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:	30 April 2019
Centre ID:	OSV-0005756
Fieldwork ID:	MON-0025996

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

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
30 April 2019	19:00hrs to 21:00hrs	Ann Wallace	Lead
01 May 2019	08:00hrs to 16:00hrs	Ann Wallace	Lead
01 May 2019	08:00hrs to 16:00hrs	Sarah Carter	Lead

What residents told us and what inspectors observed

Residents and families who spoke with the inspectors were complimentary about the quality of care and services that they received in the centre. Residents said that they were well looked after and that staff were kind and caring. However some families said that when staff were busy aspects of care such as residents' nails and dentures could be missed. Families also said that at times there were not enough staff in the evenings to provides supervision for the increasing number of new residents.

Residents said that they felt safe in the centre and that they could trust staff to help them if they had any concerns. Inspectors observed that staff interactions with the residents were respectful and that staff addressed the residents by their preferred title/name. Staff knew the residents well and were familiar with how the resident liked to be approached and what topics they enjoyed talking about.

Residents said that they enjoyed their meals and that there was plenty of choices available to them at meal times. Residents who preferred a quiet space were able to take their meals in their bedrooms. The inspectors observed the lunch time on the second day and noted that residents were offered discreet support and encouragement with their meals. Residents appeared to be enjoying their food and were socialising with each other and with staff.

Residents were very complimentary about their accommodation saying that they were warm and comfortable and that the premises was spotlessly clean. Residents said that their bedrooms met their needs and that they had enough storage for their personal belongings. Some families commented that the outdoor space was not sufficient and that they missed the access to the courtyard garden which had been available to them in the original building.

Capacity and capability

Overall the centre was well managed for the benefits of the residents who lived there. However the management of resources in the centre required improvement as the staffing levels on one unit were not adequate to provide care and services in line with the centre's statement of purpose.

There was a clear management structure in place. Residents and their families were familiar with the person in charge and the senior nursing team and told the inspectors that they saw the person in charge regularly and that she was approachable. Staff in all departments were clear about the reporting structures and

knew who to report to in relation to the care and welfare of the residents.

Staffing levels had been maintained in line with the the admissions and staffing strategies that had been agreed with the Office of the Chief Inspector at the time of the centre's registration in January 2019. However the increased number of maximum dependency residents on one unit required further review as inspectors found there were not sufficient staff to provide appropriate person centred care and support for the residents on this unit.

Staff had access to appropriate training and supervision in their work. Staff were clear about what was expected of them in their role and demonstrated accountability in their day to day work.

There were well established quality assurance systems in place. The person in charge carried out regular audits of quality and safety indicators such as falls, incidents, restraints and pressure sores. Quality and safety reports were submitted to the provider each month to ensure that they had oversight of the service. The registered provider representative and members of the senior management team met with the person in charge regularly and were knowledgeable about recent complaints and incidents that had occurred in the centre.

Regulation 15: Staffing

The registered provider had not ensured that the numbers of the staff on the high dependency unit were appropriate having regard to the high level of needs of the current residents and the layout of the unit. In contrast the staffing levels on two other units were found to be appropriate to meet the needs of the current residents living in these units.

There was a registered nurse on duty on each of the units at all times.

Staff on all units demonstrated appropriate knowledge and skills to provide safe and effective care for the residents. Staff turnover was low and as a result residents were cared for by staff who knew them well and were familiar with their preferences for care and daily routines.

The centre had introduced a bank of relief staff onto the roster and as a result agency staff were kept to a minimum. Where they were used agency staff had completed an induction to the unit that they were working on which included emergency procedures, fire safety and a comprehensive handover of information in relation to those residents they were caring for.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff working in the centre had good access to training opportunities in line with their roles. All staff were up to date with their mandatory requirements and most staff had completed a course in caring for residents who were living with dementia which included the management of residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

All new staff had completed the designated centre's induction programme and had completed a period of probation. The provider had introduced a team leader role for care staff. The team leader provided direct supervision and support to care staff in their work. Inspectors found that staff worked well together as a team and were clear about what was expected of them in their work.

Staff meetings and handover meetings were used to communicate any relevant policy changes and changes in best practice guidance. Staff were aware of the regulations and the need for compliance to ensure the safety and well being of residents in their care.

Judgment: Compliant

Regulation 23: Governance and management

Overall the inspectors found that the designated centre had sufficient resources to ensure that care and services were delivered in line with the statement of purpose. However the staffing levels on the high dependency unit required further review to ensure that, as new residents were admitted and new areas of the unit became occupied, that there were sufficient staff available at all times. This is addressed under Regulation 15.

There was a clearly defined management structure in place which identified the lines of authority and specified roles and responsibilities for all areas of the service. Staff were clear about reporting mechanisms and there were good communications between staff and managers in the different departments.

There was a comprehensive quality assurance system in place to monitor the quality and safety of the services provided. Monitoring reports were produced and communicated to the relevant staff teams. The provider and the senior management team had good oversight of key areas of performance such as complaints, incidents, falls and near misses. However some improvements were required to ensure that improvement actions were followed up by relevant managers and the outcomes of any changes were reviewed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been updated to reflect any changes that had been in made in the centre since the registration in January 2019. The document contained all of the information required in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Records showed that those incidents set out in Schedule 4 of the regulations were reported to the Office of the Chief Inspector within the required time frames.

Those incidents that occurred in the centre that were not notifiable had been recorded in line with the centre's policies and procedures. Nursing staff and team leaders had attended training on incident reporting. Records showed that any learning that was identified following an incident was communicated to the relevant staff. Families were kept informed about any incidents that occurred in relation to their relative.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place which had been made available to residents and their families. The policy had been reviewed recently and clearly stated who was responsible for managing complaints in the centre.

Complaints were recorded and records included the resident's level of satisfaction with how the complaint had been managed.

Leaning from complaints investigations was communicated to the relevant staff and records showed that changes had been made in response to complaints from residents and their families.

Judgment: Compliant

Quality and safety

The inspectors found that overall residents received good quality care and support in the designated centre. Improvements were still required in relation to care plans, meal choices, managing responsive behaviours and premises.

The inspector reviewed different care plans for 20% of residents. Care plans were reviewed regularly and there was evidence of consultation with residents and their families where appropriate.

Each resident reviewed was noted to have a selection of care plans, and care plans were specific to identified needs. In some cases, individual residents had over 20 different care plans, and some variation existed between the units in the centre on which care plan addressed which need. This increased the risk that staff may not provide care or document care correctly as per the resident's care plans.

Care plans on nutrition were clear and guided staff to meet residents' needs if the resident was losing weight or following a diabetic diet. Daily record referenced the care plan, and indicated the resident's needs were being met. A separate daily record maintained by health care assistants recorded a resident's food intake. A pictorial definition was available to guide staff to describe the quantity of food eaten however some entries seen did not use this guide instead used descriptive words which did not clearly indicate quantities. Residents were weighed routinely and when they were found to have lost weight observation records were increase and they were referred to the relevant professionals.

Care plans that should guide staff on the resident's social needs were not sufficient. Care plans recorded a list of the resident's personal history and circumstances, but did not identify a goal or steps that staff should take to meet the resident's needs. In addition not all residents had completed assessments for their social needs. In relation to ensuring that resident's needs in relation to social interactions and meaningful activities the daily records were inconsistent. Whilst some captured the activities a resident had participated in, others did not. The daily notes did not provide information about the quality or impact of the daily activity on the resident's wellbeing. As a result staff were not able to monitor whether the resident's needs were being met in this area.

Residents who experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans that were clear and guided staff to use the least restrictive option when the resident displayed these behaviours. However the policies that underpinned the practice of managing responsive behaviour and using restrictive measures, specifically the use of bedrails, required review.

The policy in relation to the use of restraints did not meet best practice guidance. The current policy was unclear regarding the resident's capacity to consent and how

to ensure that those residents who could no longer give consent were supported. In addition care records and risk assessments referenced that the resident's next of kin consented to the use of bed rails which is not in line with recommended best practice in the area. Audit records showed that bed rail usage was decreasing in line with the designated centre's aim to work towards a restraint free environment. However follow up actions from these audits were not clear. This is addressed under Regulation 23.

Resident's rights were well managed in the centre. On the second day of this unannounced inspection a resident's meeting was taking place, and several activities and social interactions were observed in the "homestead" rooms on the different units. Residents had access to TV and radios and were facilitated to vote. On walking around the units inspectors observed bedrooms doors were mostly closed ensuring the residents privacy, and staff were seen knocking on doors and requesting access before entering.

There was an advocacy service available if a resident wished for the support.

Residents had access to a range of communal areas and activities rooms and were seen mobilising around the unit on their way to activities throughout the day. However access to outside space needed to be improved as the enclosed garden space did not provide adequate seating and shelter for residents.

The person in charge had ensured that resident's had access to drinks and snacks throughout the day. There was a choice on menus throughout the day, however the inspectors noted that on one unit the fish option had been offered to one resident but had not been made available to other residents in the unit. The person in charge reported that a recent review of the mealtime experiences had resulted in some changes to how mealtimes were managed in the centre. The inspectors found that there were sufficient staff on duty at mealtimes to offer support and assistance to those residents who needed it.

Regulation 17: Premises

The inspectors found that overall the premises were appropriate to the number and needs of the residents and were being used in accordance with the centre's statement of purpose and that the premises conformed to the matters set out in Schedule 6 of the regulations. However two areas required improvement;

1. At several points over the two days of the inspection the quiet rooms on Tolka and Elms units were found to be locked and were therefore not accessible for residents.

2. The current garden did not provide a safe and appropriate outside space for residents to sit out or mobilise around and was not being utilised in line with the

centre's statement of purpose

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspectors found that residents were provided with adequate quantities of food and drink to meet their nutritional needs. Meals were freshly prepared and seasonal menus provided a range of choices at each meal time. Some improvements were required to ensure that all of the available menu options were offered to all residents at each meal time.

Residents had access to a supply of fresh drinking water. Inspectors observed residents being offered a range of hot and cold beverages at meal times and at regular intervals throughout the day. Snacks were available for those residents who required to eat little and often. The kitchen staff supplied fortified smoothie drinks for some residents who required extra calories in their diet.

Inspectors found that there were enough staff available at meal times to provide discreet support and supervision for those residents who required it.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents had access to a high standard of evidence based nursing care and a range of health and social care agencies to meet their needs.

Each resident had a comprehensive assessment of their needs and a care plan in place. Care plans were reviewed regularly and overall were found to reflect the resident's current needs. However assessment and care plans in relation to the resident's social care needs required improvement to ensure that the resident's needs were clearly identified and that an appropriate care plan was in place. In addition the review of care plans in this area needed to improve to ensure that the care delivered met the residents identified needs for social interaction and meaningful activity.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner in the centre. Evidence was seen of daily communication with the general practitioner on one unit. Evidence was also seen indicating residents had referrals made to and reviews by specialist doctors or allied health professionals if their needs changed.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Where a resident exhibited responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) staff had the knowledge and skills to respond to that behaviour in a positive manner that upheld the rights and dignity of the resident. Some improvements were required to ensure that the centre's policy used to guide staff on the use of restraints reflected best practice guidance and national guidelines.

Staff knowledge on how to manage residents who experienced challenging behaviour was good. Most staff had attended training in the management of responsive behaviours as part of their dementia training.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken appropriate measures to protect residents. New staff had been through a rigorous selection process and staff files recorded that all staff had Gardai vetting in place. Staff had received training in safeguarding and those staff who spoke with the inspectors were aware of their responsibilities to keep residents safe and knew how to report a concern or an allegation of abuse.

Records showed that where a concern had been raised that this was investigated by the person in charge and appropriate measures had been put into place to

safeguard the resident.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents' rights were upheld in the designated centre and that residents were consulted about the services they received. Residents were offered choices in care and daily routines and staff were knowledgeable about each resident's preferences. As a result care was found to be person centred.

Inspectors observed that resident's privacy and dignity were respected by staff and staff were seen to knock and request permission before entering a resident's bedroom or a bathroom. The layout of the centre helped to ensure that resident's could carry out personal activities in private.

There were adequate opportunities for residents to engage in meaningful occupation and recreation in the centre. However records in relation to residents needs and attendance at activities and entertainments required improvement. This is addressed under Regulation 5. There was an activity programme and dedicated activity staff and unit staff were also seen engaging residents in activities in the "homestead" rooms. Residents had access to TV, radios and a telephone. Local schools and voluntary groups visited the centre to provide entertainment and social events. The centre had access to a disabled access bus and staff were planning a summer schedule of trips out of the centre.

There were arrangements in the centre to facilitate voting and to facilitate residents religious beliefs.

Residents had access to an independent advocacy service in the centre.

Judgment: 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Beneavin Manor OSV-0005756

Inspection ID: MON-0025996

Date of inspection: 30/04/2019

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider and PIC has an agreed and appropriate Workforce Plan for all three units with review mechanisms in place to accommodate changes to the number and needs of residents. Given recent changes to the number and needs of residents within one unit, the current system of staff allocation has been reviewed and amended, with a structured deployment of staff and hours (including the additional use of hours deployed across the home) has been adopted to ensure effective use of the resources across the entire home. Complete 6/5/19	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: As above: The Registered Provider and PIC has an agreed and appropriate Workforce Plan for all three units with review mechanisms, in place prior to opening the Home, to accommodate changes to the number and needs of residents. Potential and actual admissions to each unit is monitored daily by the Home Manager with updates to the Registered Provider Representative, including a formal weekly meeting. Given recent changes to the number and needs of residents within one unit, the current system of staff allocation has been reviewed and amended, with a structured deployment of staff and hours has been adopted to ensure effective use of the resources across the entire home. Complete 6/5/19 (ii) A template audit analysis & action plan has been introduced, which documents the improvement measures to be implemented, with timeframes, follow up and completion dates. These will be reviewed at monthly governance meetings with senior management group. Complete 10/6/19	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The quiet room in Elms was locked on the 1st day of inspection due to a faulty electrical point that had been identified earlier. This was repaired on 1/5/19 and is now accessible to all residents. Complete 1/5/19 (ii) The quiet room in Tolka has had the 'access code' lock removed – the room is accessible to all residents. Complete 2/5/19 (iii) Garden furniture is in place, is safe and appropriate with the area being used by residents and families. Complete 10/5/19	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: The need to ensure that each resident is made aware of the available menu options has been discussed with the catering department, who take the orders in the mornings. They will ensure that the residents are made aware of the menu choices. Complete 10/6/19. All residents are offered all the available menu options at each mealtime, this is being monitored by the PIC and CNM daily. Complete 10/6/19.	
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: (i) The social care leader will be attending a planned training day on the 18th June 2019, where the importance of documenting social care needs & meaningful activities will be included. 18/6/19 (ii) The social care lead is currently attending a course of training in 'Imagination Gym', which is a healthcare program based on music therapy, relaxation skills, imagination, nature awareness, communication skills and sensory stimulation. Once completed she will use the knowledge & skills to ensure that social care plans reflect residents needs and interactions / engagement. 31/9/19	
Regulation 7: Managing behaviour that is challenging	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: All policies are under a planned review to meet best practice guidelines. The policy and procedure specific to supporting residents and managing behavior that is challenging is under review, taking into account guidelines and requirements relative to restrictive	

practice. The policy and associated procedures will be completed and agreed by the 31.08.19. Subsequently, training resources will be updated in line with the revisions with roll out of training to ensure understanding and implementation amongst staff.

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.	Substantially Compliant	Yellow	06/05/2019
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	02/05/2019
Regulation 17(2)	The registered provider shall,	Substantially Compliant	Yellow	10/05/2019

	having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	10/06/2019
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	10/06/2019
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.	Substantially Compliant	Yellow	06/05/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Substantially Compliant	Yellow	10/06/2019

	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	18/06/2019
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	Yellow	30/09/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/08/2019