wooden pallet outside one fire exit which would restrict movement if an evacuation were required.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans had been prepared for residents in line with regulations and were reviewed at quarterly intervals or earlier if required. Comprehensive assessments had been carried out prior to admission to the centre. Consultation with Residents were reflective in the care plans.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff had appropriate training in managing behaviour that is challenging. Care plans clearly reflected the individual needs of the resident and provided appropriate knowledge to staff. The use of restraints in centre were in line with National policy.

In one unit a number of residents were receiving the support of one to one staffing. This was seen to have a positive impact on the level of restrictions in place, as the

residents could follow their own preferred routine and activities, resulting in them experiencing less anxiety. This was not always the case in one of the other units, as described further under regulation 8 Protection.

Judgment: Compliant

Regulation 8: Protection

The inspectors found that the registered provider had not taken all reasonable measures to ensure that residents living in the centre were appropriately safeguarded from abuse. For example;

- A number of peer-to-peer incidents had taken place during the night in the months previous to inspection. No changes to staffing levels were made in the aftermath of these incidents and management had failed to identify the low level of supervision on nights as a risk factor.

Inspectors were also not assured that there was a robust enough system in place to protect the finances of residents, for whom the provider was a pension-agent. Practice in the centre was not in line registered provider's policy in that the named person on the pension-agent application was not the person in charge, but a senior manager of the umbrella body, which was not the registered provider. Such arrangements did not ensure residents' finances were effectively safeguarded and impacted the provider's ability to have full and effective oversight of financial arrangements for residents where they were a pension-agent.

Judgment: Not compliant

Regulation 9: Residents' rights

There was an overall lack of meaningful activities available for residents in the centre, which meant that, for the most part, residents were not participating in activities of interest to them. For example:

- Many residents were seen to be sleeping in chairs or sitting in front of the TV, throughout the days of inspection.
- Records available did not demonstrate a high level activities within the centre and were not consistently recorded.
- Activity rooms were available in the centre but they were not observed in use throughout the inspection.
- There were two activity leads on the days of inspection, one was observed providing one-to-one care, leaving one person responsible to lead activities

over five units.

Inspectors were not assured that residents could exercise choice in relation to their preferred routines. The majority of residents were in bed when inspectors arrived at the centre around 8.30. Resident were seen asking for support for toileting or going to bed, and there were insufficient staff to support them at the time of the request.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Firstcare Beneavin Manor OSV-0005756

Inspection ID: MON-0040904

Date of inspection: 27/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A comprehensive review of staffing levels has taken place since the inspection in conjunction with the review of the needs of all residents across the centre. In response to the review findings, staffing levels at night time have been increased every evening to enhance the level of supervision in the centre. An additional shift from 6 pm to 11pm has been created, the impact of which remains under continuous review. We continue to closely review the dependencies of each resident, and this information will be used to inform and adjust staffing levels accordingly. • The roster is managed by the Director of Nursing who ensures that appropriate skill mix and staffing levels are maintained in line with the Statement of Purpose, the layout of the centre and the number and clinical requirements of the residents. The roster is now reviewed on a weekly basis by the PPIM and RPR or more frequently as dictated by the changing needs of the residents. (Complete) • A time-in-motion exercise is being finalised by the Director of Nursing on medication administration at night time to ensure residents receive their medication in a timely manner in line with their preferences. The outcomes from the review will be fully implemented by 30/09/2023.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Administrators in each of the centres can access individual records for residents who the registered provider acts as pensions agent for. The finance team will reconcile these accounts on a monthly basis and will provide residents with a monthly statement to advise of these transactions at the end of each month. A refresher training is organised for nursing home staff administrators for the end of October 2023. A company wide	

policy review will be completed to bring current practices in line with best practices. This will be completed by December 2023. The company has consulted with SAGE advocacy in this review process.

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Work is ongoing with the catering provider to ensure the issues highlighted during the inspection are fully addressed. Weekly and monthly management meetings in relation to catering are now in place to ensure that the improvements made to date are sustained (Complete and ongoing). • The Director of Nursing has revised the approach to resident meetings and in-house surveys. A member of the senior management team now attends resident meetings and has dedicated responsibility to ensure that any concerns expressed by residents are responded to in a timely manner. All feedback and actions taken to address same are also discussed at monthly governance meetings. (Complete and ongoing). • The roster containing details of all staff employed to work in the centre is now overseen by the Director of Nursing who ensures that appropriate skill mix and staffing levels are maintained in line with the Statement of Purpose, the layout of the centre and the number and clinical requirements of the residents. (Complete)	
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: • Contract of Care have been revised to clearly reflect the name of the registered provider. (Complete)	
Regulation 13: End of life	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: End of life:	

• A review of care plans has been completed to ensure that a person-centred approach is consistently adopted which reflects the assessed needs and preferences of each individual resident. Care plans are audited monthly and the outcome from the audits is discussed at monthly governance meetings attended by the PPIM (Complete)
• All staff nurses have completed care plan training with a special focus on End of Life and meeting the resident's physical, emotional, social and psychological needs. A weekly audit of end of life care planning is carried out by Director / Assistant Director of Nursing to ensure compliance.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Registered Provider has engaged an external contractor and in conjunction with the local maintenance team are working to ensure all outstanding works in relation to compartmentation, fire sealing and fire door assessments are fully addressed.
• The fire seals on two external doors have been addressed and the weekly fire inspection checklist has been updated to monitor this area on a weekly basis. (Complete)
• The boxes obstructing the fire exit and the pallet to the exterior were removed at the time of inspection and daily checks carried out by the management team ensure fire exits are kept clear at all times (Complete).

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A comprehensive review of staffing has taken place since the date of inspection in conjunction with a review of the needs of all residents across the centre. In response to the review findings, staffing levels at night time have been revised to enhance the levels of supervision in the centre.
• The roster is managed by the Director of Nursing who ensures that appropriate skill mix and staffing levels are maintained in line with the Statement of Purpose, the layout of the centre and the number and clinical requirements of the residents. The roster is now reviewed on a weekly basis by the PPIM and RPR or more frequently as dictated by the changing needs of the residents
• A review of the management of resident's financial records is currently being undertaken by the RPR and finance team to ensure full compliance with the regulations and to reflect best practice.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A comprehensive review of residents assessed needs and preferences has been conducted (including choices around retiring and arising from bed). These are clearly recorded in resident's care plans and used to inform the delivery of care within the centre.
• A redesign of the activity programme is currently being undertaken. An updated programme will be in place by 30th September 2023 that fully reflects resident's expressed wishes and their social and recreational needs. A subcommittee has also been set up with senior nurse management involvement to oversee activities within the centre.
• Beneavin Manor is actively recruiting to fill the vacant activity team lead role and in the interim a member of the care team has been dedicated to fulfill this role.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	31/07/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2023
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	31/12/2023

	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.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	10/09/2023
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	10/09/2023
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)	Substantially Compliant	Yellow	31/07/2023

	of that bedroom, on which that resident shall reside in that centre.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/10/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/12/2023
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30/09/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/09/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident	Not Compliant	Orange	30/09/2023

	may exercise choice in so far as such exercise does not interfere with the rights of other residents.			