Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Beneavin House
Centre ID:	OSV-0000694
Centre address:	Beneavin Road, Glasnevin, Dublin 11.
Telephone number:	01 864 8516
Email address:	projects4@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Beneavin House Limited
Lead inspector:	Siobhan Kennedy
Support inspector(s):	Gearóid Harrahill; Ann Wallace
Type of inspection	Unannounced
Number of residents on the date of inspection:	137
Number of vacancies on the date of inspection:	13

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 November 2017 09:00	10 November 2017 19:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an unannounced inspection to monitor compliance with regulations and follow up on the matters arising from the previous renewal of registration inspection which was carried out in February 2016. The centre is registered to accommodate 150 residents and there were 137 residents on the day of inspection.

The inspectors reviewed documentation received by the Authority since the last inspection, ascertained the views of residents, relatives, and staff members, observed practices and reviewed records as required by the legislation.

The non-compliances identified during the previous inspection primarily related to the governance and management/staffing, safeguarding and medication management. Improvements were noted in these areas, however, during this inspection, inspectors found that management systems were not in place to ensure that the service is safe, appropriate, consistent and effectively monitored.

This situation was brought about primarily due to a deficit in full time care staff and although management had taken measures to address the problem including in the short-term the employment of agency staff and the appointment of new staff, this did not in all instances bring about a positive outcome for residents.

Management have recruited healthcare staff mainly from abroad to address the long-term effects in respect of the deficits created by full-time healthcare staff terminating their contracts. However, the recruitment process has not been finalised and so these staff members are not yet working in the centre.

As highlighted in the previous inspection there were still insufficient resources in place to ensure the delivery of quality care services to the 150 residents for whom the centre is registered but management are actively recruiting.

Full-time long-term staff informed inspectors that there were good opportunities for staff training and in the main records supported this view. However, inspectors found that all staff did not have access to appropriate training and supervision.

In general, residents and relatives were positive in their feedback to the inspectors and expressed satisfaction about the facilities and the services and care provided. However, some relatives expressed their concerns to the inspectors regarding the number of full-time care staff who no longer work in the centre and the negative impact that this had on residents in particular the reduction in a consistent caring approach. Some relatives explain that they had already highlighted their concerns to the person in charge. Some residents and relatives expressed their satisfaction with the premises commenting that it was maintained to a high standard.

In the main, residents had good access to nursing, medical and allied health care and the administration of medicines had improved. Residents' assessed needs and arrangements to meet these assessed needs were set out in individual plans. End of life care planning was comprehensive but involvement of the resident was unclear.

While there were measures in place to protect residents from being harmed or suffering abuse all staff had not participated in safeguarding training.

Inspectors saw that opportunities for residents to participate in activities, appropriate to their interests and capacities especially regarding group activities.These were well organised and stimulating for residents who had participated, however there were periods whereby there was no/limited interaction/stimulation for residents.

Overall there were provisions in place relating to health and safety and risk management but some hazards were not identified and assessed and therefore appropriate action had not been implemented.

An action plan at the end of this report identifies the areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The matter arising from the previous inspection highlighted that the total staffing complement outlined in the statement of purpose did not reflect the staffing levels in the centre at the time of the inspection. Inspectors found that the statement of purpose had been reviewed and updated in October 2017 and reflected the current management and staffing structure. This identified the deficit in full time health care staff.

The statement of purpose described the services and facilities, however aspects of the delivery of care were not reflected in practice.

A copy was on display in each of the units and in the front foyer of the centre.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

implemented.

Findings:
The matters arising from the previous inspection highlighted the following issues:
• The outcome of consultation with residents was not included in the annual review.
• The annual review did not include recommendations on how to improve the quality of care and service delivered in 2016.
• There was no system in place to review medication related incidents including medication errors and 'near misses' to identify any trends, and to ensure appropriate action was taken when necessary.
• The management structure in place was not effective enough to support the person in charge. There were two vacant posts (deputy and operations managers).

Inspectors found that the first two points above had been satisfactorily actioned. There was evidence that residents and relatives had been consulted with throughout 2017 and the person in charge knows to include these views in the 2017 annual report.

An examination of the annual review for 2016 identified plans to further improve the quality of services to residents during 2017. These plans primarily related to the maintenance of the centre and all the areas identified have been achieved with the exception of creating a sensory garden.

There was evidence that consultation had taken place between management and the pharmacy services to review medication errors and put an action plan in place to prevent the incident re-occurring. The person in charge had taken responsibility for reviewing incidents to determine trends. Unannounced audits had been carried out by the management team to ensure adherence to the policy and procedures. There was evidence that errors and incidents were discussed with the health and safety and risk management team at monthly meetings and where any learning was identified changes were made to the practices. A number of medication errors were examined by the inspectors and the process in place was found to be satisfactory with the exception that the documentation did not clearly set out the action plan which would bring about improvement and confirmation that it had been implemented.

Since the last inspection the management structure of the centre had been reviewed. The team consists of a managing director, quality compliance manager who currently also has responsibility for operations (the vacant position has not yet been filled), a clinical bed manager, person in charge and 2 deputy managers one of whom was recruited since the previous inspection and has been working in the centre since 1 March 2017.

Recruitment is in progress for a clinical nurse manager and it is anticipated that a vacant post will be filled following interviews during the week commencing 13 November 2017. Presently the deputy managers are supporting nursing staff to complete clinical audits and manage rosters.

Inspectors were told that the major challenge for the centre was the number of full-time healthcare assistants who had terminated their contracts which resulted in a deficit of 17 whole time equivalent staff members. This situation had been ongoing for approximately

3 to 4 months and was reflected in the centre' s statement of purpose. This situation is being addressed on a short-term basis (hourly, daily and weekly) by requesting core staff to work additional hours or employing agency staff/new staff.

On the morning of the inspection the management team were involved in reorganising staff to work throughout the designated centre as a vacant staff employee position had not been covered and the person in charge was liaising with a local agency to employ a staff member to cover a shift which had already commenced.

During the course of the day inspectors gathered information which showed that management systems were not in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored and this most likely came about because the core staff team had been depleted and agency and new staff did not have the necessary time to develop relationships with the residents, develop required skills and competencies to respond to the needs of residents and were not fully supervised. See outcomes 8, 16 and 18 for further details.

Inspectors were informed that the measures taken on a long-term basis related to a large recruitment drive with health care staff being recruited from abroad. This has resulted in sixteen full-time care assistants having been employed in accordance with employment and equality legislation. These personnel are currently being vetted, however, they will not work in the centre until completion of orientation and induction training.

Judgment:
Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The matter arising from the previous inspection identified that records of medication administration were not being maintained in accordance with relevant professional guidelines as medicines administered at 11:00 hours were documented as being administered at 09:00 hours. In response to the action plan management stated that a computerised medication management system which would rectify all of the issues

relating to the times medicines were administered would be in installed however this has not yet been actioned.

Inspectors were provided with 3 different documents associated with the rostering of the persons working at the designated centre for the period commencing 9 October 2017. Therefore it was difficult to ascertain the staff members who were on duty. The planned rosters identified named staff members who no longer worked in the centre. The person in charge subsequently provided the inspectors with a list identifying nursing and caring staff on duty in each of the units/floors, however, the list did not tally with the rosters. This situation has probably arisen due to the constant changes being made on a daily and sometimes hourly basis regarding covering shifts.

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

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
The matter arising from the previous inspection identified that restraint (bed rails) in use in the centre were not used in accordance with the national policy. Inspectors found that the documentation around the use of bedrails including the assessment of the suitability of their use was reviewed and updated. There was evidence that other options were trialled prior to using bedrails and this had led to a significant decrease in their use. Inspectors saw that there was alternative equipment available such as low low beds, alarmed mats and crash mattresses.

There was a policy in place which covered the protection, detection and prevention of elder abuse and there was evidence that the person in charge had investigated incidents/allegations of abuse. An examination of the training records showed that not all staff had up-to-date training. This included staff who required initial and annual refresher training. There were measures in place to safeguard residents from exiting the centre and staff are available in the reception area up to 22:00 hours.

Person centred dementia care was not evident during an observation period by inspectors in the lounge where residents were sitting. A resident was involved in disruptive noisemaking behaviours which was distressing for the resident and subsequently distressed a further 3 residents. Care staff were busy with routine activities in respect of assisting/hoisting residents to come into and leave the lounge. The staff members did not have the time/knowledge/skills to engage with the resident to seek an understanding and explanation for the resident's behaviour in accordance with the centre's policy. Some staff confirmed that they did not have a lot of experience of working with residents with dementia and some staff did not know this resident's behaviours. A senior staff member successfully distracted the resident and alleviated the resident's distress.

There were no residents currently being accommodated who required one to one supervision.

The management of residents' finances was not fully reviewed on this inspection as it was reported on as being satisfactory in the previous report. However some contracts of care were examined in relation to additional charges. See outcome 16.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The matter arising from the previous inspection showed that the procedures to be followed in the event of fire were not displayed in a prominent place on each floor of the designated centre. Inspectors saw that this matter had been satisfactorily addressed. Other precautions against the risk of fire were also noted, for example, fire exits were unobstructed, there was suitable fire fighting equipment and during the morning handover meeting between night and day staff a summary of the fire safety procedures was communicated to the staff group in each unit. This included evacuation routes and exits, however, some staff in the individual units did not know the number of residents being accommodated and therefore adequate arrangements were not in place for evacuating residents in the event of a fire/emergency.

An examination of the training records showed that the majority of staff had participated in fire safety training, however, 5 new staff members had not received this training but it was scheduled to take place on the 21 November 2017.

While there was a risk management policy inspectors noted that the health and safety of residents, visitors and staff was not always promoted and protected. There was no hazard identification and assessment of risks associated with staff on duty taking telephone calls regarding the day-to-day operations of the centre while providing services directly to residents, for example, this occurred constantly during the administration of medicines and while assisting a resident to have a meal.

Although training records reviewed showed that all staff had up-to-date training in moving and handling, practices observed were not in line with best practice.

Infection control practices were good with hand washing and drying facilities and hand sanitizers available throughout the centre.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
The matters arising from the previous inspection highlighted the following: –

- A number of residents required their medicines to be crushed prior to administration but the prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
-A number of prescription sheets did not specify times of administration.
-There were no resident specific care plans in place for residents who had been prescribed more than one psychotropic medicine on a PRN (as required) basis to guide staff in the administration of these medicines. The above matters had been actioned.

In addition during the previous inspection it was identified that there was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds. There was also the potential for medication errors to occur due to the length of time between the last administered dose for some medicines and the next medication administration round. These matters have not yet been fully actioned. However currently in some instances nursing staff record the exact administration time of each medicine administered until a new computerised system is implemented which will highlight administration time frames.

Inspectors saw that there were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents. Medicines were supplied to the centre by a retail pharmacy business, with the majority of the medicines dispensed in a monitored dosage system that consisted of individual pouches. All medicines were stored securely within the centre, and fridges were available medicines or prescribed nutritional supplements that required refrigeration, and the temperature of the fridges was monitored.

Controlled (MDA) medicines were stored in secure cabinets, and registers of these medicines were maintained with the stock balances checked and signed by two nurses at the end of each working shift.

The inspectors were satisfied that nurses were knowledgeable regarding residents' individual medication requirements. Nursing staff were observed to safely administer medicines.

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

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

Judgment:
Substantially Compliant

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

Theme:
Effective care and support

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

Findings:
In the main, each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care, however, issues were identified which require to be reviewed and appropriate action taken.

Inspectors saw evidence that in general residents' received appropriate nursing, medical and allied health care, however, it was noted that one resident was not referred to the

physiotherapy services and the resident is currently not mobilising, another resident did not have a clear plan requiring the use of the full hoist and therefore the resident is continually in bed and for a third resident who has been in bed on a long-term basis there was no evidence that other measures had been trialled to enable the resident to have an alternative lifestyle.

While residents did have an individual up-to-date moving and handling assessment this record was not up to date and current in the residents' care plans.

Residents were seen by their general practitioner on a frequent basis and had their medications reviewed every three months.

With the exception of the above issues care plans examined showed, in general, that residents' assessed needs were updated within a four month period. Residents care plans reflected the care recommended by visiting community specialists and any change in care had been provided by staff. However it was noted that the standard of care planning was varied over the units. There was written evidence that residents/relatives were involved in the assessment and care plan review with the exception of an end of life care plan whereby the involvement of the resident was unclear.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
The matter arising from the previous inspection identified that the procedure to make complaints did not make the process easily accessible to residents on each unit/floor. Staff on each unit did not have access to the required documentation to record a complaint made to them. Persons with complaints were sent to the person-in-charge's office to have them addressed but the person in charge was not always available. Hence, minor issues were not being dealt with promptly.

In the written response to the action plan management stated that a system to record compliments/complaints/concerns would be available on each floor/unit so that residents/relatives in each area of the home would have the ability to log satisfaction/concerns immediately without having to seek out a member of the management team. Management would review the record on a weekly basis and follow up on any issues or concerns. This matter was not fully actioned as scrutiny by the

inspectors of this process highlighted that not all staff on each of the individual unit/floors were aware that this process had been set up.

Some relatives who communicated with the inspectors confirmed that they had highlighted to the person in charge (who is the nominated person to deal with complaints) their anxieties regarding the rapid turnover in healthcare assistants and the negative impact that this had particularly on residents who have a diagnosis of dementia. The person in charge explained the reasons for the turnover in staff and the action taken by the company to date to ameliorate the situation.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Staff were seen to be polite and courteous when interacting with the residents and the relationship between the staff and residents was caring. Residents' and relatives who communicated with the inspectors were complimentary of the staff who provided a service. However inspectors observed incidents whereby the dignity and privacy of all residents was not respected by members of the staff group. For example, some staff did not knock on residents' bedroom doors (as outlined in the statement of purpose) and staff members were on a number of occasions observed entering residents' bedrooms to provide care to the residents and did not close the door.

Inspectors found that on the morning of the inspection that all residents did not have a choice with regard to their preferred time for getting up.

There were no restrictions on visitors and inspectors observed many relatives and friends visiting residents' throughout the duration of the inspection. There were a number of rooms and areas where residents could receive visitors in private if they wished to do so.

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

Inspectors found that residents were consulted with about the running of the centre. Residents meetings took place and residents were also consulted via the completion of a questionnaire in relation to the quality of care and services being provided to them. Contact details for the advocacy service were available.

Residents were facilitated to exercise their religious rights. Residents had a choice to attend Mass on a weekly basis in the centre and a number of structured religious prayer meetings were held each day.

There was group and one to one recreational activities scheduled daily to meet the needs of residents. Timetables for these activities were displayed throughout the centre and there was evidence that residents knew what was scheduled. Residents who participated in the group activities were satisfied with the variety of activities available. The activity coordinator maintained a record of those participating.

Activities specific to meeting the needs of residents' with a cognitive impairment were timetabled but were limited in practice. The activity therapist informed the inspectors that a staff member from each of the units/floors is allocated to assist in the provision of activities, however, on examination this was not evident in practice.

An additional cost is highlighted in residents' contracts of care in respect of receipt of appropriate recreational activities to meet their needs and preferences with no opt out clause. Inspectors observed periods whereby residents had no opportunities to participate in activities. In some of the units/floors where activities had taken place on a one-to-one basis with residents these sessions were not consistently recorded with the result the service could not be audited.

During a period following lunchtime the activity programme did not take account of the age, gender and different levels of functioning and ability of residents in a lounge accommodating 12 residents and there were no activities other than a CD playing in the background.

Inspectors who communicated with some highly dependent residents in their bedrooms and their visiting relatives during the period of the inspection confirmed that activities mainly consisted of routine care as opposed to stimulating activities. Some residents expressed the view that the day could be long with not much to do.

Judgment:
Non Compliant - Moderate

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

Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The matter arising from the previous inspection highlighted that there were not enough staff in place to ensure the delivery of quality care services to the 150 residents for whom the centre is registered. This matter is still outstanding. The provider's written response to the action plan was that induction and training of additional staff in preparation for the opening of the additional beds (23) is ongoing and admission of residents would be on a phased basis.

On the day of the inspection the majority of residents were assessed and having maximum to high dependency (96 out of 137 residents).

The levels of nursing staff on duty met the requirements of the legislation. Since the last inspection two team leader roles have been filled.

From an examination of the staff duty rota, communication with residents and relatives, management and staff the inspectors obtained the following information which highlighted that the service provided was not safe, appropriate, consistent and effectively monitored as identified in outcomes to 2:
• In the main, management requested from the recruitment agency staff who were familiar with working in the centre, however, inspectors spoke with a number of health care staff who were not familiar with residents' routines and preferences primarily because it was the first time that the health care staff had been assigned to the particular unit/floor.
• The inspectors observed a staff member assisting a resident to have a meal but on 2 occasions left the resident to attend to other residents but did not assign another staff member to assist this resident. On the 3rd occasion when the staff member had to leave the resident another staff member took over these duties. Throughout this time the resident's meal was left at a place setting on the dining table and at no time was it probed for heat.
• Some residents' call bells were not answered promptly and some call bells were then not turned off when staff had assisted residents.
• A relative expressed a view to the inspector that it was worrying to see so many new health care staff move through the dementia unit/floor, as it is confusing for residents.
On the day of the inspection the health care team in this unit consisted of 4 agency staff (the first day for one staff member and the 3rd day for another staff member), a pre-registration nurse who normally works in other parts of the centre, two newly appointed full-time staff and a full time long term staff member.
• Two activity therapists were on the roster however the person in charge informed the inspectors that currently there is only one staff member whose full time role is to provide activities.

• There was insufficient numbers of trained health care staff to support an activity programme that is suitable for all residents.

Supervisory arrangements in the centre highlighted that clinical nurse managers are supervised and supported by the person in charge and deputy managers. Nurses are supervised by the senior management team and they and the two team leaders support the health care assistants.

Inspectors were informed that agency staff are generally mentored by the full-time staff, however, on one unit/floor there was only one full-time long-term health care staff member, a staff nurse and clinical nurse manager in the team. As all staff were involved in providing care to residents there was insufficient time available to mentor/supervise new staff. The staff rosters did not indicate supernumerary time for the clinical nurse manager to formally supervise staff.

The skill mix of care staff necessitated management and senior nursing staff to be involved in the direct delivery of services to residents. While this is beneficial it depleted the time for supervisory arrangements to develop staff.

Staff appraisals identified during the previous inspection had not yet been fully actioned.

The inspectors were informed that following the recruitment drive new staff members will commence induction over a three-week period. All staff will be trained in-house as the company has a trainer facilitator and this would be supplemented by external trainers particularly in relation to mandatory training. Following a start date a period of induction will be completed and new staff members will be supervised and supernumerary for a two-week period.

Overall there was good evidence of staff having participated in training and records were well maintained, however, all staff were not up to date on training in accordance with their role and responsibility, for example, dementia and behaviours associated with dementia. Some staff had received specialised training such as wound care, diabetes care, venepuncture and continence care.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Beneavin House
Centre ID:	OSV-0000694
Date of inspection:	10/11/2017
Date of response:	16/01/2018

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The delivery of services was not provided as described in the statement of purpose.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take:
The statement of purpose has been updated to reflect information contained in Schedule 1. A copy of same has been provided with this action plan reply.

Proposed Timescale: 31/01/2018

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Management systems were not in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored as the following matters were identified:

-Staff did not have the required skills and competencies to respond to the needs of residents and this led to poor outcomes for residents.
-The vacant position of operations manager has not yet been filled.
- In respect respect of medication errors the documentation did not clearly set out the action plan which would bring about improvement and confirmation that it had been implemented.
-Recruitment is in progress for a clinical nurse manager however at the time of inspection the position had not been filled.

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

Please state the actions you have taken or are planning to take:
Post inspection nine new healthcare assistants who were interviewed prior to the inspection, commenced in-house induction on November 26th, 2017. Once induction is completed these staff will have a further two weeks supernumerary on the floor to support them in their new role. This group of staff will be actively working on the floor in Beneavin House on week beginning December 25th, 2017. There were a number of agency staff working in Beneavin House during inspection. Beneavin House's policy is to use agency staff that are very familiar with our residents, and the policies and procedures of FirstCare.

A further 10 staff have been interviewed with offers made and compliance paperwork in progress. This group of staff will commence induction on January 2nd and will be actively working on the floor in Beneavin House on January 30th, 2018.

Training, both mandatory and additional, is ongoing in the home. A copy of the Training Schedule has been enclosed with this response to indicate the level of ongoing training

within the home, and the support give to staff in this respect.

Informal training and supervision takes place on the floor with both Health Care Assistants and Nursing Staff, through the Team Leaders and Senior Management presence on the floors. The Deputy Home Managers are solely responsible for the daily supervision of Nursing Staff in liaison with the Clinical Nurse Managers. Regular Health Care Assistant and Nurse meetings take place on the floors to ensure communication and learning.

Further interviews took place on November 30th and similarly on December 5th.

The Operations Manager Role is being advertised internally and externally, and the FirstCare Senior Management Team are committed to filling this position.

The medication audit assessment tool has been reviewed and the area pertaining to learning lessons, action plans and outcomes, has been updated to ensure appropriate information is captured, reflecting oversight and accountability for all learning and action plans.

Recruitment remains ongoing within Beneavin House for Clinical Nurse Managers with interviews scheduled for December 19th. Interviews took place on November 30th but were unsuccessful.

Proposed Timescale: 31/01/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Records in respect of the administration of medicines did not in all instances reflect the time of administration.

3. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
As per our last action plan a computerised medication management system is due for installation in Beneavin House. This system has been trialled in a sister Nursing Home and will be implemented in Beneavin House in February and March 2018.

In the interim all staff nurses have been requested to record the administration time of all medications on the MARs sheet to ensure safety in the practices of medication administration.

Proposed Timescale: 31/03/2018

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The duty roster of persons working at the centre did not reflect the actual staff who were working.

4. Action Required:
Under Regulation 21(4) you are required to: Retain the records set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4 for a period of not less than 4 years from the date of their making.

Please state the actions you have taken or are planning to take:
The roster has now been redesigned to reflect both regular staff and agency staff on each floor as opposed to two separate rosters for each. This clearly identifies all staff working on any day and is legible and clear for all.

Proposed Timescale: 01/12/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received training in managing responsive behaviours .

5. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Responsive behaviour training (Challenging Behaviour training and MAPA Training) has been scheduled for: 18th and 19th January 2018 for MAPA and 30th for Challenging Behaviours. Further MAPA training has been scheduled for 10th to 12th January, and 7th to 9th February.

All newly recruited staff receive this training at induction and prior to commencement of employment on the floors.

Proposed Timescale: 30/01/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An examination of the training records showed that not all staff had up-to-date training in safe guarding. This included staff who required initial and annual refresher training.

6. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
Elder abuse training has taken place in Beneavin House on 22nd November 2017. All staff within the home are now fully trained. All inexperienced staff receive elder abuse training during induction and prior to commencement of employment on the floors with additional training on 27th, 28th, 29th and 30th November with further training scheduled for 1st February 2018.

Proposed Timescale: 01/02/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no hazard identification and assessment of risks associated with staff on duty taking telephone calls regarding the day-to-day operations of the centre while providing services directly to residents, for example, this occurred constantly during the administration of medicines and while assisting a resident to have a meal.

Although training records reviewed showed that all staff had up-to-date training in moving and handling but practices observed were not in line with best practice.

7. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Staff nurses are no longer permitted to carry the telephone during medication rounds and mealtimes. All calls are screened, answered and managed at reception during these times. The Home Manager and Deputy Home Manager(s) on duty will take any emergency calls and speak with GPs etc if required during these times. Where calls are not a priority the nurse on duty will call back once medication rounds are over.

The Home Manager and Deputy Home Manager are currently auditing practices within the home in relation to Manual Handling. Refresher training is scheduled on December 4th and January 16th, 27th and February 1st, 2018 in the home. Manual Handling and appropriate practices are discussed at handover, during appraisals and probationary meetings. Where staff are observed to be engaging in inappropriate lifting and handling techniques they will be advised of the appropriate techniques and requested to complete refresher training as a matter of urgency.

All new staff are teamed with experienced Carers and Nurses to ensure only appropriate manual handling techniques are put into practice by new staff members following induction, and hoists other resident handling equipment are used as learnt at induction.

Proposed Timescale: 01/02/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An examination of the training records showed that the majority of staff had participated in fire safety training, however, 5 new staff members had not received this training but it was scheduled to take place on the 21 November 2017.

8. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable 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.

Please state the actions you have taken or are planning to take:
Fire training has taken place in Beneavin House on November 21st with further refresher training taking place for existing staff on December 18th, 2017. Training is also scheduled for 9th January 1st, 15th and 28th February 2018.

Proposed Timescale: 28/02/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place for evacuating residents in the event of a fire/emergency as some staff in the individual units did not know the number of residents being accommodated.

9. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
Additional refresher training due to take place on December 18th in the Nursing Home. All staff have been reminded of the fire evacuation procedures with training drills due to be held in-house on November 30th, December 5th, 13th and 20th.

Fire safety and evacuation is discussed at morning and evening handover and the Fire Policies are also discussed with staff at these times.

Proposed Timescale: 20/12/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds.

There was also the potential for medication errors to occur due to the length of time between the last administered dose for some medicines and the next medication administration round.

10. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Staff have been requested to record the administration time of all medications on the MARs sheet to ensure safe practices during administration. Records of the times of administration will allow nurses to make informed decisions regarding the administration of medication and will also give clarity of the timeframes between doses being received.

Proposed Timescale: 29/11/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
In respect of a resident who has been in bed on a long-term basis there was no evidence that other measures had been trialled to enable the resident to have an alternative lifestyle.

While residents did have an individual up-to-date moving and handling assessment this record was not up to date and current in the residents' care plans.

11. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
All residents are assessed by GP and OT pertaining to seating. In some instances, a decision was made that it was unsafe for some residents to be seated in a specialised chair due to advanced symptoms of dementia. The PIC is now actively seeking an alternative solution for any resident in this situation, in conjunction with the occupational therapist.

Proposed Timescale: 30/12/2017

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident did not have a clear plan requiring the use of the full hoist and therefore the resident is continually in bed.

12. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
All residents within Beneavin House are reviewed by the Occupational Therapist when an assessment is warranted following a deterioration in their health and/or mobility, and/or Clinical assessment by the GP and Nursing Staff within the home. Some residents can decline to be hoisted from their bed, despite ongoing encouragement from our management team, and the resident's family. In this instance Beneavin House will trial as many different hoists and other mobility aids as possible for any given resident. In some instances, no alternative suggested has been accepted by the resident. Each residents' family are involved on an ongoing basis. Beneavin House has determined that the rights of the resident are paramount, and recognise our continued commitment to ensure we meet the residents' needs, whilst upholding the residents' wishes and choice.

Going forward all interactions with any resident and their family, in the Management Teams' ongoing attempts and consultation, in relation to the use of any alternatives available will be documented.

Proposed Timescale: 16/01/2018

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The involvement of a resident in end of life care planning was unclear.

13. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
The Home Manager has spoken in length with the GPs to ensure that all discussions around end of life care, wishes and preferences including NFR decisions, are clearly documented.

All residents with an active NFR in place has been reviewed and the discussion around this decision documented and recorded to show involvement of the resident and/or family.

Careplans documenting any end of life care, wishes and preferences are also being reviewed to ensure all records clearly reflect the residents known wishes.

Proposed Timescale: 15/12/2017

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident was not referred to the physiotherapy services and the resident is currently not mobilising.

14. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
A physiotherapist is sought to review any resident requiring additional support/treatment within Beneavin House. Where a residents' deteriorating health has compromised their mobility, a reassessment will take place. The resident identified in the report was reviewed by the OT in November 2017. The OT advised that due to the resident being unable to weight bear on the right leg, the resident may now require an intermittent sit to stand hoist. This hoist is now in place and in use.

Proposed Timescale: 30/12/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was not accessible to residents and staff in the units were not familiar with the new system management had put in place.

15. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The complaints procedure is available to all residents in the Residents Handbook and is clearly displayed in the Nursing Home.

Existing staff will receive training on the complaints procedure within the home. All newly recruited staff receive complaints management training at induction.

Complaints refresher training is to be conducted with all existing staff on December 19th, 2017 and January 10th, 2018.

Proposed Timescale: 10/01/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
All residents did not have opportunities to participate in activities in accordance with their interests and capacities.

16. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
A complete review will take place of the activity provision in the home which will include residents and families input. Any suggestions noted will be implemented where possible.

Beneavin House are currently recruiting two activity personnel within the Home. Interviews are due to take place the week beginning 11th December, 2017.

Proposed Timescale: 31/01/2018

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
On the morning of the inspection all residents did not have a choice with regard to their preferred time for getting up.

17. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
The Home Manager has spoken in length with all staff to ensure they are fully aware of the rights and choices of residents. Clinical staff are fully aware of the right to choice, and where failings occur we are always willing to address same. Residents right to either remain in bed or get up should always be upheld and respected.

The Management Team in Beneavin House will continue to audit resident's right to choice in this area.

Proposed Timescale: 31/01/2018

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
-There were not enough staff in place to ensure the delivery of quality care services to the 150 residents for whom the centre is registered.
-The vacant activity therapist posts has not yet been filled.
-There was insufficient numbers of trained health care assistants to support an activity

programme that is suitable for all residents.

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

Please state the actions you have taken or are planning to take:
Recruitment is ongoing in Beneavin House. Nine new healthcare assistants which were interviewed prior to the inspection commenced in house on induction on November 26th, 2017. Once induction is completed these staff will have a further two weeks supernumerary on the floor to support them in their new role. This group of staff will be actively working on the floor in Beneavin House on week beginning December 25th, 2017.

A further 10 staff have been interviewed with offers made and compliance paperwork in progress. This group of staff will commence induction on January 2nd and will be actively working on the floor in Beneavin House on January 30th, 2018.

Interviews for the activity therapist post are due on week beginning December 11th, 2017.

Recruitment in Ireland is ongoing weekly through recruitment agencies, on line portals, and our own website. Senior Management are also travelling to a number of European countries in January 2018 to recruit new staff.

Rosters are managed by the Home Manager and Deputy Home Managers to ensure staff are evenly distributed throughout the home to provide good quality care, whilst also ensuring junior and new staff are supported and guided by experienced staff.

Proposed Timescale: 28/02/2018

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not up to date on training in accordance with their role and responsibility with regard to dementia and behaviours associated with dementia.

19. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Dementia training has been scheduled for January and February 2018 for all existing staff. All newly recruited staff receive Dementia Training at induction.

Proposed Timescale: 28/02/2018

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

The written formal appraisal system had not been implemented for all staff.

20. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
All staff within the Nursing Home have had either a formal appraisal or were on probation and receiving their required probationary meetings and support.

Those staff yet to receive their annual appraisal will have same completed prior to years end. A review will take place of all staff files to ensure they have received appropriate supervision, and same is documented.

Moving forward into 2018, a planned formal supervision schedule will be compiled to ensure all staff receive ongoing formal supervision and support, and that all need areas are documented and addressed, as well as strengths.

Proposed Timescale: 28/02/2018