Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Beneavin Manor
Name of provider:	Beneavin Lodge Limited
Address of centre:	Beaneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	14 August 2019
Centre ID:	OSV-0005756
Fieldwork ID:	MON-0027605

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:	67

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
14 August 2019	19:00hrs to 21:00hrs	Helen Lindsey	Lead
15 August 2019	09:30hrs to 13:00hrs	Helen Lindsey	Lead
14 August 2019	19:00hrs to 21:00hrs	Gearoid Harrahill	Support
15 August 2019	09:30hrs to 13:00hrs	Gearoid Harrahill	Support
14 August 2019	19:00hrs to 21:00hrs	Michael Dunne	Support
15 August 2019	09:30hrs to 13:00hrs	Michael Dunne	Support

What residents told us and what inspectors observed

Inspectors met and spoke with a number of residents and relatives during the inspection. Residents told inspectors that they found staff to be kind and caring. Relatives also stated that staff were caring, however they went on to add that they often found that there was not enough staff available to support residents with their needs. As a consequence they mentioned that residents had to wait for staff to assist them to the toilet or to bed due to lack of staff available on the units.

Residents said that they enjoyed the food provided in the centre and that staff helped them with accessing additional food and drink if they wanted it.

There was an arranged activity programme in place, however there were no evening activities underway on the ground, first or second floor during the inspection resulting in residents having fewer options other than watching television for the evening. A number of residents were seen to be walking around the areas of the centre where they resided, some were in bedrooms and others were in communal areas.

Resident accommodation was provided in single bedrooms, all of which had en-suite facilities. Resident rooms were nicely decorated and provided sufficient space for the storage of personal items and space to meet with residents in private.

Capacity and capability

While areas such as staff training and complaints management were being managed well, the governance and managements arrangements required improvement to ensure the service being provided was safe. A review of resources to ensure appropriate staffing levels was required to meet residents' needs. This was the second inspection in 2019 with this finding.

The Chief Inspector was contacted with information about the staffing levels in the centre. Inspectors visited the service in the evening and the following morning to review the service being provided and to assess how well residents' needs were being met. Observation by inspectors identified that there was an insufficient number of staff available to meet the needs of residents. Inspectors observed practice in the centre, spoke with residents where possible, as well as their relatives, spoke with staff, and reviewed records. Staffing rosters confirmed that staffing levels were set per floor and not in line with residents' needs.

There was a clear complaints policy that was displayed in a prominent position through the centre. Residents were seen raising their concerns directly with staff

who were responding where possible. A review of complaints made in the centre showed they were being dealt with seriously and there were clear records setting out if issues were still being addressed or whether the matter had been closed.

There was a good programme of staff training in place including an induction programme that included learning about policies and procedures in the centre as well as the practical day-to-day roles to be carried out.

All incidents which required notification to the Chief Inspector had been made within the appropriate timescales.

Regulation 15: Staffing

Inspectors were not assured there were sufficient staffing levels in the designated centre during the evening and at night. Inspectors observed that at 8pm the number of staff available was not sufficient to supervise the number of residents, and meet their identified needs. It reduced further at 9pm.

Inspectors spoke with families and staff members during the inspection. They reported that residents were impacted by the staffing levels sometimes in the day, and often in the evening. While some healthcare assistants (HCAs) said they would go and attend to a resident if the nurse call bell went off, and leave the lounge area unsupervised, others said they had to supervise the communal area and so could not leave, and could not answer the nurse call. Families reported there was often a long wait for the nurse call to be answered, or that lack of supervision impacted the range of activities in which their relatives could be involved.

Inspectors observed that at 8pm on one unit there were two healthcare assistants, and one nurse supporting 27 residents. The area being supervised consisted of a full floor which was separated in to two areas. At 8pm the nurse did a handover in a separate room and then needed to do an evening medication round, which meant they were not available to support resident care. This left one HCA in each side of the floor. The roster showed at 9pm only one HCA remained available on that floor. Inspectors observed there were up to 13 residents in the communal areas after 8pm and some sitting in their bedrooms. A review of care records showed that a number of the residents required the support of two members of staff to meeting their personal care needs, or if they were to experience responsive behaviour. For example one resident had been assessed as requiring constant supervision following a fall, but they were seen a number of times during the inspection with no supervision.

Inspectors observed occasions where the staff left for another area and so could not observe the residents in the communal room or on the corridor.

As the staffing levels after 9pm were two staff per floor, any resident requiring the support of two people after 9pm would result in the rest of the residents on that unit having no supervision or access to support. Staff reported there was one

member of staff who would support each of the three floors during the shift, and they could be called to offer support if needed.

On the day of the inspection there was also some uncertainty in the units on who would be covering the night shift as there were short notice absences that needed to be covered. Staff on the day shift remained on for an agreed period to provide cover until an alternative was identified. A review of the rosters showed that while there was a planned roster, not all changes that took place had been updated to provide a roster of the actual shifts worked, as well as reflecting staff who were relocated to other floors to cover absences.

While residents were being impacted by the low staffing levels, the quality of support provided by the staff available was seen to be of a good standard. Staff were seen to know the residents well, and were seen to offer them comfort and support both in the evening and the following day of the inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training records were well-maintained and available for review. Records seen confirmed that staff had attended a range of mandatory training such as fire safety, safeguarding and moving and handling. There was a range of supplementary training offered to staff including infection control, responsive behaviour, care planning, communication with people with dementia, falls prevention, and medication management. There was also a programme in place to assist staff from overseas to adapt to the Irish care system and included assistance with English language skills.

Staff spoken with confirmed that they found the suite of training on offer beneficial to their daily work and assisted them in providing person centred care to the resident group.

Judgment: Compliant

Regulation 23: Governance and management

Not all aspects of this regulation were assessed on this inspection.

A range of quality assurance checks were being used in the centre to provide information to the provider about the quality of the service. A sample of the audits carried out in the centre were reviewed by inspectors and they were seen to cover a wide range of areas of practice in the centre, including restrictive practice, care plans, and implementation of policies. Facts and figures were gathered and then

reviewed to identify areas where practice could be improved. There were action plans in place, and individuals were identified as being responsible for delivering said actions.

Inspectors found there were insufficient resources to ensure appropriate levels of staffing were available to provide effective care in the centre. The senior management team were at the designated centre during the inspection and said they were aware of the issues raised with them during the inspection, through their own internal assurance processes, and were reviewing a range of models to find the right solutions. However, at the time of the inspection the staffing levels were insufficient and action had not been taken to improve the standard of care being provided.

Judgment: Not compliant

Regulation 31: Notification of incidents

There had been four unwitnessed falls in the centre that resulted in residents requiring hospital treatment in the week before the inspection. Three had been notified to the Chief Inspector, and the nurse was aware of the one remaining notification to be submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a procedure in place for making complaints and a digital log was maintained which summarised the details of the matter and engagement between the complainant and the provider. Records were kept of correspondence and actions agreed upon to address the matters raised, and the satisfaction status of the complainant was noted upon completion. There were some open complaints at the time of the inspection, and inspectors reviewed records which evidenced the provider continuing to engage with the other parties to achieve a satisfactory outcome. Complaints received by the provider verbally were recorded with the same level of detail as those received formally in writing. There were arrangements in place for the complainant to avail of an appeals procedures, should they be dissatisfied with the outcome at local level.

Judgment: Compliant

Quality and safety

While there were arrangements in place to assess residents' needs, develop care plans, review those care plans and meet their identified needs, improvements were required in relation to developing and updating care plans. Improvements were also required to ensure residents were engaged in meaningful occupation and recreational activity.

A review of care plans on each floor found that each resident had a full assessment on admission to the centre, and care plans were in place setting out how their needs were to be met. In some examples these plans required review to ensure they were person-centred, as standard text had been used for the same topic in different resident's records. Examples were also seen where residents' needs had changed but the relevant care plans had not been updated to reflect this. The provider had identified improvements were required and had a plan in place to support staff with further training. A range of nursing tools were being used to support the nursing assessments, and these were reviewed and updated on a four-monthly basis.

There were regular resident meetings in the centre, and residents were supported to vote in recent elections if they chose to do so. Residents had access to television, radio, newspapers and magazines in the centre. There was also a cordless telephone that residents could use to speak with their family and friends, and staff were seen to be facilitating residents with this.

During the evening part of the inspection there was very little social engagement as the staff present were supporting a number of residents with different needs. While some residents were seen talking to the staff or watching TV a number of other residents were walking around the units or seated with little or nothing to do in the environment around them. The following morning staff were seen to be supporting residents to attend the communal areas, but the activity coordinator's role on the morning of the inspection was limited to supporting residents to go to the hairdresser. A review of the activities programme showed there was a range of activities planned that included arts and crafts, music, exercise and quizzes on weekdays, weekend activities were centred around family visits or religious observance which was not relevant to all residents.

Regulation 5: Individual assessment and care plan

While care plans were in place for residents' identified needs, improvements were required to ensure they were updated and provided enough detail to guide staff in how to meet residents' care needs.

There was an assessment carried out prior to residents being admitted to the centre, and then a comprehensive assessment was completed by a nurse when they were admitted to the centre. The assessment included a range of accredited nursing

tools to assess resident skills and abilities, and any risks there may be in relation to their care needs. For example, risk of developing pressure wounds or risk of falling. These were seen to be completed and updated at four-monthly intervals or more frequently if required.

The sample of care plans reviewed set out residents identified need, the goal to care or support, and also the details of how needs were to be met. However improvement was required to ensure they were person-centred and contained sufficient guidance to ensure correct care and support was provided. A number of examples were seen where text was identical between residents' care plans, for example in responsive behaviour care plans. There were also examples seen where text had been input in a care plan but was not about them, or made repeated reference to 'he' for a female resident, indicating direct copying from other plans. Examples were also seen where there was insufficient detail about how a care need was to be met. For example, a nurse was able to provide a lot of detail verbally about a resident's skin care needs, but the care plan did not reflect the detail provided.

There was a process in place for reviewing care plans on a four-monthly basis, or more frequently if required. However, some examples were seen where a resident's needs had changed, but it had not been updated in the care plan. For example, a resident who had fallen had been assessed by an occupational therapist, but their recommendation had not been reflected in the care plan and the daily notes did not provide sufficient detail to provide assurance the new plan of care was being implemented.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While residents' rights were overall being upheld, improvements were required to ensure there was access to meaningful occupation.

Staff were observed to be courteous and respectful of residents' rights. Staff engaged with residents taking into account the individual needs of the residents. There were good communication approaches used by staff, and they were effective in supporting residents who were asking questions or needed support. Residents and relatives commented on how caring the staff were, and this was seen to be the case in practice.

While staff were effective in supporting residents when they were available, there were occasions when residents could not avail of timely support due to staff being required to attend to other duties or to remain in communal areas for supervision.This resulted in residents having to wait for assistance, it also meant that staff were unable to respond to unexpected requests for assistance.

There was an activity programme in place, however it was noted there was one

activity coordinator covering all three floors (five areas) of the designated centre. Their role on the day of the inspection included taking residents to the hairdresser which limited their ability to run any other activities. It was noted that residents who required one-to-one support to engage in activities did not have this support available. While there was a range of activities set out on tables in the units very few of the residents were able to engage with them without support, for example magazines, puzzles and games. In the evening, as staff were providing drinks or supervising the communal areas the main options for activity were walking around the units, or watching the television. In one area a resident said they didn't like what was on TV but didn't want to go to bed so early. There was an activities programme posted in the units, it covered a range of activities including art, exercise and music. It was noted however that the weekend activities mainly focused on religious services and watching movies, which would not be meaningful for all residents in the centre.

Residents' rooms were tastefully decorated with accommodation being provided in single bedrooms, all with an en-suite facility attached. Bedrooms contained sufficient space for residents to store their personal belonging and there was space available for residents to see their relatives in private.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Beneavin Manor OSV-0005756

Inspection ID: MON-0027605

Date of inspection: 15/08/2019

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: Prior to, during and subsequent to the inspection a full review of staffing levels and the model of care took place in the Nursing Home. Staffing profiles set out in the Workforce Plan (Jan 2019) were identified to occur as the number of residents increased; however, as part of our review we brought forward the timeframes to introduce this resource allocation to support the needs of the current residents. These actions include: 1. ADON post has been filled (ahead of the workforce plan) 2. The vacant CNM position has been back filled and CNM's were allocated additional supernumerary hours that will allow them to provide further supervision/ coaching and mentoring to staff 3. Social Care Leaders hours have been increased, so that 3 Social Care Leaders are employed across the designated hours (including evenings and weekends) to ensure residents social care needs are being met 4.The previous 'floater' night HCA post has been allocated to the unit identified as requiring extra support to ensure resident needs are being met. As per our model of care review a reallocation of residents and staff has been mapped out and will occur within the home week beginning the 16th September. These changes to resident and staff allocation will be monitored on an ongoing basis to ensure residents are assisted as required, supervised appropriately, their needs are being met and staff resources are being deployed effectively. There is a planned and actual roster in place which changes on a regular basis to reflect actual staff rostered to a floor, any changes that occur are communicated to the CNM/SN on duty to ensure the daily staff allocation sheets are reflective of the daily roster.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

23 (a) Prior to the inspection, senior management had carried out a staffing review and identified that staffing levels in place at the time of the inspection were in line with national norms and the staffing grid agreed with HIQA prior to registration of the Nursing Home. However, residents' needs, the layout of the centre, and staff deployment required review to ensure residents needs were being met and resources were being deployed to best effect. As indicated in the response to Regulation 15 staffing, a full review of staffing levels and the model of care took place in the Nursing Home and immediate actions were taken to address concerns. A decision has been taken in consultation with residents, relatives and staff to modify the model of care which involves relocation of residents and staff within the home. A full review of residents' needs was carried out; including resident's dependency levels, cognitive status, responsive behaviours and social needs. Following the review and subsequent consultation residents and staff from one of the floors are being relocated across the remaining 2 floors effective from the 16th September. The intended outcome of this modification to the model of care is that residents' needs are being met in a more holistic manner, there will be an opportunity for different residents to interact with each other in a more positive manner, and responsive behaviours can be managed more effectively. Effective and efficient staff deployment will ensure that staff are available to supervise appropriately, meet residents needs in a more timelier manner.

23 (c) As outlined under staffing (15) we are fully committed to addressing the changes required and have brought forward the appointment of the ADON/Deputy Home Manager role, ensuring the timely backfill of the third CNM role as well as providing extra hours to these roles that will further enhance supervision and monitoring so that the services are safe and meet the residents' needs. The model of care review and subsequent actions have had senior staff involvement throughout the process and the home will continue to be supported by the Operations team. There are formal governance structures in place that include: weekly and monthly meetings with the senior Operations team (including the RPR) where the PIC has the opportunity to discuss all clinical and corporate governance matters, be fully involved in decision making and agreeing actions.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

As per regulatory requirements all residents are assessed when they are admitted to the Nursing Home and at 3 monthly intervals or sooner if their condition should change. Care plans are developed once the assessment is carried out and is reflective of a resident's care needs. The Home also has a weekly MDT meeting in place.
Staff have had access to assessment and care planning training during the year and have been provided with feedback and instruction to write up care plans as per each residents' assessed needs and to never use generic templates or a copy and paste function in resident records. The current audit tool is being reviewed to ensure all elements of the care plans are routinely audited; the CNMs are providing additional supervision and care plan guidance.
All staff have been made aware that they need to be careful in documentation so that

care plans are clear and updated when any changes occur – this is being monitored by the CNMs and through the audit process.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

9 (2) b The changes outlined under Regulation 15: and Regulation 23 - planned actions have been taken to address resource allocation to meet residents needs as well as the improvements being implemented to the model of care which will be reviewed on an ongoing basis to ensure residents needs are being met to the optimum level. Part of the review focused on residents' social activities with the social care leader hours increased from 40 to 70 hours per week by 3 Social Care Leaders. This provides both male and female staff in the Social care team that will provide the opportunity for residents to engage in meaningful occupation. The activities program has been reviewed to ensure activities are suitable to residents needs and the schedule has been adapted to cover more hours over the day, including later into the evening and weekends.

9 (3) a The program has been reviewed in terms of what residents individual preferences are and tailored to their individual health and wellbeing. To assist with this, we have engaged the assistance of our OT/Physio provider to ensure activities are tailored to meet all resident's needs in line with such assessments as individuals MMSE. The program will be monitored to determine resident's engagement and satisfaction and regularly updated according to changed needs, interest and new residents requirements.

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 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	30.9.2019
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	30.9.19
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	30.9.19

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	16.9.19
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant		31.9.19
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	02.9.19
Regulation 9(3)(a)	A registered provider shall, in so far as is	Substantially Compliant	Yellow	30.9.19

	reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			