



Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

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:	04 February 2020
Centre ID:	OSV-0005756
Fieldwork ID:	MON-0027844

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:	64
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 4 February 2020	18:30hrs to 21:00hrs	Sarah Carter	Lead
Wednesday 5 February 2020	09:30hrs to 18:10hrs	Sarah Carter	Lead
Tuesday 4 February 2020	18:30hrs to 21:00hrs	Deirdre O'Hara	Support
Wednesday 5 February 2020	09:30hrs to 18:10hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

The inspectors attended the centre during an evening time and also the following full day.

During the evening period it was observed that approximately half of the residents on each floor of the centre (there are two floors currently in use) were in or around the day rooms areas on the units. The remainder were in their bedrooms and as doors were mostly closed, it was not possible to ascertain if residents were watching TV or in bed.

There were four day room areas, two in each unit. During the late evening part of the inspection three of these four areas were found to be very bright with all ceiling lights on, in addition to the TV and some music.

Some parts of the centre were in need of a deep clean. Some dust and marks were observed on windowsills and behind hand rails. There were food particles on the dining tables and the floor beneath them. A malodour was also observed on one corridor that persisted for almost an hour.

Some sensor alarms were noted to have an extremely high volume, and when they were ringing it was difficult to continue conversations in the vicinity of the alarm.

Inspectors approached several residents, who made varying remarks about being in the centre. Some said they were enjoying their days, others found it harder to verbalize, but were able to acknowledge the questions being asked. Staff were observed to be attentive to residents needs and respond to their verbal and non-verbal signs that they needed assistance.

Staff were observed supervising the day rooms, and going in and out of bedrooms mostly in pairs to complete personal care tasks. On a number of occasions residents who were walking around the units, were noted to be walking to the end of corridors and often out of the eye line of staff. On occasions they tried the handles of different bedroom doors, sometimes entering and sometimes not. It was not always possible for staff to see residents mobilizing around the corridors due to the design of the building having some corners and vestibules. Bedroom doors were brightly painted in different colors and corridors were heavily decorated with plastic plants and household objects of interest. There were memory boxes at bedroom doors, many filled with the residents personal objects.

There were mixed views shared by relatives and visitors to the centre. Most relatives spoken with noted that there was an overall improvement in staffing numbers in the centre in the last 3-4 months. However some reported that they felt there was still not enough staff working and that the care their relative received was inadequate. Some said that their relative was not engaged in activities and was isolated in their bedroom. Other relatives pointed out that they were very satisfied and felt that their

relative was well cared for, engaged in activities, and that they had regular contact with the nurses and doctors who cared for their relative. Some relatives reported that when they had raised concerns and complaints with the management team, the issues had not been addressed. Others said that their complaints had been swiftly and satisfactorily dealt with.

Capacity and capability

Governance and management arrangements in the centre had improved since the last inspection which took place in August 2019. This was reflected in the standards of care and operations that were seen over this two day inspection. Some aspects of care and some operations of the centre were identified as needing further improvement to ensure residents were receiving quality care in a safe and pleasant environment.

The following improvements had been implemented, which increased the quality of care residents received:

- There was an overall increase in staffing allocations to each Unit during a portion of the evening.
- The increase in occupational therapy and physiotherapy resources had improved outcomes for residents; for example resident's falls and behaviors that challenge were well assessed and had appropriate care plans.
- Staff had the support of a clinical practice facilitator who was working in the centre three days a week, who worked directly with staff to improve care practices.
- Policies and procedures had been reviewed and updated to help guide staff to practice in a consistent safe manner.
- There was a consistent decrease in falls and other incidents within the centre in the last three months.

However some areas required continued focus to ensure all aspects of the governance system were working on improving care for residents. For example, clinical audit results were not made available to the inspectors, and were noted to be behind schedule in meeting minutes reviewed. Regular auditing forms part of robust governance, and allows the services to be measured and improved. The oversight of infection control and cleaning in the centre also required improvement.

The risk management process in the centre was under-utilized, and the assessment of key risks in the centre had not been entered into the centre's risk register for monitoring, in line with the centres own risk management policy. For example the provider had not entered the outcomes of risk assessments regarding the temporary closure of Ferndale unit and the relocation of residents to different floors. A project

team had overseen this process and it was reported that they assessed risks, however the documentation around this was not seen on the day of inspection and the centres own policy of entering risks onto the risk register was not followed.

The provider had also been advised that they had failed to pay their annual fees in a timely fashion the previous year and this non-compliance would be identified in their next report.

An annual review was available in draft form. The inspectors were informed that this would be completed by the incoming person in charge. The centre was being managed by an experienced team of senior managers with clinical backgrounds, and an experienced assistant director of nursing. The person-in-charge position had been filled, and there was an imminent start date for the person taking up the role.

On the days of inspection residents were living in two floors of the building, the third floor (Ferndale) was vacant. Staffing levels had improved in the centre. Overall the dependency levels of residents were similar across both floors. An additional "twilight" resource was available in the two units where residents were currently living until 10pm. If there were staff absences, staff from the centre's own relief panel were accessed, and if that was not available then agency staff were used.

During the first part of the inspection, which took place in the evening, the first floor was noted to be much busier and stimulating than the ground floor. All lights were on in the two large day rooms (called homesteads), making the room very bright, TVs were also on and music was playing. More residents were active and mobilizing through the homestead rooms and the corridors on the first floor. By contrast on the ground floor one of the large day rooms was less stimulating, with lower lighting and noise levels and residents were observed to be relaxing.

As stated above two floors of this three-storey centre were being occupied in the months preceding the inspection. The governance team had made decision to occupy and staff two of the three floors to reach compliance with regulations. The size and layout of the centre was found to be an ongoing barrier to adequate supervision and ensuring resident's safety at all times. Corridors which had the largest numbers of bedrooms were located out of sight of the main nursing station. Corridors contained many angles and corners preventing line of sight observation. The large day room spaces (called homesteads) were where residents tended to gather were positioned in the centre of the almost T-shaped floors. The nurse's stations were positioned to facilitate observation in these rooms, but were away from the doorways that would allow some observation of the corridors. This increased the risk that residents who like to mobilize away from these areas were frequently out of sight of staff. This was observed on both floors by both inspectors.

Staff records were well maintained, and in the sample seen all required documents were available as required. This included evidence that staff had been Garda vetted in advance of their start dates. Other records reviewed included; accident and incident reports, the complaints records, records of restrictive practices in the centre, and records of staff training.

There were clear records of staff training maintained. Records indicated that staff

training was available in the centre, however significant numbers of staff required safeguarding training. Dates for training had been identified. A large number of staff were also awaiting training on managing challenging behaviors. The provider had planned training in the coming months to coincide with the launch of their new policy. Nursing staff had completed training on medication management, and some were awaiting additional supplementary training.

Complaints were thoroughly handled in the centre. All complaints received by the provider in the last five months were reviewed. Concerns and complaints had timely response's, which appeared comprehensive, and the outcomes and level of satisfactions with the resolutions were recorded.

The inspection was carried out following the receipt of several pieces of information which alleged poor staffing levels, poor levels of care, and poor levels of supervision and poor responses to complaints. These issues were reviewed in detail by inspectors. Any open complaints in the centre were being discussed and plans were being formulated to address the issues raised.

The provider told the inspectors that they had made, or were finalizing plans, to address the outstanding issues regarding staff training and were making plans to address the challenges that accompany the layout of the building. The provider always outlined plans to conclude any open complaints in the centre. Inspectors requested these details be included in the Centre's action plan that accompanies this report; to assure the chief inspector that residents care will continue to improve.

Regulation 15: Staffing

Additional staffing resources had been put in place since the last inspection, to meet residents needs.

Further review was required to ensure that the numbers and allocations of staff had full regard for the layout of the units in the centre and to ensure sufficient levels of supervision were in place for all residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A wide variety of training was available in the centre. Some staff were overdue for repeat training in the area of safeguarding. There were dates for this training identified over the weeks following inspection. Staff were supervised in their duties and staff spoken with were knowledgeable about the regulations.

Judgment: Substantially compliant

Regulation 21: Records

Staff records were maintained and contained all the requirements of the regulation. A record of all complaints in the centre was maintained to an appropriate standard. Records of any incidents that had occurred in the centre were maintained, and a clear record of residents falls in the centre was also maintained.

Judgment: Compliant

Regulation 23: Governance and management

Governance systems to oversee the operations in the centre were contributing to the improvement in compliance noted on this inspection, the provider had placed sufficient resources in the centre to meet the needs of the current number of residents.

There was a clear governance structure in place. A new person in charge had been recruited and was due to commence in their role. An assistant director of nursing was taking on person in charge responsibilities with the support of a senior manager in the service.

The governance systems did require some improvement:

- Audit: The clinical audit programme was not up to date
- Systems were required to oversee and manage maintenance and cleaning in the premises.
- Risk assessment processes required review to ensure the provider was following their own risk management policy

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints were recorded online in the centre. Records were complete as per the requirements of the regulations.

Complaints received had received prompt responses, and any investigation and its

outcome were detailed in the records.

The assistant director of nursing was the designated complaints officer, and a senior manager oversaw the complaints process.

Judgment: Compliant

Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people

The provider had also been advised that they had failed to pay their annual fees in a timely fashion the previous year and this non-compliance would be identified in their next report.

Judgment: Not compliant

Quality and safety

The findings showed, that on the day of inspection, the designated centre was providing good quality care and support to residents.

However improvements were required in relation to specific care plans and documentation to indicate what care had been provided to residents. A number of inconsistencies were noted in some records and improvement was needed with regards to documentation of intimate care, nutritional intake, responsive behaviour care plans and associated care plan records. Documentation outlining residents participation in activities also needed improvement.

Residents were provided with support that promoted a positive approach to responsive behaviours. Staff were observed to be led by residents wishes and residents responded well to staff. More detail was required in some care plans to guide staff in care delivery for residents that had responsive behaviours.

Staff who spoke with inspectors knew residents well and were knowledgeable regarding their individual needs. A recently formed clinical group met regularly to discuss residents who had falls and who experienced responsive behaviours. Residents' care was discussed, and care plans agreed which were updated to support staff in care delivery.

Residents said they felt safe in the centre and spoke positively about the care team and management in the centre. A safeguarding policy was in place. However some family members who spoke with inspectors during the inspection expressed dissatisfaction with the way complaints were managed and had raised concerns regarding care delivery. Family members were reminded that the service provider

has a legal responsibility to investigate any allegations and complaints of poor care.

There were dedicated activity staff, who were supported by care staff to provide residents with a range of activities. On several different occasions inspectors observed residents engaged in activity groups, which were running in the different units at the same time. Residents' religious and civil rights were upheld through regular access to religious services and arrangements made to facilitate residents to vote in a nearby polling station. Records detailing residents' attendance at activities required improvements, as they lacked detail on the quality of the residents engagement and the impact of the activity on the resident.

The residents' committee met regularly and residents were consulted with regard to their care and the service provided. The provider said they valued residents' views and provided them with opportunities to participate in the running of the centre. However feedback to residents regarding the actions taken as a result of points raised by residents at these meetings were not made available.

There was a risk management policy in place in the centre, which met the requirements of the regulations. A process was in place to investigate incidents and share any learning with staff. There were plans in place to manage major emergencies. A risk register was in place in the centre, however as stated earlier in the report the risk register did not contain evidence that some key risks had been assessed. For example; key risks relating to the transition of residents moving from one floor to another had not been included in the risk register.

Regulation 26: Risk management

There was clear risk management policy in the centre.

Clinical risks were identified in care planning. Incidents were recorded and when they occurred, analysis took place to assist in staff learning. Staff had up to date manual handling and staff knowledge was robust when asked about the management of various clinical risk, for example the management of a falls risk.

Operational risks were reported and entered onto the risk register. The oversight and management of risks are discussed further under regulation 23.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The nursing and medical care needs of residents were assessed on admission and

reviewed at intervals not exceeding four months.

Residents care records were stored on an electronic system. Inspectors reviewed the records with members of the nursing team who answered questions and provided additional information. The sample of care plans reviewed found that there were some gaps in records detailing the care that was given and did not align with the care nursing staff described was taking place. For example in relation to personal care and nutritional intake.

Resident's were seen to have access to a GP in the centre, and on call arrangements were in place out of hours. Access to a range of allied health care professionals was available in the centre, such as speech and language therapist, occupational therapist and physiotherapist. Examples of referrals for to assess residents needs were seen to be happening. However, the record of the delivery of recommendations were not consistently available, for example the record of dietary intake for a resident following a review by a dietitian. An example was also seen where residents had identified intimate care needs and there was no care plan in place setting out how it would be met.

Records of resident's engagement in the recreational programme required improvement as they did not record resident's participation levels or the impact of the activity on the residents well-being. Staff spoken with seemed to know residents and their preferences and overall resident feedback was that the staff were helpful and kind.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment in line with the national policy was promoted in practices reviewed. The centre's policy dated January 2020 reflected the national guidance document and was available to guide restraint usage as a last resort. Training to accompany the launch of this new policy was imminent. Due to their medical conditions, some residents had experienced responsive behaviours. During the inspection, staff were observed approaching residents in a sensitive and appropriate manner, and the residents responded positively to techniques and approaches adopted by staff. The centre's management was actively promoting a restraint free environment. There was very little chemical restraint in use in the centre.

An inspector reviewed a sample of a residents files who had a history of responsive behavior issues. The documentation and care plans in place were detailed, person centered. However, some inconsistencies in behavioural care plan records were found. For example, gaps were identified in documentation of the behavior displayed by some residents. As a result, insufficient guidance was available to guide staff in care delivery and some plans did not direct staff when to use PRN (a

medicine only taken as the need arises).

Judgment: Substantially compliant

Regulation 8: Protection

There were policies and procedures in place to set out the measures in place to protect residents from harm. A number of staff had not completed formal safeguarding training, there was a training schedule being finalized to address this. Staff were clear of the procedure to follow if they observed, suspected or were informed of an allegation of abuse. This is addressed in regulation 16 above.

The person in charge investigated any incident or allegation of abuse that was reported to them. There were comprehensive records kept of any investigations that has taken place. The investigations indicated if the allegation was upheld or not, and what action was taken. These records were maintained separately from care plans, and increased oversight was required to ensure any findings that resulted in changes to care plans were monitored and checked. There was a mixed response from relatives who spoke with inspectors that were visiting the centre with regards to the feeling of safety within the service.

There was a theme in information received by inspectors that some residents and relatives were not happy with other residents entering their bedrooms. A factor that contributed to this was the layout and design of the corridors, and as stated earlier in the report residents were frequently out of sight of staff.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights to privacy and dignity were upheld by staff through respectful interactions, and honouring the resident's choices on a day to day basis. Inspectors observed that staff were kind and gentle with residents and addressed them by their preferred name.

To encourage residents to participate in the organisation and running of the centre residents' meetings were held regularly and minutes were available. While there were regular meetings the feedback regarding the actions taken as a result of points raised at previous meetings were not made available to residents, and there were no clear records of what action had been taken to address the issues raised. For example at the December meeting, residents provided feedback on their preference to use soup bowls at mealtimes, but there was no record of action taken.

There was a varied activity programme in place and residents could choose what

they wished to attend. Activity coordinators were available to provide opportunities for residents to participate in activities in accordance with their interests and capacities. If they did not wish to join in group activities there was opportunities for one-to-one time with activity staff or they were facilitated to pursue their own interests independently. Residents were seen to enjoy a visiting musician, dancing and playing bowls. Television, radio and newspapers were available for residents. Staff were observed reading newspapers with the residents. Residents' links with the local community were maintained where possible, and this was supported by access to local media, telephone services and students visiting from a local school. There was a resident choir and other choirs came to give recitals in the centre. A number of residents enjoyed gathering in lounge areas and in the activity room where there was access to art materials, men's shed, beauty day, aromatherapy and hairdressing.

Residents had access to regular religious services in the centre and access to advocacy services which was advertised in the resident's guide.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people	Not compliant
Quality and safety	
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beneavin Manor OSV-0005756

Inspection ID: MON-0027844

Date of inspection: 05/02/2020

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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: The center operates in compliance with the statement of purpose and the Staffing profiles set out in the Workforce Plan (Jan 2019) submitted to HIQA at the time of registration with regard to staffing. 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. Staffing review post inspection identified that staffing levels in place at the time of the inspection were in line with national norms. However, the provider intends to review possible adjustments in the layout as well as other measures that will improve the line of sight of people that might be utilising opportunities to walk within the various corridors of the unit. The provider had planned to review such measures with design and other specialists but due to the current COVID 19 infection control measures this exploratory work had to be postponed. All final recommendations will be assessed to ensure compliance with health and safety, fire regulations as well as GDPR. This review and subsequent actions will commence as soon as the current COVID 19 crisis has stabilised. In the interim staff allocation includes staff being allocated to supervising residents that might frequently use corridors, this will continue until such time as the provider can review with the design team opportunities within the physical layout of the building as well as any other recommended measures.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: On the days of inspection some staff were due refresher safeguarding training however,</p>	

it was acknowledged that dates for training had been scheduled and staff were awaiting their dates. As per the centres induction process, all staff had all been made aware of the safeguarding policy and staff spoken with on the day of inspection were knowledgeable regarding the process in place. All staff nurses had completed the online HSE medication management training as per the centres policy. The training that was outstanding was an additional/ supplementary training from the pharmacy regarding psychotropic medications which was due to be completed by the end of March 2020 for all SN's however, given the current COVID situation this has not been completed. Once systems return to normal the additional training by our pharmacy will be undertaken. Training on managing challenging behaviour, on the day of inspection, the inspector was informed that a new policy/procedure was being put in place regarding responsive behaviour/restrictive practice. The policies and procedures were only put in place end of January 2020 and all staff were to be trained in their content and implementation. In the interim staff were following the previous policy and linked training. While there were policies that had not been completely implemented these were new policies and according to FirstCare policy there is a 12-month period for introduction and full implementation of the new policies. The provider had plans in place to commence staff training on the new policies and procedures to be completed by the end of May 2020 however, given the current COVID 19 requirements of social distancing and infection control guidelines this is not possible as well as the number of competing priorities. The provider is currently concentrating on training for existing staff in areas such as infection control, social engagement during COVID19 and communication and has adapted an online training program for all new staff in addition to above to include acculturation, safeguarding, manual handling and fire safety. Once the current situation within the home has stabilised training on the new policy and procedure will commence and the anticipated completion date will be end of December 2020

Regulation 23: Governance and management	Substantially Compliant

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

The government systems in place were reviewed post inspection to ensure systems already in place were adhered to in regard to auditing, overseeing and management of maintenance and cleaning of the premises.

The system of clinical audit in place includes monthly review of restrictive practice, falls, accidents/injuries, pressure ulcers, medication errors and complaints and staff were reminded of the importance of maintaining these audits up to date. However, in this current climate with more urgent priorities addressing COVID 19, staff have been instructed to maintain these items under review to ensure any issues are identified and appropriate responses put in place to address any concerns. Full audit will commence once the current situation stabilizes. This management decision had been risk assessed and added to the centers risk register.

There is a system in place regarding routine maintenance and cleaning of the center,

whereby daily cleaning is recorded, and staff have been spoken with to ensure records are up to date. A system of maintenance whereby a ticket system is in place to address any issue, the maintenance person then prioritizes the maintenance requirement and will address any issue promptly. As discussed on the day of inspection a new system was being put in place regarding risk management, which was acknowledged as a good and robust system, but unfortunately due to the current the home is following the existing risk management system. It was noted that there is a transition period whereby we were following the current processes while implementing the new processes in line with the new policy. There is a robust risk register in place to ensure all current risks are being responded to with appropriate actions taken within identified timeframes.

Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people

Not Compliant

Outline how you are going to come into compliance with Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people: The annual fee payable to HIQA by Beneavin Manor is paid in three installments covering four monthly periods, at €183 per resident per annum, and due to an oversight the fee payable at the end of September 2019 for the four months to the 31st of December 2019, was paid on the 21st of November 2019, following which the Provider has put in place a system to ensure fees are paid as required by the regulations.

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.

To ensure residents care plans are kept under review and accurately reflect the care to be given there is a monthly care plan audit carried out, the purpose of this audit is to identify any gaps in documentation and ensure staff are accurately reflecting the care being delivered to residents. In addition to this there is a weekly MDT meeting where any changes in resident's presentation is discussed, a plan of action is put in place and any additional/changed interventions are then recorded in the resident's care plan.

Subsequent to the inspection all staff have been reminded of the importance of accurate documentation so that care plans are clear and updated when any changes occur – this is being monitored on an ongoing basis by the Person In Charge, the CNMs and through the audit process.

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:

There is a weekly MDT meeting in place where all residents who have exhibited responsive behaviours during the preceding week are discussed. The members of the MDT team include CNM (with a specialist interest in the area), occupational therapist, physio, clinical facilitator, and the social care leader. Each resident is discussed to ensure a holistic approach is taken to assist them manage their behaviour, to minimise the risk of accidental injury and to ensure that all interventions which can be taken have been considered. Post the meeting if any interventions are required a responsible person is appointed to ensure the action is implemented and the residents care plan is updated to reflect the current plan. Subsequent to the inspection 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 on an ongoing basis by the Person In Charge, the CNMs and through the audit process. Staff have been reminded that the use of PRN medication to manage responsive behaviour is as a last resort and should be recorded in the resident's care plan.

Regulation 9: Residents' rights

Substantially Compliant

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

At all times in the nursing home the person in charge and all staff endeavor to ensure that residents rights are respected. Regular meetings are held to ensure residents have the opportunity to engage in the running of the service and have their suggestions/feedback listened and responded to. Post the inspection the meeting the minutes template had been amended to include a process whereby resident's feedback is documented, suggestions are acted upon and actions arising are recorded. To ensure residents suggestions are addressed the minutes of the previous meeting are read out at the next meeting and residents' satisfaction, or not, is recorded which ensures all items raised by residents are addressed.



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
Registration Regulation 8(2)	The annual fee is payable by a registered provider in three equal instalments on 1 January, 1 May and 1 September each year in respect of each four month period immediately following those dates and each instalment is payable not later than the last day of the calendar month in which the instalment falls due	Not Compliant	Yellow	31/12/2019
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	Substantially Compliant	Yellow	30/09/2020

	of the designated centre concerned.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/10/2020
Regulation 23(d)	The registered provider shall ensure that 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.	Substantially Compliant	Yellow	31/10/2020
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	Substantially Compliant		31/07/2020

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/07/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/07/2020