Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Beneavin Lodge Nursing Home
Name of provider:	Beneavin Lodge Limited
Address of centre:	Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	01 and 02 August 2018
Centre ID:	OSV-0000117
Fieldwork ID:	MON-0022164

About the designated centre

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

The centre offers long and short term care for adults and respite care and convalescence for adults over 18 years old including individuals with a diagnosis of Alzheimer's or Dementia. The designated centre provides 118 beds in a purpose built premises which is divided into five units. The original accommodation provides 70 beds in two units Botanics on the ground floor and Iona unit on the second floor. There is an enclosed courtyard garden which is accessible from the ground floor. The more recent wing is located over three floors and consists of three units; Tolka, Elms and Ferndale and provides accommodation for 48 residents.
The centre is located close to local amenities and public transport routes. There is a large car park at the front of the building.

The following information outlines some additional data on this centre.

Current registration end date:	09/12/2019
Number of residents on the date of inspection:	99

How we inspect

To prepare for this inspection the inspector or 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
01 August 2018	08:00hrs to 18:00hrs	Ann Wallace	Lead
02 August 2018	08:30hrs to 17:30hrs	Ann Wallace	Lead
01 August 2018	08:00hrs to 18:00hrs	Gearoid Harrahill	Support
01 August 2018	08:00hrs to 18:00hrs	Sonia McCague	Support
02 August 2018	08:30hrs to 17:30hrs	Gearoid Harrahill	Support

Views of people who use the service

Overall residents and families who spoke with the inspectors were complimentary about the care and services that they received from the centre's established staff team. Residents said that staff were kind and caring and that they could approach staff if they had any concerns. However a number of residents and their families did express concerns about the management of staff on the units and the regular use of agency carers to cover staff vacancies and absences. Families reported that there was a lack of continuity of care for their relative and that they often found it difficult to obtain accurate information about the resident's health and well-being from staff on duty when they visited.

Family members told the inspectors that when they raised concerns about staffing and other issues, staff and managers dealt with the issue at the time but that their complaint was not fully resolved and as a result the same problems would recur again. Families and residents said that they did not know who was responsible for managing complaints in the centre.

Residents told the inspector that they were comfortable in the centre and that the premises met their needs. Residents took pride in their bedrooms and private space commenting on the cleanliness of the bedroom and en-suite facilities.

Residents were generally complimentary about the food in the centre and said that they enjoyed their meals and that there was sufficient choice. However some families commented that there was a lack of staff available to support the residents who needed assistance at meal times and that meals were not always served hot enough.

Residents enjoyed the activities that were organised in the centre but both residents and families commented that there needed to be more activities and that there were long periods in the day where residents had little to do and no access to meaningful activity.

Capacity and capability

Inspectors found that improvements were required in relation to communication with residents and families, the systems that were in place to review the quality and safety of care provided for residents and the management of resources in the centre.

The person in charge was a registered nurse who was appointed to the role in May 2018 and works full time in the centre. During the inspection it became clear that the assistant director of nursing took overall responsibility for the more recently opened units in the centre;Tolka, Elms and Ferndale. This included new admissions and the deployment and management of staff and as a result communication and reporting systems were not clear for staff and residents.

The centre had systems in place to review resources to ensure that they were in line with the statement of purpose. However these needed significant improvement as inspectors found that resources such as staff were not being managed to meet priority needs and to ensure the effective and safe delivery of care and services for residents.

Over the two days of the inspection, inspectors found that planned rotas did not match the staff on duty and the allocation of staff including the use of agency staff was not appropriately managed. For example, a number of agency staff working in the centre did not receive a thorough induction to the unit they were working on. As a result agency staff who spoke with the inspectors were not familiar with the fire safety procedures and the location of emergency call bells on the units they were working on.

On both days during the inspection, agency staff were moved between the units and did not receive an appropriate handover report. As a result, these staff were not familiar with individual residents' personal history, care needs and preferences for care and daily routines. This was verified by families who told inspectors that they were often unable to find a member of staff on the unit who could provide up to date information about their relative's health or well-being.

In addition rosters showed that shortages in nursing staff were managed by allocating clinical nurse managers to work as the nurse in charge on the unit. Inspectors observed a number of poor staff practices in relation to moving and handling residents, the storage of unused medications and supporting residents to take adequate diet and fluids. These incidents were not picked up by senior staff working on the units at the time. As a result, inspectors found that nursing and care staff were not adequately supervised in their day to day work

There was a comprehensive training programme in place in the centre which included mandatory training in fire safety, moving and handling and the protection of vulnerable adults. Records showed that all directly employed staff were up to date with the designated centre's mandatory training requirements. However as discussed above, inspectors also found that some staff practices in relation to moving and handling residents and supporting residents with drinks and meals were not in line with the centre's own policies and procedures in these areas.

Training in key areas such as dementia care and challenging behaviours was being

rolled out in the centre, however a number of staff had not completed this training at the time of the inspection.

The staff carried out a number of monthly audits in key areas such as falls, resident dependencies, wounds, restraints and incidents. The inspectors reviewed a sample of audit documentation and incident reviews and found that although the systems were rigorous in the amount and quality of the data that was collected, the process did not analyze the data and identify areas for improvements. As a result there was no clear record that improvements had been implemented following audit findings and incident reviews.

There was a clear complaints procedure in place and information in relation to the complaints procedure was available in the resident's guide and was displayed in the centre's reception area. The person in charge maintained a log of formal complaints that were received in the centre however there was no log of informal complaints received by staff on the units and no record of how these had been managed. Residents and families who spoke with the inspectors were aware that there was a complaints process in place but a number of those spoken with were not aware of who was responsible for managing complaints in the centre. Residents and families told the inspectors that when they raised issues with staff on the units the issues had been dealt with at the time but that the same problems would recur again and they had to report the issue a second or third time. Records showed that one resident council meeting had been held in the centre in January 2018, however these meetings should have been held every quarter in line with the centre's statement of purpose. As a result, inspectors found that residents and families were not sufficiently included in the systems used in the centre to review and monitor the quality and safety of care and services.

Regulation 14: Persons in charge

Although the person in charge had day to day responsibility for the management of residents and staff in Botanics and Iona units clearer processes were required in relation to her role and responsibilities in relation to the three units on Tolka, Elms

and Ferndale.

Judgment: Substantially compliant

Regulation 15: Staffing

Rosters showed that there were registered nurses on duty at all times in the centre. Inspectors found that although some improvements had been made in the recruitment of staff since the last inspection, significant improvements were still required as staff resources were not being managed to meet priority needs and to ensure the safe and appropriate delivery of care and services for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Training in key areas such as dementia care and challenging behaviours was being rolled out in the centre but a number of nursing and care staff had not completed this training at the time of the inspection.

Due to staffing shortages clinical nurse managers were regularly rostered to work as the nurse in charge on the unit. As a result staff were not appropriately supervised in their work.

Agency staff did not receive an appropriate induction from senior staff when they were allocated to a unit. As a result, agency staff were not familiar with the emergency procedures including fire safety and the layout of the unit on which they were working such as the location of fire exits and where to locate the nurse call bell in the event of an emergency.

Judgment: Not compliant

Regulation 19: Directory of residents

There was a directory of residents available in the centre however the directory did not include the details of next of kin and general practitioner for two residents and therefore did not include all of the information as specified in Schedule 3 of the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

Significant improvements were required in relation to staffing to ensure that the centre managed the staff resource effectively in order to provide safe and appropriate care for residents in accordance with its statement of purpose.

Clarity was required in relation to the current role and responsibilities of the assistant director of nursing and their reporting responsibilities to the person in charge.

Significant improvements were required in the systems that were in place to ensure that care and services provided were safe, appropriate and consistent and that feedback from residents and families was recorded and acted upon.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Not all contracts for care reviewed by the inspectors contained a record of the fees as agreed with the resident and/or their family on admission to the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The revised Statement of Purpose dated July 2018 did not contain the information required in Schedule 1 of the regulations as listed below;

- The accurate number of registered beds in the centre as outlined in Condition 7 of the centre' current registration.
- An accurate list of all bedrooms in the centre with the occupancy levels of each.
- A complete and up to date list of all staff working in the designated centre including the assistant director of nursing and the clinical nurse managers.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had submitted notifications for incidents set out in Schedule 4 of the regulations within the required time frames and had submitted the quarterly returns to the office of the Chief Inspector in line with the requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. Information in relation to the complaints procedure was displayed in the reception area. The person in charge maintained a log of formal complaints that were received in the centre.

Complaints made to staff on the units were not entered into the complaints log and there was no record of how these had been managed or a record of the complainant's satisfaction with the outcome.

Residents and families were unclear about who was responsible for managing complaints in the centre.

Judgment: Not compliant

Quality and safety

Overall residents said that they were comfortable in the centre and that the premises met their needs.The centre was clean and well ventilated. Communal lounge/dining areas were comfortably furnished and were bright. There was also a large activities room on the ground floor where activities staff provided group activities and where entertainments were held.

Residents were encouraged to personalise their bedrooms with photographs and small items of furniture and artefacts from home. As a result, bedrooms were quite individualised. Adequate wardrobes and storage cupboards were available and residents had access to lockable storage space if requested.

Some improvements had been achieved since the last inspection in relation to noise levels in the centre. However further improvements were required at meal times in

the dining rooms on Botanics and Iona units, and throughout the day on all units in relation to mobility alarms and unanswered call bells.

Inspectors found that improvements were also required in the maintenance of equipment for use by residents. This was a particular issue with the pressure mat alarms in use in the centre where a number were sounding fault alarms throughout the two days of the inspection and being ignored. Staff also reported that they were waiting for a hoist to be repaired and were sharing a hoist between units at the time of the inspection. This meant that residents had to wait for the hoist to become available if they required a hoist for transfers.

Two bathrooms were not accessible for residents due to the equipment stored in them.

There was a pleasant courtyard garden which had seating and tables organised for residents. The garden was enclosed and was accessible to residents throughout both days of the inspection.

Overall residents said that they were happy with the quality and choice of food available to them. Meals were prepared by qualified catering staff in the main kitchen on site. Special diets were catered for and had oversight from a dietician. Choices were available at each meal and there were a selection of snacks and finger foods available for residents who did not want a full meal. However a number of staff who spoke with the inspectors were not aware of the range of snacks and finger foods that were available for residents and did not know how to order a cooked meal for a resident outside of the scheduled meal times.

Staff offered discreet support and supervision for residents who needed assistance at meal times however inspectors observed that at times residents had to wait for staff to become available to help them. They also noted that on the first day of the inspection the kitchen on Ferndale unit did not have adequate arrangements in place to keep meals hot for residents. This was reported to catering staff who resolved the issue during the inspection.

Inspectors noted that improvements were also required in the systems that were in place to monitor those residents who were at risk of weight loss. Two residents did not receive their prescribed nutritional supplement drink at lunch time on the first day of the inspection. In addition records showed that two residents who had significant weight loss did not have a daily record of their fluid and food intake completed as directed in their care plan.

Overall care plans were found to provide clear guidance on the nursing and care interventions that were in place to meet the resident's current needs although improvements were still required in relation to the grading of pressure sores. Each resident had a pre-admission assessment prior to coming to live at the designated centre. Improvements had been made in relation to the prescribing of medications for new residents admitted to the centre and the prescribing of as required (PRN) medications. Following admission the assessment information was used to develop a care plan with the resident and their family. Care plans were reviewed every four

months or more often if the resident's needs changed.

Residents, needs were met through a range of nursing, medical and specialist health care services. These included access to a general practiitoner (GP), dietician, speech and language therapy, chiropody and community mental health care services.

Records showed that where a resident was transferred to hospital or discharged from the centre the nursing staff provided relevant nursing and medical information to ensure a safe transfer of care or discharge back into the community setting.

Improvements had been made since the last inspection in relation to the prescribing and administration of as required (PRN) psychotropic medications. Inspectors found that psychotropic medications had significantly reduced and there was a clear monitoring process in place to review staff practices in this area. Residents were reviewed by their general practitioner (GP) and if required appropriate referrals were made to the specialist mental health services.

Staff who had attended training in responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social of physical environment) were seen to offer discreet support and appropriate techniques to distract and reassure residents at these times. However some staff were not confident in their interactions with residents who became agitated or displayed responsive behaviours. On these occasions staff were observed encouraging residents to remain seated rather than engaging positively with the resident and offering appropriate types of distraction and reassurance.

There was a planned programme of activities which was managed by the centre's two activities coordinators. Residents reported that they enjoyed the activities that were on offer. The programme included group and 1:1 activities, musical entertainments and pet therapy sessions. The scheduled programme did not include any trips out of the centre after April 2018. The person in charge informed inspectors that this was due to transport problems which was being resolved.

Over the two days of the inspection, residents attended music and entertainment sessions and arts and craft workshops. Inspectors observed residents enjoying a gentle exercise session led by care staff on one of the units on the second day of the inspection. However over the two days, inspectors noted that residents who either chose not to attend the activities on offer or who had high levels of cognitive impairment spent significant amounts of time without access to meaningful activities or significant engagement with staff.

Televisions and newspapers were available for residents in the communal areas however a number of the residents occupying the lounges did not appear to have any interest in what was being televised and inspectors noted that staff did not engage with residents or offer a more suitable viewing option. This was also a finding in the centre's last inspection.

Overall inspectors found that resident's rights, privacy and dignity were respected in

the centre. Daily routines and care practices were designed to give the residents choices about the care and services they received. However this was significantly impacted by the staff available on the unit and their knowledge about individual residents and their preferred routines. In addition, inspectors found that some staff did not have sufficient fluency in the English language to communicate effectively with residents and their families. This was reflected in feedback from residents and families who had experienced language difficulties when trying to communicate their needs or preferences to some staff.

Inspectors also observed that personal and private information about individual residents was discussed between staff at the nurses stations in the communal areas on each unit. This happened during handover reports, telephone calls to general practitioners (GPs) and during an emergency on one of the units. The information could be overheard by other residents, visitors and ancillary staff. This was also a finding from the centre's previous inspection.

Residents told the inspectors that they felt safe and secure in the centre and that they were able to talk to staff if they had any concerns. This was verified by the families who said that staff were kind and courteous with their relatives. The centre had comprehensive polices and procedures in place in relation to safeguarding residents. All staff had attended safeguarding training and staff who spoke with the inspector were aware of their responsibility to keep residents safe. The person in charge informed the inspector that all staff working in the centre had Gardai vetting in place. The person in charge was aware of her responsibility to notify and investigate any concerns in relation to the safeguarding of residents however record keeping in relation to a recent investigation was not maintained in line with the centre's policies and procedures.

Staff had received training in relation to risk management issues such as infection control, moving and handling and fire safety. However as discussed earlier, supervision of staff required improvement to ensure that their practice was in accordance with the centre's policies and procedures. In addition staff who were working on the recently opened units;Tolka, Elms and Ferndene had not practised a fire drill in these areas.

Although the centre maintained comprehensive information in relation to incidents such as falls and responsive behaviours there was no clear evidence of how the learning from incidents were communicated to the relevant staff. For example there was a number of un-witnessed falls in the centre and although these were recorded there was no clear strategy to review the incidence of falls in the centre, investigate the root cause and implement an action plan to reduce same.

Regulation 17: Premises

Two bathrooms were not accessible for residents due to the equipment stored in them. As a result the number of accessible bathrooms and toilets was reduced and were not in line with the Statement of Purpose prepared under regulation 3.

Some improvements were still required in relation to noise levels. This was a particular issue at meal times in the dining rooms on Botanics and Iona and throughout the day on all units in relation to mobility alarms and unanswered call bells.

Inspectors found that improvements were also required in the maintenance of equipment for use by residents. This was a particular issue with the pressure mat alarms in use in the centre.

A hoist was in need of repair and was not available for use when required by residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Meals and snacks were available to order from the main kitchen however some staff were unaware that they could order a meal or snack for a resident from the main kitchen at any time of the day.

Two residents did not receive their supplement drink at lunch time on the first day of the inspection as was prescribed in their care plan and medication kardex.

Two residents who had significant weight loss did not have a daily record of their fluid and food intake completed as directed in their care plan.

During lunch time on two units some residents had to wait for staff to become available to assist them with their food.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a resident's guide which was made available to residents in the centre. The guide included all of the information required in the regulations.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

There were clear policies and procedures in place for the temporary absence and discharge of residents from the centre. Records showed that where a resident was transferred from the centre all relevant information about the resident was provided to the receiving hospital or care facility.

Discharges form the centre were planned in a safe manner and agreed with the resident and their family and were carried out in accordance with terms and conditions of the resident's contract for care.

Judgment: Compliant

Regulation 26: Risk management

There was a comprehensive risk management policy in place which included an emergency plan in the event of a major incident.

There was no clear evidence of how the learning from incidents such as falls and behaviours that challenge were communicated to relevant staff.

Not all incidents and near misses were captured by senior staff and managers such as the two examples of poor moving and handling practices observed by inspectors.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Not all staff working in the more recently opened units; Tolka, Elms and Ferndale, had completed training relevant to these units in fire emergency procedures including evacuation procedures, building layout and escape routes.

Agency staff working in the centre reported that they had not been made aware of the fires safety procedures.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Some improvements were required to ensure that all medications administered by nursing staff were recorded in line with the centre's policies and procedures and best practice guidance.

Inspectors found that medications no longer in use were not stored securely in one unit due to a faulty lock on the storage cabinet.This had been reported to the maintenance team two days earlier but had not yet been repaired. Nursing staff obtained alternative secure storage for the medication during the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements were required in care plan documentation relating to the assessment and grading of pressure sores.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a General Practitioner and specialist medical and health services when required. Referrals to specialist services were timely and where specific interventions were prescribed, these were implemented by the relevant staff.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Although the centre had improved access to training in the management of challenging behaviours, not all staff had attended the training and did not demonstrate appropriate skills and knowledge in this area including what constitutes

a restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

Improvements were required to ensure that any investigations into safeguarding concerns were recorded in line with the centre's own policies and procedures and included evidence of any learning and improvements required.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Personal and private information about individual residents was discussed between staff at the nurses stations in the communal areas on each unit. This happened during handover reports, telephone calls and during an emergency on one of the units. The information could be overheard by other residents, visitors and ancillary staff. This was also a finding from from the previous inspection.

Some residents did not have sufficient opportunities to participate in activities in accordance with their interests and abilities. This was a particular issue for those residents who had cognitive impairments or who needed a high level of supervision and support from staff.

Overall staff worked hard to ensure that residents were able to make choices in relation to their care and daily routines however this was not possible when the staff on the unit did not know the resident and their preferred routines and preferences for care and support.

Some staff did not have sufficient fluency in the English language to understand residents who were attempting to communicate their needs or preferences.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	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	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Beneavin Lodge Nursing Home OSV-0000117

Inspection ID: MON-0022164

Date of inspection: 01 & 02/08/2018

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Senior Management Team meetings continue with the Group Director of Operations with a strong governance structure in place in Beneavin Lodge, with a Deputy Home Manager/ADON reporting to and supporting the PIC, who is further supported by our five CNM's, for the 5 units, Iona, Botanic, Tolka, Elms, and Ferndale. Actions completed and scheduled to ensure all stakeholders are aware include: the PIC attendance at the residents meeting (5/9/18); meeting with families on target with all being met by the end of October; resident and family newsletter is in draft and will be circulated 28/09/18; discussion on governance and structures at staff meetings (22/08/18; 6/09/18; 13/09/18); and included in the induction program for new staff and agency staff. CNMs and Team Leaders are fully aware of, and provide support to, the governance structure. The Statement of Purpose has been reviewed and updated.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All rosters continue to be completed for five units in consultation with ADON and CNM's to ensure skill mix, staff experience and changing needs of residents are reflected in allocations. As part of continuous service improvement, the PIC has updated the roster template, which reinforces the management structure, while providing a clear view and recording of staffing changes which makes it easier to analyse requirements for all units. Our continued recruitment efforts over the last year has allowed us to increase the number of Team Leaders from 1 to 5, fully in place since 27/08/18 and increase Social Care Leader positions from 2 to 3 full time staff from the 13/08/18. Regular fortnightly meetings continue with both the CNM's and Team Leaders. Our ongoing recruitment drive has also provided us with a full complement of Healthcare Assistants. All of these staff either have had, or are having, a full induction and orientation program. As per our policy, when and if we require agency staff, those that	

are known to Beneavin Lodge and residents, are booked and allocated. All agency staff receive an appropriate induction.

Ongoing clinical supervision is provided by our ADON and CNM's. This ensures that all staff are working within their scope of practice, following policies and procedures, and best practices are being adhered to. The skill mix of the staff is addressed through rostering practices and daily oversight by the PIC, ADON and CNM's, to ensure that each unit has a high standard of suitably qualified staff to address the needs of our residents.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Beneavin Lodge is supported by a Training Coordinator who works closely with the PIC and ADON. Training needs that have been identified are prioritized with an agreed timeframe for rollout. This occurs on a continuous basis and most recently included fire training and evacuation, safeguarding, infection control, MAPA, and food safety. There is ongoing MAPA training with seven staff recently completed and next training scheduled for 3/10/18. All new staff recruited attend a very comprehensive induction program to ensure they have the knowledge, skills and competency, to be rostered as part of our care team.

As well as the induction, all new staff have seven twelve-hour supernumerary shifts, that include policy specific training, with Q&A sessions and final sign off. Clinical supervision as noted above is overseen by our ADON and the CNM's, includes night supervision. To ensure supervision is available on both day and night shifts, CNM's are rostered one night each per month, with the ADON also completing night shifts. All agency staff are provided with an appropriate induction to their assigned units and same is documented. It is expected that agency usage going forward will be minimal, and only used to cover for sickness.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:

The directory of residents is updated and reviewed by the CNMs in each unit on a weekly basis. When a unit has a new admission, the CNM on duty will ensure that all relevant information has been entered. The PIC/ADON will continue to monitor the directory of residents as part of the monthly audit.

Regulation 23: Governance and management	Not Compliant

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

Our recent recruitment drive has yielded an increase in both our Team Leaders to five

(one on each floor), and our Social Care Leaders to three, which will continue to support the teams to deliver safe and appropriate care for residents in accordance with our Statement of Purpose. All new staff attend a comprehensive induction program to enhance their knowledge and skill in becoming full time staff as well as participating in seven twelve-hour supernumerary shifts. As per actions set out under Regulation 16, a comprehensive training program continues along with staff participating in policy classes where a wide range of policies are read, understood, where questions and answers are facilitated, and the staff sign off that they fully understand and can implement these policies. Clinical supervision of staff continues including both day and night shifts. Staff meetings and communications ensure that staff are clear on the governance and reporting structure and roles of management.

Residents, families and staff meetings continue which includes relevant updates and reminders such as the management structure, role of PIC and ADON. Further initiatives such as the introduction of a newsletter is in progress. As part of the ongoing normal processes and policy, feedback from residents continues to be encouraged, both direct as individuals and also through the resident and family meetings. Feedback is also encouraged from families with individual family meetings held and further meetings are scheduled, as well as a unit specific (Elms) meeting held with families most recently on 5/09/18. There is a schedule proposed for all units to have family meetings held by end of October.

As part of ongoing service improvement, a suggestion box is at reception to encourage further feedback. All feedback is reviewed by PIC/ADON on weekly basis for follow up actions. Documentation of all meetings and feedback is reviewed by the PIC and the Beneavin Lodge management teams to agree actions, the action owner and timeframes for completion. The PIC will continue to monitor the action log, share feedback and learnings with peers and the Group Director of Operations.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

Contracts for the Provision of Services are undergoing a review, and if any require updates, the appropriate follow up with our resident and/or family will be arranged.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The Statement of Purpose is updated and includes the number of registered beds as outlined in Condition 7, with maps attached showing all bedrooms, and an updated list and organogram including ADON and CNM's.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

In keeping with our policy, we value feedback and seek ways to engage with residents, families and visitors in a timely way. As well as the ability for people to provide feedback verbally, letters and through email, a folder is available on each unit with complaints/compliments forms making it easier to provide feedback at the time of concern. All concerns and complaints are reviewed by our CNM's on daily basis, and reported to PIC. Staff know to log all concerns and complaints, even when the issue is dealt with immediately and the resident or/or family are satisfied with the outcome. This process will continue to be an agenda item on resident and family meetings.

As part of our ongoing policy review, the management of complaints is under review, and any necessary updates will be communicated to all staff on completion of this review. When issues are notified actions are completed in a timely manner with a record of the complainant's satisfaction of the outcome recorded. The record of concerns and complaints is audited for themes and will be reported on a monthly basis to the newly appointed Group Director of Operations. This is also addressed through the quarterly audits completed by the PIC, including a monitoring role ensuring actions are completed and communicated to staff, residents and families.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Noise reduction mechanisms are in place, that include the following: all staff are aware of feedback in relation to the noise levels; appropriate actions are in place such as plastic scraping spoons being utilised instead of metal; the pantry kitchen door is closed during meals times; and appropriate music is available. Communication and supervision continues which includes staff awareness about ensuring there is noise de-escalation with all call bells and alarms mats being appropriately de-activated on reaching the resident.

Maintenance addresses any issues with pressure mat alarm faults with a daily review and repair if necessary. As well as ongoing normal maintenance, a replacement hoist has been purchased and delivered. All bathrooms have been reviewed by the PIC, and any equipment items that were in temporary storage in some of the bathrooms, are now stored elsewhere. All equipment is in the storage room and ongoing, areas are being monitored to ensure staff adhere to utilizing the storage room.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

All staff have been reminded that they can order a meal or snack for a resident from the main kitchen at any time of day. The PIC has included updates in meetings with all CNM's and Staff Nurses as well, so that reminders are included each day during handover report. These reminders include follow up to care plans and kardex in relation to

residents receiving supplement drinks with the CNM's monitoring both the kardex and monthly order of supplements.

The PIC, ADON and CNM's, are including in the monthly audits, and more frequently if needed, the monitoring of daily records, to ensure compliance, and take immediate corrective actions if and when required, based on residents' changing care needs. As part of the ongoing service improvement initiatives, meal time routines were reviewed and an additional hotbox for the Iona unit is due for delivery, to ensure all residents receive meals at the same time as all other units. Nurses start medication round on each floor during dessert time to ensure all residents are receiving meals at the same time. Nurses always stay in the area to supervise and assist with safety of our residents.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

Audits are completed on a monthly basis and both the PIC and ADON have completed a quarterly analysis of all audits, which are highlighting decreasing levels of falls, and wound progression. Feedback is provided to staff on daily morning and night reports, and staff meetings. The analysis and feedback is provided to Group Senior Management, with further structures being developed to share learnings across the group. Any issues identified such as moving and handling practice, are supervised by CNM's during clinical supervision. The Emergency policy has been reviewed, is currently being updated and will be made available to all by 28/09/18. Manual Handling training has been and will continue to be provided, with two sessions completed in the last two weeks.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

All staff are rostered on Fire Training and fire drills, and all new staff receive fire training and fire drill as a component of their compulsory induction program. Any agency staff are receiving induction and as part of this are made aware of fire safety procedures and evacuation plans.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Audits continue to monitor and ensure compliance, and nurses are made aware of any improvement required, with our CNM's providing supervision to support practice. All staff nurses have completed the HSE Medication Management on line. All medications that are no longer in use are stored securely on the unit in the treatment room until collected by the pharmacy.

Regulation 5: Individual assessment	Substantially Compliant

and care plan	

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

Continuous assessments are ongoing and staff nurses are utilizing the NICE guidelines for pressure areas https://www.nice.org.uk/guidance/qs89. As per normal practice residents are referred to TVN, Dietician and SALT. Ongoing staff nurses complete individual assessments within 48 hours and care plans for newly admitted residents within 72 hours. CNM's are responsible for contacting families and arranging a care plan meeting to ensure all care is individualised. All staff update our EPIC system, and report on daily basis of any issues regarding care for residents.

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:

Nursing and HCA staff have been allocated to MAPA training, and supervision from the CNM's and ADON supports this further. All residents with ongoing behavior that challenges are reviewed by our GP's and referred to the Geriatrician for further advice. Each resident has documentation in our EPIC system, including ABC forms for staff to follow planned care. Staff are aware of and use the appropriate techniques for residents with behaviors that challenge. Our Social Care Leaders are providing one to one engagement with residents where required, and tailoring activities for residents that may have behaviors that challenge, for example SONAS, aromatherapy, hand, foot head massage, relaxations music therapy.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Our CNM's and ADON continue clinical supervision including safeguarding, with staff attending safeguarding training as required. The PIC is aware of their role and responsibility to notify HIQA/safeguarding team/Garda, if any safeguarding issue has taken place. All records are kept securely in the PIC's office. Families and residents are aware of SAGE service. The PIC and ADON undertake monthly and three-monthly analysis and the outcomes are provided at staff meetings.

Regulation 9: Residents' rights	Not Compliant

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

A review is underway to ensure residents who require more one to one, or tailored, activities have these opportunities provided. This will be supported through the increased number of Social Care Leaders. Interactions boxes have been provided. Where required, English classes and other supports are in place for staff to improve their language proficiency, which ongoing improves communication with residents, families, and

colleagues. Handovers are being completed in appropriate areas with the use of the clinical and doctor's rooms, for meetings and phone calls.

The successful recruitment of new staff ensures continuity of the care team for residents with full knowledge of residents' care needs, their daily routines and to assist them in making choices. The extra support, with the increased number of Team Leaders and Social Care Leaders, promotes residents' rights and choices, including completing actions arising from resident and family meetings.

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 14(4)	The person in charge may be a person in charge of more than one designated centre if the Chief Inspector is satisfied that he or she is engaged in the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	31st October 2018
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	24rd September 2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	21st December 2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are	Not Compliant	Orange	Completed 14th

	appropriately supervised.			September 2018
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	Completed 10th September 2018
Regulation 17(2)	The registered provider shall, 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.	Substantially Compliant	Yellow	Completed 7th August 2018
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	Completed 13th August 2018
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	Completed 13th September 2018
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	Completed 13th September 2018
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	Completed 7th August 2018.
Regulation 23(a)	The registered provider	Not		Completed

	shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Compliant	Orange	10th September 2018
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Yellow	21st September 2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	21st September 2018
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	19th of October 2018
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	31st October 2018
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable	Not Compliant	Orange	Completed 14th September 2018

	training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	Completed 17th September 2018
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	Completed 17th September 2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	Completed 10th September 2018
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	31st October 2018
Regulation	The registered provider	Not	Orange	31st October

34(1)(f)	shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Compliant		2018
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	31st October 2018
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	31st October 2018
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	Completed 3rd August 2018

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	Completed 3rd August 2018
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	21st December 2018
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	Completed 14th September 2018
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	Completed 7th September 2018
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	16th November 2018
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	16th November 2018
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.	Not Compliant	Orange	Completed 5th September 2018