**Health Information and Quality Authority Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Beneavin House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000694</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Beneavin Road, Glasnevin, Dublin 11.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 864 8516</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:beneavinhm@firstcare.ie">beneavinhm@firstcare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Beneavin House Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>John O'Donnell</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Jim Kee</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>126</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>24</td>
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</table>
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 03 February 2016 10:00  To: 03 February 2016 18:30
From: 04 February 2016 09:00  To: 04 February 2016 17:00

The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
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<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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Summary of findings from this inspection

This inspection was announced following an application by the provider to renew the registration of the centre. As part of the inspection, inspectors met with residents, relatives and staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.
Prior to the inspection, inspectors reviewed written evidence all documents submitted by the nominated person on behalf of the provider, for the purposes of application to register were found to be satisfactory.

The centre is registered to accommodate 150 residents and there were 122 residents on the day of inspection with four off site, leaving twenty four vacant beds.

The provider and the person in charge were found to be operating in compliance with the conditions of registration and in compliance with fourteen of the eighteen outcomes inspected against. Inspectors found that the nominated person on behalf of the provider had addressed two of the four action plans from the last monitoring inspection which took place on 22 January 2016. The two actions plans addressed included the up-dating of the policy on elder abuse and notification of an incident to the Authority the remaining two were in the process of being addressed.

The four outcomes not met on this inspection related to no enough support being in place to assist the person in charge. The non-inclusion of residents/relatives feedback in the centres annual review, medications not being administered in accordance with professional guidelines and restraint records not being in line with the National policy. Finally current staff numbers were not adequate to meet the needs of 150 residents (as per application form). The action plans at the end of this report reflect these non-compliances.
Compliance with Section 41(1)(c) of the Health Act 2007 and 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 Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was a statement of purpose which described the services and facilities provided. However, it required review as the current copy did not accurately reflect all staff working in the centre.

The statement of purpose was kept under review. It had been reviewed and updated in December 2015 and January 2016. Staff were familiar with its content and a copy was on display in each of the units and in the front foyer of the centre.

**Judgment:**
Substantially Compliant

**Outcome 02: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was a clearly defined management structure which was outlined in the statement
of purpose. However, due to a number of vacant posts it was currently not strong enough to support the person in charge.

The person in charge was supported in her role by a team of people including an operations manager, a managing director and the provider all of whom worked across the groups five nursing homes. She was normally supported by two deputy directors of nursing and four clinical nurse managers however, a deputy director of nursing post and one clinical nurse manager post were vacant at the time of this inspection and a second clinical nurse manager had submitted a letter of resignation.

Inspectors were told the deputy director of nursing post was in the process of being filled and the management team were actively recruiting to fill the current vacant clinical nurse manager post.

An annual review of the quality and safety of care delivered to residents had taken place and was available for review. It included evidence of a review having been carried out on some aspects of care delivered such as falls, incidents, occurrence of pressure ulcers and use of restraint. Although residents and relatives had been asked for their view on different aspects of the quality of care and service via a questionnaire issued to them throughout 2015. The analysis of this consultation had not been included in the annual review. In addition, the review did not include a plan of improvement based on the outcome of the quality of service review. Hence, there was no evidence of what measures were planned to improve the quality of service delivered to residents'.

Inspectors had concerns about the managements team response, investigation and non compliance with notifying the Authority of an incident which occurred in 2016. However, this has since been addressed by the provider.

There was no system in place as outlined in Outcome 9 to review medication related incidents including medication errors and near misses' to identify any trends, and to ensure appropriate action was taken when necessary.

**Judgment:**  
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 03: Information for residents</strong></th>
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<tr>
<td><strong>A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.</strong></td>
</tr>
</tbody>
</table>

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**
There was a resident guide made available to residents and each had a contract of care. The residents guide listed the services and facilities provided, the terms and conditions of residency in the centre, the complaints procedure and the arrangements for visitors to the centre. Inspectors were told that a copy was made available to residents on admission to the centre together with their contract of care.

Each resident had a written contract of care agreed on or shortly post admission. A sample were reviewed, they included details on care and welfare and on services provided. They also included fees to be charged and a list of possible additional fees charged.

**Judgment:**
Compliant

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**Outcome 04: Suitable Person in Charge**

*The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. She demonstrated a good level of clinical knowledge and knowledge of the regulations and her legislative responsibilities. She worked full-time and was supported in her role by the provider nominee, an managing director, operations manager, a deputy home manager and three clinical nurse managers.

The deputy home manager and clinical nurse managers worked full-time and demonstrated good clinical knowledge of all residents. The deputy home manager was named on the application for renewal to take over the running of the centre in the absence of the person in charge.

**Judgment:**
Compliant

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**Outcome 05: Documentation to be kept at a designated centre**

*The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and*
The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Documentation in the centre was seen to be relatively well kept.

The directory of residents within the centre contained all of the required details of each resident as set out under Regulation 19.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a resident's property. The insurance policy was on display in the front foyer.

Resident records were kept secure and were easily retrievable. Records of residents' medical and nursing care were kept up-to-date. However, records of medication administration were not being maintained in accordance with relevant professional guidelines as required under Schedule 3 (d) of the regulations in that;
- Medicines administered at 11am were documented as being administered at 9am.

All policies outlined in schedule 5 were in place. The centres policy on elder abuse had been updated since the last inspection.

A review of a sample of staff files confirmed that effective recruitment procedures were in place, all three files contained the required documents outlined in Schedule 2, including evidence of up-to-date registration with the relevant professional body for staff nurses.

**Judgment:**
Substantially Compliant

**Outcome 06: Absence of the Person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There had been no period to date where the person in charge was absent for 28 days or more. Inspectors were satisfied that suitable arrangements were in place to cover any period of her absence. The deputy home manager was the named person on the application form to take over in her absence. She had been previously deemed fit to hold this position.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The centre was safe for residents. The front door was manned by a receptionist during the day and staff at night time. There was a policy in place which covered the protection, detection and prevention of elder abuse. Inspectors were informed that the investigation into one alleged incident was underway.

Records reviewed showed staff had completed training in the protection, detection and prevention of elder abuse and those spoken with had a good clear and concise understanding of this policy.

There were a number of residents in each unit with bed rails in use as a form of restraint. Although there was several different types of alternative equipment available such as low low beds, alarm mats and crash mattresses. The restraint assessment did not outline what if any of these had been tried, tested and failed prior to bed rails being used as a form of restraint. Inspectors observed that the assessment forms required review to ensure the assessment for use of bed rails as a form of restraint was in line with the National policy for use of restraint. This was discussed with the operations manager and person in charge during the inspection.
Residents' displaying behaviours that challenged were being managed appropriately during this inspection. Records reviewed showed that staff had received training in this area within the past two years. Residents' who displayed behaviours that challenged had a detailed plan of care in place. These plans ensured the safety of the resident and those residents and staff in their vicinity was priority. For example, one resident was having one to one supervision to ensure all residents' safety.

The management of residents' finances was not reviewed on this inspection as they were reviewed and found to be managed well during a recent inspection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Health and Safety and Risk Management**
*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The health and safety of residents, visitors and staff was promoted and protected.

The centre had a risk management policy, an emergency plan and an up-to-date health and safety statement in place. The risk register was comprehensive. It identified risks and specific measures put in place to reduce the level of risk. Infection control practices were good with hand washing and drying facilities and hand sanitizers available throughout the centre.

Inspectors saw that there was adequate means of escape and fire exits were unobstructed. However, a floor plan showing the nearest fire exit was not on display behind on each floor of the centre.

Records reviewed on inspection showed that the fire alarm was serviced on a quarterly basis and fire safety equipment and emergency lighting was serviced. All staff had recently completed fire safety training which included the entire building. Records reviewed showed that a mock fire drill was practiced once per month. Staff spoken with were clear on what to do in the event of the fire alarm sounding. Inspectors saw that there was adequate means of escape and fire exits were unobstructed. However, a floor plan showing the nearest fire exit was not on display behind on each floor of the centre. Fire doors were available throughout the nursing home. Corridor doors were attached to the fire alarm and were self closing however other room doors such as bedroom doors were not. Self closing doors are currently recommended.
Manual handling practices observed were in line with best practice and records reviewed showed all staff had up-to-date training in place.

**Judgment:**
Substantially Compliant

### Outcome 09: Medication Management

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors reviewed the practices and documentation in place relating to medication management in the centre. There were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents. All medicines were stored securely in the centre. However there were a number of issues relating to the prescribing and administration documentation that required improvement to ensure medication management practice was to an appropriate standard. Inspectors found that there was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds. Inspectors were informed that the planned implementation of an electronic medication management system was now planned for later in the year.

Medicines were supplied to the centre by a retail pharmacy business, with the majority of the medicines dispensed in a monitored dosage system that consisted of individual pouches. All medicines were stored securely within the centre, and fridges were available for all medicines or prescribed nutritional supplements that required refrigeration, and the temperature of these fridges was monitored. At the time of the inspection nursing staff had to spend a significant amount of time assembling the pouches containing residents’ medicines on to a tray that contained individual photographs of the residents which could then be placed in the medication trolley. All controlled (MDA) medicines were stored in secure cabinets, and registers of these medicines were maintained with the stock balances checked and signed by two nurses at the end of each working shift.

The inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents’ individual medication requirements. Nursing staff were observed to safely administer medicines. However the inspectors observed that on one of the floors the morning medication administration round was not completed until 11am. The inspectors reviewed the
administration records and these records indicated that the medicines had been administered at 9am. The inaccuracy of the medication administration records is included under Outcome 5. There was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds. There was also the potential for medication errors to occur due to the length of time between the last administered dose for some medicines and the next medication administration round at 1pm.

There were procedures in place for the handling and disposal of unused and out of date medicines.

The inspectors reviewed a number of the prescription and administration sheets and identified a number of issues that did not conform with appropriate medication management practice:
- A number of residents required their medicines to be crushed prior to administration and this was documented at the top of the prescription sheet. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
- Inspectors found that a number of prescription sheets did not specify times of administration.
- There were no resident specific care plans in place for residents who had been prescribed more than one psychotropic medicine on a PRN (as required) basis to guide staff in the administration of these medicines (in some cases the prescription did not indicate which medicine was to be administered first. There were no protocols in place as part of behaviour support plans or care plans to guide practice to ensure appropriate consistent administration)

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis, conducting reviews of residents’ medications and medication audits.

There were systems in place within the centre for reviewing and monitoring medication management practices, including medication management audits that reviewed administration practice during medication rounds, administration records, prescription sheets and storage of medicines within the centre. Medication incidents including medication errors were recorded and nursing staff spoken to by the inspectors were knowledgeable of the procedure to be followed. There was no indication that medication errors were reviewed to ensure that any trends could be identified. This finding is included under Outcome 2.

**Judgment:**
Non Compliant - Moderate

**Outcome 10: Notification of Incidents**

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.
**Theme:**  
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
A record of all incidents occurring in the designated centre was maintained. A notification was provided to the Authority within 3 days of the occurrence of any incident set out in paragraphs 7(1) (a) to (j) of Schedule 4 since the last inspection.

A quarterly report was provided to the authority to notify of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4. A report had been provided to the Authority at the end of each quarter.

When the cause of an unexpected death was established, the Authority was informed of that cause.

**Judgment:**  
Compliant

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**Outcome 11: Health and Social Care Needs**  
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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**Theme:**  
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
Each resident’s wellbeing and welfare was maintained by a high standard of evidence-based nursing care.

The inspector saw evidence that residents received appropriate nursing, medical and allied health care without delay. Residents were seen by their general practitioner on a frequent basis and had their medications reviewed every three months.

Each resident had an assessment in place which was updated within a four month period. Inspectors reviewed a sample of residents’ files and saw that each identified need had a care plan in place. Residents care plans were updated to reflect the care
recommended by visiting inter disciplinary team members and any change in care been provided by staff. There was written evidence that residents' were involved in their assessment and care plan review.

There was group and one to one recreation activities scheduled daily to meet the needs of residents. Timetables for these activities were displayed throughout the centre and residents' spoken with knew what was scheduled. They told inspectors that they were given a choice whether to attend or not and their choice was respected by staff. They were satisfied with the variety of activites available a number complimented the two activity leaders and staff who participated in the delivery of these activities. Activities specific to meeting the needs of residents' with a cognitive impairment were included in the activities timetable. Staff were observed facilitating a small group of residents to participate in a creative activity in a peaceful environment while having a cup of tea. They all were seen to be participating in some small way.

**Judgment:**
Compliant

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**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

**Findings:**
The design and layout of the centre was in line with the Statement of purpose.

The centre was well light, clean and suitably decorated. The building was well heated and residents confirmed it was always kept warm enough for them.

The design and layout met the needs of resident. Corridors were wide and free from obstruction. The centre was homely with enough furnishings, fixtures and fittings. The open plan living area developed in some of the units enabled a homely atmosphere to be replicated.

There was a functioning call bell system in each residents bedroom and in communal rooms. The layout promoted residents’ dignity, independence and wellbeing as all bedroom and ensuite/bathroom doors had privacy locks in place. Twin bedrooms had adequate screening in place to maintain ones privacy. There was enough storage
facilities available to residents’ in their bedrooms. Residents' were facilitated to bring personal furnishings and fixtures into their personal space. •

Equipment to meet resident needs was available to staff. This equipment was maintained and said records were available for review.

Most areas of the centre were well signposted. The signage had been personalised in areas where residents with a cognitive impairment lived. This coloured pictorial signs facilitated residents’ to navigate their way around their home a little easier.

Judgment:
Compliant

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Complaints made were managed in line with the centres complaints policy. The complaints policy met the legislative requirements and was clearly outlined in the statement of purpose and the residents guide. The process was clear, accessible to all residents and displayed in prominent places throughout the centre.

The person in charge was the nominated person to deal with all complaints. The inspector reviewed records of complaints received since the last inspection, all had been fully investigated with clear concise records kept including the residents level of satisfaction with the outcome of the complaint. A number of residents and relatives who provided written feedback stated that they had never had a reason to complain or if they did they would go to the person in charge.

Inspectors found that the policy on dealing with complaints could be improved. Staff on each unit did not have access to the required documentation to record a complaint made to them. Persons with complaints were sent to the person-in-charges office to have them dealt with and inspectors were told she was not always available. Hence, minor issues were not being dealt with promptly. This was reflected in the fact that the Authority had been contacted on 6 separate occasions (since inspection on 25 February 2015) with concerns of various aspects of care being delivered. The issues within these
concerns have all been followed up upon on this registration inspection.

Judgment:
Substantially Compliant

**Outcome 14: End of Life Care**
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The policies and practice in place ensured that each resident received care at the end of their life which met their physical, emotional, social, psychological and spiritual needs and respected their privacy, dignity and autonomy.

There was overnight accommodation available to the dying residents family. The centre had access to a palliative care team and there was no delay in seeking their expert advice.

Inspectors reviewed the files of two residents who were receiving end of life care. Each resident's end of life preferences were recorded and each of the residents had a detailed resident specific an end of life care plan in place. This included details of their preferred resting place. It was evident that this plan of care had been discussed with the resident prior to their condition deteriorating. All religious and cultural practices were facilitated by staff.

Judgment:
Compliant

**Outcome 15: Food and Nutrition**
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was a policy in place for the monitoring and documentation of nutritional intake.

Residents had access to fresh drinking water at all times. Residents stated that the food provided met their needs and overall they received a good variety and choice in sufficient quantities at each meal time. Meals and snacks were available at times suitable to residents. The inspector saw that the special dietary requirements of each resident were provided for. Catering staff spoken with had a good awareness of residents’ dietary needs. They had an updated reference list containing information regarding the residents preferred diet and the consistency each residents food and drink needed to be served at.

Food appeared to be properly prepared, cooked and served, and appeared wholesome and nutritious.

The inspector saw evidence that residents' with a weight loss which was of concern to staff had been reviewed or had been referred and were awaiting review by a dietician. Nutritional supplements recommended by the dietician were being administered to the resident as prescribed by the resident's GP. Recommendations made by the dietician and care been provided by care staff were not reflected in the residents food and nutritional care plan.

**Judgment:**
Compliant

**Outcome 16: Residents’ Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found that dignity and privacy of the residents was respected by the staff. They were consulted with throughout the year about the running of the centre.

Staff were seen to be polite and courteous when interacting with the residents and the relationship between the staff and residents was seen to be warm and caring. Residents’
spoken with were extremely complimentary of staff particularly the level of attention they paid to them. Residents in communal areas were supervised by staff during the inspection.

There was a visitors policy which stated there were no restrictions on visitors. This was observed as many relatives and friends visited residents' throughout the duration of the inspection. There were a number of rooms and areas where residents could receive visitors in private if they wished to do so.

Residents had access to a portable telephone which they were facilitated to use in private however most had their own mobile phone. Residents who wished were provided with a copy of the daily and local weekly newspapers of their preference.

Inspectors found that residents were consulted with about the running of the centre. Residents meetings took place at least once every three months but usually within an 8 week time frame. These were facilitated by an independent advocate, minutes were available for review and issues brought up by residents were brought to the attention of the person in charge and a response was provided to residents at the next meeting. Residents were also consulted with by being asked to complete a questionnaire in relation to the quality of care and of service being provided to them. As mentioned under outcome 2, an analysis of this feedback was not available on inspection. Contact details for the advocacy service were available within the resident's guide and the statement of purpose.

Residents were facilitated to exercise their civil, political, religious rights and were enabled to make informed decisions about the management of their care through the provision of appropriate information. They had a choice to attend Mass said weekly in the centre and a number of structured religious prayer meetings held each day. Other religious sacraments were provided to them such as holy communion and anointing of the sick which residents expressed satisfaction with.

A number of residents told inspectors that they had been facilitated to vote at the last election and the person in charge confirmed that she had offered all residents to be registered to vote in 2015.

**Judgment:**
Compliant

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**Outcome 17: Residents’ clothing and personal property and possessions**

Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

**Theme:**
Person-centred care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents were able to maintain control over their personal property and appropriate storage facilities for their belongings was in place.

There were adequate laundry facilities provided. Laundry was collected and returned twice weekly. All clothing was seen to be labelled for each resident. An inventory was also kept of each individual resident's personal belongings.

Residents confirmed that they had adequate storage facilities in their bedroom which included their a personal wardrobe and a bedside locker.

Judgment:
Compliant

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**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of the 126 residents in the centre at the time of this inspection. This care was been provided by both staff employed to work in the centre and employed via an nursing agency.

There were not enough staff to meet the needs of 150 residents the full capacity of centre. The management team were aware of this and had not gone above 127 residents since the application to vary conditions of registration from 127 beds to150 beds was granted in 2015.

Inspectors were informed by the management team that they had a large turnover of staff which had been continuous since 2015. There had been a large recruitment drive with a number of staff nurses being recruited from abroad. A number had completed
their training and were awaiting registration with Bord Altranais agus Cnáimhseachais na hÉireann. Others were in the process of completing the in-house training programme developed by the management team.

There was an actual and planned staff rota. Inspectors saw that there was a minimum of one staff nurse on duty at all times and the numbers of staff rostered during the day and night took into account the statement of purpose and size and layout of the building. The roster showed that agency staff were supported by long term staff members with similar or higher qualifications. Residents spoken with confirmed that staffing levels were good, stating they never had to wait long for their call bell to be answered or their requested needs to be met.

Records reviewed confirmed that all staff had mandatory education and training in place. Staff had also been provided with in-house education on a variety of topics, such as, dementia training, palliative care, infection control, medication management and scope of practice. This enabled staff to provide care that reflects current best practice. Staff spoken with told inspectors their learning and development needs were being met and they demonstrated a good knowledge of policies and procedures.

Staff nurses were available to supervise carers on each floor. However, as mentioned under outcome 12 a large portion of their time was taken up administering medications to residents’. There was an appraisal system in place for all staff, however these were completed by a small number of staff mainly due to the vacant posts within the management team which had lead to a lack of time to complete this level of formal supervision with staff.

Inspectors spoke with staff who confirmed that they were given adequate opportunities to take up training of their preference. Some stated that due to the current demands of the job, covering vacant shifts they did not feel they could commit to further training. However, they were made aware that funding was available to them for this purpose. Care staff expressed a need to be valued more especially when they had a number of years experience, knowledge and passion for their job. The management team informed inspectors that they were in the process of advertising team leader roles within the centre.

Inspectors noted that processes had not been put in place to facilitate the retention of staff. The management team acknowledged this informed inspectors that they were looking at a number of different options.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.
Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Beneavin House</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000694</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>03/02/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21/03/2016</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The total staffing complement required review to ensure it reflected all staff currently working in the centre.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Statement of Purpose will be revised to ensure it reflects all staff currently working in the Nursing Home including those of our contracting partner.

**Proposed Timescale:** 31/03/2016

### Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no system in place as outlined in Outcome 9 to review medication related incidents including medication errors and 'near misses' to identify any trends, and to ensure appropriate action was taken when necessary.

2. **Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The Home Manager will meet with the Pharmacy the week beginning March 21st to devise a process which will identify and examine an incident should it occur. This will enable us to capture a trend, establish learning lessons and to mitigate a reoccurrence. Staff will be advised of the changes through changes to policies and procedures and also through any additional training that may be warranted as a result of the new process being introduced. The Home Manager will be responsible for reviewing incidences with the Operations Manager initially to determine trends and they will then liaise with the pharmacy where appropriate to attempt to minimise and reduce any associated events within processes that may be contributing to these incidences.

**Proposed Timescale:** 31/03/2016

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The outcome of consultation with residents was not included in the annual review.

3. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.
Please state the actions you have taken or are planning to take:
FirstCare had consulted with residents and families throughout the year regarding the annual report. However, these consultation results were not included in the Annual Report. Moving forward all consultations with residents and families will be included.

Proposed Timescale: 30/04/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure in place was not effective enough to support the person in charge. There was currently two vacant posts.

4. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
As advised on the day of Inspection a new Deputy Home Manager has commenced in the Home on March 1st. Additionally the management structure supporting Beneavin House has been changed. FirstCare now have a Managing Director, an Operations Manager, and a new Compliance Manager, supporting the Home Manager with the day to day running of her home. FirstCare continue to advertise and interview for the available Clinical Nurse Manager posts. However, the Nursing crisis does not lend positively to this and FirstCare are not prepared to appoint a Clinical Nurse Manager that does not have the relevant experience, knowledge or ability. At present we are supporting staff from within the Nursing Home to achieve the competencies required through succession planning in the form of a Fetac Level 6 Management and Leadership Course. On the two floors that we are currently looking to recruit CNMs, the Deputy Home Managers support the Staff Nurses and complete all clinical audits and manage the roster for those floors. This practice will continue until the appropriate individuals are recruited and appointed.

Proposed Timescale: 31/05/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review did not include recommendations on how to improve the quality of care and service delivered in 2016.
5. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
FirstCare had completed an Annual Review of the Quality and Safety of Care in consultation with residents and families. FirstCare have an Annual Operational Plan for the company and in particular each Nursing Home. These plans contain further service and quality improvements for the care of Residents in our Nursing Home. Moving forward these plans will be included in the Annual Report.

Proposed Timescale: 31/03/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of medication administration were not being maintained in accordance with relevant professional guidelines as required under Schedule 3 (d) of the regulations in that;
-Medicines administered at 11am were documented as being administered at 9am.

6. Action Required:
Under Regulation 21(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
FirstCare are implementing a computerised medication management system which will rectify all issues relating to the times medications are administered. The implementation of this Medication Management system has been delayed due to our software supplier needing to make enhancements to this program following a general upgrade of their software package late last year. In the interim all Nursing Staff will record the time each medication is administered on the MARs sheet.

The Compliance Manager has meet with the pharmacy on March 16th, 2016 and all Nursing Home Prescriptions for all residents will be generated from our computerised system from April 30th 2016. This will ensure that all crushed medications are recorded by the GP, and that all medications are noted for prescribing at the time indicated by the prescriber. The Home Manager and the Operations Manager will meet with the pharmacy on April 30th to plan and communicate the implementation of the electronic MARs system for all staff.
**Proposed Timescale:** 31/07/2016

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Restraint (bedrails) in use in a designated centre, were not used in accordance with national policy as published on the website of the Department of Health.

7. **Action Required:**
Under Regulation 07(3) you are required to: 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.

Please state the actions you have taken or are planning to take:
The documentation around the use of bedrails including the assessment of the suitability of their use will be reviewed and updated to reflect the National Policy. Trials will commence within the home to reduce the use of bedrails bearing in mind the resident's choice, wishes and preferences. In liaison with residents and families post inspection discussions will take place with regard to the choices available to residents to ensure their comfort and safety other than bedrails.

**Proposed Timescale:** 30/06/2016

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The procedures to be followed in the event of fire was not displayed in a prominent place on each floor of the designated centre.

8. **Action Required:**
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
The procedures to be followed in the event of fire had been removed during planned preventative maintenance (painting) earlier in the week of the inspection, and were not replaced. When this was brought to the attention of management team during the inspection, they were replaced immediately in the two areas they were missing.
Proposed Timescale: 03/02/2016

<table>
<thead>
<tr>
<th>Outcome 09: Medication Management</th>
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<tr>
<td>Theme:</td>
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<tr>
<td>Safe care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds. There was also the potential for medication errors to occur due to the length of time between the last administered dose for some medicines and the next medication administration round.

**9. Action Required:**
Under Regulation 29(5) you are required to: 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.

Please state the actions you have taken or are planning to take:
As discussed in Outcome 5 all Nursing Staff will record the exact administration time for each medication administration until the new computerised system has been implemented. This will highlight administration timeframes and allow all Nursing Staff to make appropriate decisions relating to administration of medications including but not limited to PRN medications.

The Home Manager and Deputy Home Managers will audit the medication administration to establish what, if any interruptions are lending to the timeframes taken. The Home Manager will also liaise with the GPs to ensure that all medication reviews conducted are taking into consideration the administration times of medications and if and where possible, medication administrations are not all being confined to one particular time in the day.

Proposed Timescale: immediate

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Proposed Timescale: 21/03/2016

| Theme:                           |
| Safe care and support           |

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspectors reviewed a number of the prescription and administration sheets and identified a number of issues that did not conform with appropriate medication
management practice:
- A number of residents required their medicines to be crushed prior to administration and this was documented at the top of the prescription sheet. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
- Inspectors found that a number of prescription sheets did not specify times of administration.
- There were no resident specific care plans in place for residents who had been prescribed more than one psychotropic medicine on a PRN (as required) basis to guide staff in the administration of these medicines (in some cases the prescription did not indicate which medicine was to administered first. There were no protocols in place as part of behaviour support plans or care plans to guide practice to ensure appropriate consistent administration)

10. **Action Required:**
Under Regulation 29(5) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
All issues noted on inspection will be attended to by Nursing Staff in liaison with the GP’s. All medications that require crushing prior to administration will be prescribed as ‘crushed’ by the 16th of April 2016.

All care plans of resident’s on Psychotropic medication will be reviewed by the Nursing Team in liaison with and supported by the Home Manager and Deputy Home Managers and amended to guide and support staff in relation to best practice and agreed protocols with the prescriber by the 30th of April 2016.

Proposed Timescale: see each individual entry

**Proposed Timescale:** 21/03/2016

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**Outcome 13: Complaints procedures**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The procedure to make complaints does not make the process easily accessible to residents on each unit.

11. **Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.
Please state the actions you have taken or are planning to take:
Post inspection a Compliments/complaints/concerns record will be available on each floor so that individuals in each area of the home have the ability to log satisfaction/concerns immediately without having to seek out the Home Manager or one of the Deputy Home Managers. The Home Manager (or designated other) will review the record weekly and follow up on any issues of concern ensuring all respondents are aware of the compliments/complaints and appeals procedure where necessary. The FirstCare Policy will be updated to reflect this change.

**Proposed Timescale:** 30/04/2016

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The there are enough staff currently employed to meet the assessed needs of 150 residents.

12. **Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
At the time of inspection there were 126 residents residing in Beneavin House. Firstcare recently commissioned an additional 23 beds in Beneavin House, to meet local demand, increasing the capacity of the home to 150 beds (from 127 beds). Beneavin House is currently inducting and training additional staff in preparation for the opening of these 23 beds. When we are in a position to admit residents to these additional 23 beds, the process will be a gradual one, with due consideration for the number of resident’s being admitted on a weekly basis.

**Proposed Timescale:** 31/05/2016

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**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The written formal appraisal system had been completed with some but not all staff.

13. **Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately
Please state the actions you have taken or are planning to take:
All staff currently employed within the Nursing Home will have a formal appraisal with their line manager within the first Quarter of 2016. Those staff who have commenced within the previous 9 months have had their probationary meetings with management and will receive their appraisal on their year’s anniversary of successful completion of probation with the company (31st December, 2016).

All Clinical Nurse Managers are supervised and supported by the Deputy Home Manager and Home Managers. In turn nurses are supported and supervised by the CNM’s and the Home Management Team. Health Care Assistants are supported by Nursing Staff and the addition of the new Health Care assistant Team Leader roles, will allow for additional supervision of staff within the Nursing Home.

Proposed Timescale: 31/05/2016