

# eDeposit Ireland

## **Beneavin Lodge Nursing Home, OSV-0000117, 17 November 2017**

Item Type	report
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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Beneavin Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000117
<b>Centre address:</b>	Beneavin Road, Glasnevin, Dublin 11.
<b>Telephone number:</b>	01 864 8577
<b>Email address:</b>	evelinesheeran@firstcare.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Beneavin Lodge Limited
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	Siobhan Kennedy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	85
<b>Number of vacancies on the date of inspection:</b>	17

## 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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 17 November 2017 08:15 To: 17 November 2017 18:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

An announced inspection of the centre took place on 8 February 2017 in response to the provider submitting an application to vary condition 7 of the certificate of registration to increase resident capacity from 68 to 118. As a result of that inspection and documented in the inspection report of 8 February 2017 registration was granted to accommodate a maximum of 102 residents.

This inspection took place following a request by the provider seeking approval to have the designated centre registered to accommodate a further 16 residents (on a designated floor) and to increase the total capacity of occupants to 118.

On the day of the inspection 84 residents were being accommodated in the centre with one resident in hospital and 17 vacancies.

Prior to the inspection the provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA). The inspectors reviewed this documentation, ascertained the views of residents, relatives, and staff members, observed practices and reviewed records as required by the legislation.

Inspectors found that staff involved in the management of the centre were knowledgeable of the legislation and standards governing the provision of care in the

nursing home. Staff of various grades were aware of the organisational structure of the centre and were aware of the ethos and principles underpinning the provision of nursing and social care in the designated centre. However, the person in charge had not been fully involved in the recruitment process for relevant staff and assessment of prospective residents. Residents had not been admitted in accordance with the schedule previously agreed with HIQA.

While there was a defined management structure that identified the reporting structure within the organization, the lines of authority and accountability for assessment, medicine management practices required improvement, and vacant positions that included an assistant director of nursing position, two clinical nurse managers remained outstanding from the previous inspection. Vacancies in activity staff existed since the previous inspection.

While an active recruitment process was in place, at the time of this inspection there were insufficient staff to increase resident capacity or to accommodate a further 16 residents in a particular unit/floor of the designated centre. It was agreed that when this is satisfactorily finalised and failings found were addressed the application to vary the registration conditions will progress.

Residents had good access to nursing, medical and allied health care. Residents' assessed needs and arrangements to meet these assessed needs were in the main set out in individual plans.

There were measures in place to protect residents from being harmed or suffering abuse, however, there was over use of chemical restraint for residents' following their admission to the centre and or transition to units.

Inspectors found that the premises was designed and laid out to meet the needs of the residents with some improvements required. The provisions in place relating to health and safety and risk management were satisfactory.

Residents and relatives were positive in their feedback and expressed satisfaction about the facilities and the services and care provided. They were complimentary about residents' care and the support provided by staff and management.

The findings are discussed within the body of this report and improvements required are set out in the action plan at the end for response.

**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):**

No actions were required from the previous inspection.

**Findings:**

The statement of purpose was reviewed by inspectors. It detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the regulations.

However, improvements were required in relation to the following matters:

1. The total staffing complement, in whole time equivalents, for the designated centre. The management and nursing complements were not in accordance with the statement of purpose attached as a condition to the existing registration. The staff numbers specified were inadequate for the registered number of residents. This was described by management as an administrative error that needed to be corrected
2. The arrangements made for dealing with complaints did not sufficiently detail those involved in the management and processing of complaints at each stage.

The provider nominee and person in charge were informed of the areas in need of review and understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function 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:**

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The inspectors found that there was a clearly defined management structure that identifies the lines of authority and accountability, specified roles and details responsibilities for the areas of care provision. This was outlined in the statement of purpose, and staff were familiar with their responsibility to report to line management.

There was no change to the person in charge from the previous inspection 8 February 2017 granting an increase in resident occupancy from 68 to 102. Some decreases in numbers of persons participating in the governance of the centre were noted such as the departure of a company director and operations manager.

Vacant management posts at the time of the last inspection February 2017 that included a deputy to the person in charge (assistant home manager) and two clinical nurse managers remained unconfirmed and vacant. Inspectors were informed that interviews had been completed for the deputy home manager and CNM posts, and those shortlisted were to have a second round interview that was planned for 23 November 2017. Recruitment and induction procedures described and outlined by operational management aimed to have all vacant posts filled by the end of February 2018. However, the person in charge had not been fully involved in the recruitment process.

The recruitment of nurses and carers was also on-going with up to eight pre-registered nurses rostered and working as carers currently. The transition from a carer to a nurse would consequently deplete the number of existing care attendants. Eleven care attendants had been recruited internationally, three had commenced and others were to commence on receipt and completion of schedule 2 documents and a minimum of six days induction.

The turnover of staff since the previous inspection had also resulted in two vacancies within the dedicated activity staff that was also in need of recruitment and replacement. As a result of the staff vacancies across many disciplines, the designated centre did not have sufficient resources to increase resident numbers following an application made in September 2017 to vary the condition and to increase occupancy from 102 to 118. Furthermore, residents had not been admitted in accordance with the schedule agreed with HIQA in relation to the existing registration for 102 residents.

On review of the directory of residents inspectors noted that five residents had been admitted within two days on the week previous. At the time of granting the current registration assurances were given by the provider to the Health Information and Quality Authority (HIQA) that the admission of residents would be limited to a maximum of three per week. Additionally, on review of the pre-admission assessment, inspectors noted and confirmed with staff that the responsibility for pre-admission assessments was assigned to the group's bed manager and not the person in charge. The governance and management of resident admissions required improvement to ensure

they were safely co-ordinated and managed appropriately to include and demonstrate assessment by the person in charge. Gaps were found in resident pre-admission assessment, transition and admission procedure and process.

Inspectors concluded that improvement was required in relation to the admission process and centre's admission policy to ensure the lines of authority and accountability, specifies roles, and detail of responsibilities for admissions and all areas of care provision were clearly defined. Improvement was required to ensure the person in charge had sufficient oversight and was fully engaged in the admission procedures and management arrangements to ensure practices were safe, appropriate, consistent and effectively monitored. Other examples to demonstrate this are discussed in outcomes 7 and 9.

Inspectors informed the management team that an increase in registered numbers could not be recommended until sufficient resources were available and in place to ensure the safe and effective delivery of care. On the day of inspection resident occupancy was at 85 and the ability to increase occupancy within the existing units and within registered numbers was possible but dependant on resource availability.

Management had systems in place to capture statistical information in order to compile an annual review of the quality and safety of care delivered to residents. For example audits were carried out and analysed in relation to accidents, complaints and skin care. A quality of care report was made available to the inspectors. Audits completed informed governance, management and health and safety meetings attended by senior managers and staff involved in operational developments and resident outcomes. Some improvement was required in relation to the analysis of some audit findings and practices found.

An annual review of the quality and safety of care delivered in 2016 to residents in the designated centre was completed in accordance with relevant standards to form a quality improvement plan for 2017. Areas identified for improvement included extending resident occupancy, improving environmental features, staff training and induction of new recruits. There was evidence of consultation with residents and their representatives in a range of areas, for example, the assessed needs of residents, the care planning the review process, and meals provided. The views were captured in the centre's annual report.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

Measures were in place to protect residents from being harmed or suffering abuse.

There was a policy which provided guidance for staff to manage incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences. The person in charge demonstrated her knowledge of the policy and was aware of the necessary referrals to external agencies.

The training records identified that staff had opportunities to participate in training in the protection of residents from abuse. Staff were knowledgeable regarding reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse.

Inspectors saw that a number of measures had been taken to ensure that residents were safe including staffing of the reception area and a key coded entry and exit system to each unit. At the same time residents had opportunities for maintaining their independence and communal areas were accessible to residents. Inspectors saw that there were facilities in place to assist residents to be mobile for example hand and grab rails in all areas.

During interviews with the inspectors residents confirmed that they felt safe in the centre due to the measures taken and relatives confirmed that they were satisfied that residents were protected from harm and were safe in the designated centre.

A policy reflecting the national guidance document was available to guide restraint usage. A restraint register was maintained that was subject to a monthly audit by the person in charge. The usage of bedrails had reduced with 20% of residents using bedrails. Risk assessments and records of decisions regarding the use of bedrails were maintained and staff demonstrated that various alternative equipment such as, low beds, bumpers/wedges, sensory alarms and floor mats were available.

Some residents displayed behaviours that challenged them or those responding to them. Inspectors found that staff did not have sufficient skills to respond to and manage behaviour that was challenging and had not demonstrated the use of chemical restraint as a last resort. The person in charge and staff spoken with described interventions used to respond to individual residents' behaviour that may challenge that included the use of p.r.n. medicines (a medicine only taken as the need arises). On review of the medicine prescription kardexs and administration records it was evident that the use of p.r.n. psychotropic medicines was used on a regular and p.r.n. basis to modify some residents' moods and to manage behaviour that was deemed to be challenging. However, a behaviour log to describe the behaviour did not form part of the nursing assessment and care plan process. As a result the rationale and effect of p.r.n. medicines in association with changes in behaviour could not be adequately analysed for possible trends and to inform reviews undertaken by the GP, geriatrician or psychiatric team.

This finding did not demonstrate that staff had sufficient skills to respond to and manage 30% of residents who were reported to have responsive behaviours.

Based on the inspectors' findings, a comprehensive review of practices and procedures regarding chemical restraint or the use of PRN (medicines only taken as the need arises) was required in accordance with best practice and to ensure and demonstrate that p.r.n psychotropic medicines were only used as a last resort. Medicine management practices found are discussed in outcome 9.

**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):**

No actions were required from the previous inspection.

**Findings:**

The risk management policy was in accordance with the regulations. There was a comprehensive risk register which identified the risks and put controls in place either to minimise or fully control the risk.

There was an up to date health and safety statement and related policies and procedures. Information was available regarding identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Inspectors reviewed the emergency plan and found it to be sufficient to guide staff and management in their roles and duties in the event of an emergency evacuation, major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Arrangements were in place in the event of an emergency evacuation whereby residents and staff would be unable to return to the designated centre.

There was a clear personal emergency evacuation plan (PEEP) for each resident that identified the resident's cognitive and mobility levels and requirements for assistance in the event of an emergency evacuation. This was on display inside residents' wardrobes in their bedrooms.

Regular checks/tests were carried out on fire fighting equipment, emergency lighting and fire drills were conducted and records were maintained. Staff working in the centre had received fire safety training and was able to explain the procedures.

Inspectors were informed that any furniture brought into the centre by the resident had

been treated with a flame retardant spray.

Fire doors were fitted with electronic or magnetic hold open devices which would close in the event of an emergency situation.

Emergency exits and fire assembly points were clearly indicated.

Infection control precautions within the centre were satisfactory. The centre was clean and household staff were able to describe the infection-control procedures in place.

**Judgment:**

Compliant

***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):**

No actions were required from the previous inspection.

**Findings:**

Policies were in place to guide medicine management practices in line with professional standards.

Processes were in place for the handling, safe storage and checks of controlled drugs in accordance with current guidelines and legislation. However, improvements were required to ensure residents were protected by safe medicine management procedures and practices.

The medicine management and prescription arrangements for newly admitted residents were determined by the receipt of a copy of a medical/hospital prescription in advance of a planned admission and the information contained within a pre-admission assessment record completed by the Groups 'bed-manager'. These records had informed the transcription of medicines by nurses onto the prescription kardexs that was subsequently reviewed and signed/completed by the GP following each resident's admission. However, from a review of a sample of residents' prescription and administration records, inspectors found the following unsafe practices that compromised residents' safety and wellbeing:

- The pre-admission nursing assessment influenced the transcribed prescription more than the doctors/medical prescription and discharge letter
- Residents were prescribed up to eight p.r.n medicines that included psychotropic medicines which were not included in the medical prescription received in advance or on admission with the resident
- A nursing assessment that included details of medicines previously taken had incorrectly influenced the transcription, prescription and administration of medicines that

were no longer prescribed on transfer of the resident to the centre due to a history and recent diagnosis of polypharmacy

- Medicine administration records showed that a resident that was prescribed regular and p.r.n. psychotropic medicines had inappropriately received both the regular and p.r.n dose at the same time
- The rationale, alternative tried prior to the administration of p.r.n. psychotropic medicines and effect following administration was not sufficiently recorded as referenced in outcome 7
- Antibiotic medicine was administered for over two days from a faxed prescription

Management and nursing staff were requested to undertake a comprehensive audit and review of medicine management practices and protocols to bring about improvements in line with professional standards and national guidance.

An audit system was in place to improve the overall management and review of medicines, however, an analysis of the data and findings was required.

**Judgment:**

Non Compliant - Moderate

***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:**

The centre provides care primarily for residents with long-term nursing needs and residents with dementia.

Relatives confirmed that staff informed them of their relatives' health care needs and any changes in the conditions.

From an examination of a sample of residents' care plans, discussions with residents, relatives and staff, inspectors were satisfied that the nursing and medical care needs of residents were assessed and appropriate interventions/treatment plans implemented. For example, there was information which detailed residents' choices with regard to daily routines, risk assessments such as dependency, moving and handling, falls, use of bed rails, nutrition and continence. The care plans were up-to-date and had been audited.

There were arrangements in place to manage and monitor wounds. The nursing team were aware that wound prevention and treatment was multi-factorial and the inspectors saw specific person-centred care plans and regular reviews. Wound assessment charts were in place and provided a clinical picture for comparative purposes to monitor whether the wound was progressing or regressing. There was a policy of photographing wounds and this was practiced by the staff. There was documentary evidence that residents were reviewed by tissue viability specialist services. Repositioning charts and monitoring charts for fluid and nutritional intake were available. Aids such as pressure relieving mattresses and specialist cushions were in place for those residents at risk of developing pressure ulcers. Evidence was available that these were serviced annually and there was a procedure in place to regularly check the correct functioning of these aids and to ensure settings were correctly set. Pain assessment charts were in place and evidence was recorded in the narrative notes of residents' care plans that prescribed analgesia was administered to promote comfort if the assessment recommended this, prior to completing a dressing of a pressure ulcer.

There was evidence of appropriate medical and allied health care for example, referrals to the dietician, occupational and physio therapists and speech and language therapists.

There were systems and practices operating regarding physical restraint and where restraint was used for example, the use of bedrails and personal alarms to keep residents safe. The documentation showed consultation with the resident or the resident's relative, the general practitioner and the nurse in charge. Reviews of restraint measures were evident and records were maintained, for example the times when lap belts were released. Improvements required in relation to the assessment and care planning for residents with responsive behaviours is outlined in outcome 7.

**Judgment:**

Compliant

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

The premises takes account of the residents' needs and was in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. The premises consisted of three floors which have been described in detail within previous inspection reports.

The location, design and layout of the centre were suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely manner. The premises was suitably and tastefully decorated throughout and benefited from good natural and artificial lighting, and contrasting colours. A view outdoors was available from bed and communal rooms occupied by residents.

As previously reported rooms were well equipped, spacious and decorated to a high standard with colourfully co-ordinated furnishings and fittings. The centre was well maintained, and refurbishment of older parts of the centre had been completed. The centre was laid out over three floors, with passenger lifts and stairwells between all floors. The ground floor included the main entrance and foyer; dining, day and activity rooms and staff offices. Residents' bedroom accommodation was laid out within self-contained units on each floor that has been previously described in inspection reports.

The purpose of this inspection was to inspect the second floor accommodation (Ferndale) that had capacity for 16 residents in single bedrooms that had full en-suite facilities which had not been previously registered to open/operate due to a shortage in staffing. While the premises was suitably equipped and furnished to an excellent standard, the provision of staffing resources was not available to extend into or operate Ferndale at this time.

During the course of the inspection inspectors noted that while the premises had many excellent features and advantages, it also had some design and operational matters that required review and improvement as follows:

1. The noise levels from the sensor alarm mats was heard constantly and alarms were seen in use by up to or over 50% of residents in units. The noise levels were extremely irritating, loud and distracting. However, staff working within units had not noticed, responded to or silenced the alarms that were heard constantly going. One alarm rang for over 20 minutes and when the inspector highlighted this to the staff member they confirmed that the resident was not within the bedroom where the alarm device was linked to. On examination of the alarm device it was signalling 'out of range'. The use, purpose and management of alarms required immediate attention
2. The volume of the public tannoid/announcement system was also very loud
3. Periodically the noise levels increased in the communal day/dining room from routine kitchen activities which was unnecessarily created by staff clearing away cutlery and plates after meals
4. Music playing on T.V screens was inappropriate and detracted from the intended ambience
5. A repeated news channel remained on the TV of one unit for the duration of the inspection
6. The location of nurse's station within residents communal day/dining rooms required review to ensure residents privacy was maintained and sensitive information was not

overheard during telephone or face to face conversations or seen on the laptop in use by staff.

**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):**

No actions were required from the previous inspection.

**Findings:**

From an examination of the staff duty rota, communication with residents and staff the inspectors found that the levels and skill mix of staff at the time of inspection were in the main, sufficient to meet the needs of residents currently being accommodated with the exception of a vacant activity post which is included in the action plan of outcome 2. However, there were insufficient staff to accommodate a further 16 residents in a particular unit/floor of the designated centre which is also included in the action plan of outcome 2.

An active recruitment process was in place.

Inspectors observed staff working with residents being patient and provided care in a respectful manner.

Inspectors were satisfied with the arrangements for supervision and development of staff which included induction, probationary period and an annual appraisal system.

Systems were in place for vetting, supervising and establishing the level of involvement for volunteers and persons on work experience in the centre.

A sample of documents held in respect of staff working in the centre were examined and found to be satisfactorily maintained.

**Judgment:**

Compliant

## 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:***

Sonia McCague  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Beneavin Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000117
<b>Date of inspection:</b>	17/11/2017
<b>Date of response:</b>	17/12/2017

### 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 statement of purpose did not include the following matters:

1. The total staffing complement, in whole time equivalents, for the designated centre. The management and nursing complements were not in accordance with the statement of purpose attached as a condition to the existing registration. The staff numbers specified were inadequate for the registered number of residents. This was described

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

my management as an administrative error that needed to be corrected

2. The arrangements made for dealing with complaints did not sufficiently detail those involved in the management and processing of complaints at each stage.

**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.

**Please state the actions you have taken or are planning to take:**

The Statement of Purpose was reviewed and the information set out in Schedule 1 revised to ensure it reflected both the staffing and complaints procedure in the centre. A copy of the amended Statement of Purpose was attached to the action plan to demonstrate this.

**Proposed Timescale:** 27/11/2017

**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:**

Vacant management posts at the time of the last inspection February 2017 that included a deputy to the person in charge (assistant home manager) and two clinical nurse managers remained unconfirmed and vacant.

The turnover of staff since the previous inspection had resulted in two vacancies within the dedicated activity staff that were to be recruited and replaced.

The person in charge had not been fully involved in staff recruitment or the pre-admission assessment of residents which was attributed to time/resource constraints.

An increase in registered numbers could not be recommended until sufficient resources were available and in place to ensure the safe and effective delivery of care.

On the day of inspection resident occupancy was at 85 and the ability to increase occupancy within the existing/registered units and numbers was dependant on extending the staffing resources.

**2. Action Required:**

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**

Staffing within the Nursing Home is assessed and reviewed by the Home Manager and Operations Team on a continuous and ongoing basis. Strategies and contingency plans are in place in relation to recruitment and retention of staff.

Post inspection interviews took place and the following staff were recruited:

1 x Activity Personnel due to commence 2nd January 2017  
1 x Clinical Nurse Manager due to have second interview this week  
1 x Deputy Home Manager position offered and accepted and compliance paperwork being compiled, expecting commencement on the 2nd January 2018.

The two remaining Clinical Nurse Manager position has been filled internally with both parties commencing their new roles on January 2nd, 2018.

Appropriate NF's will be forwarded to HIQA Registration for both the DHM and CNM, in the coming weeks.

**Proposed Timescale:** 30/01/2018

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Residents had not been admitted in accordance with the schedule agreed with HIQA in relation to the existing registration for increasing to 102 residents. Five residents were admitted within two days despite assurances given by the provider to the limit admissions to a maximum of three per week.

The pre-admission assessment, responsibility, governance and management required improvement to ensure practices were safe, appropriate, consistent and effectively monitored with the involvement of the person in charge as the accountable person for comprehensive assessments.

Improvement was required in relation to the admission process and centre's admission policy to ensure the lines of authority and accountability, specifies roles, and detail of responsibilities for admissions and all areas of care provision were clearly defined.

The person in charge did not have sufficient oversight and full engagement in the admission procedures and management arrangements.

Some improvement was required in relation to the analysis of medicine management audits and practices.

**3. 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:**

FirstCare have in place a dedicated Clinical Bed Manager (with a Nursing background) to assist and support the Home Manager with all pre-assessments, admissions and documentation pertaining to same.

The pre-admission policy and documentation has been reviewed. The admission policy was also reviewed with additional measures and guidelines put in place to ensure appropriate communication and safety around decisions to admit, admission procedures, and recording of information.

Procedures relating to the management of medication for a new admission have been reviewed with very clear guidelines noted for staff for all new residents in relation to the receipt of a prescription, the ordering of medication, and the transcribing of new medications.

A copy of the admission policy accompanies this action plan.

Medication Management Audit and practices:

- Transcribing of Kardex will only be completed based on hospital prescriptions, and as per the Admission Policy.
- The CNM responsible for the admission of the new resident, is to review the Kardex prior to it being sent to the pharmacy.

The Five residents were admitted to Beneavin Lodge in one week. Four of these were residents from another FirstCare Nursing Home with complete oversight by both Home Managers and absolute concern for the greater good of all residents involved. The admission of these four residents was not viewed as a breach of the commitment given to HIQA to admit a maximum of three residents per week as they were already residing within a FirstCare Home, were well known to staff and careplans were already in place.

The moves were conducted in such a manner to ensure consistency of care, familiar faces and surroundings for all residents involved. Both moves were pre-planned which also involved regular staff moving with the residents to ensure consistency. The moves were communicated to all families in advance with appropriate viewing times of the new more suitable environment. All moves were agreed by families involved and supported by the GP.

The rationale for the four admissions took great consideration into the needs of the residents involved and was conducted in this manner to mitigate the impact the move would have had if those four residents had been parted for a period of time. Given their diagnosis it was felt a breach to the agreed admission numbers was necessary as it was felt by all staff that prolonged staggered admissions would increase anxiety and cause undue stress to each of the residents involved.

The fifth resident admitted was admitted from hospital and was also a planned admission to a separate floor from the four residents moved from a FirstCare Home. All admissions had a dedicated nurse for admission.

Prior to and post inspection the agreed three admissions has been adhered to in Beneavin Lodge.

**Proposed Timescale:** 30/11/2017

## **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:**

Staff did not demonstrate they had sufficient skills to respond to and manage behaviour that was challenging and had not demonstrated the use of chemical restraint was as a last resort.

The use of p.r.n psychotropic medicines was used on a regular and p.r.n. basis to modify some residents' moods and to manage behaviour that was deemed to be challenging. However, a record or log to describe the behaviours did not form part of the nursing assessment and care plan process seen.

The rationale for administering psychotropic medicines and effect of using regular and or p.r.n medicines was not sufficiently recorded and the information available was inadequate to inform a review by the GP, geriatrician or psychiatric team.

### **4. 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:**

Beneavin Lodge in conjunction with the Training Co-Ordinator has systems and protocols in place to manage the training matrix. All staff in Beneavin Lodge are fully up to date on mandatory training and all staff have access to appropriate training.

The Training Co-ordinator has completed a comprehensive review of the training needs in Beneavin Lodge in conjunction with the Home Manager and the Operations Team.

Training for staff on 'Managing and Responding to Challenging Behaviour' as well as 'MAPA Training' has been scheduled for 18th, 19th and 30th January 2018. Refresher training will take place on January 10th, 12th and February 7th and 9th. In the interim the Home Manager has scheduled a training workshop for Wednesday the 13th of December 2017.

Beneavin Lodge has in place a policy in relation to the additional training needs of staff. This has been and will be discussed with all staff during appraisals and staff are fully aware of the pathways available to them should they wish to avail of any additional training to improve their knowledge and care provided to our residents.

**Proposed Timescale:** 09/02/2018

**Theme:**

Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

A comprehensive review of practices and procedures regarding chemical restraint and the use of PRN (medicines only taken as the need arises) was required to ensure p.r.n psychotropic medicines were only used as a last resort.

Inspectors' findings did not demonstrate that alternatives were available or tried before the use of chemical restraint as a last resort.

**5. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**

FirstCare fully support the fundamental approach to working with behaviours that challenge and support staff to become effective in supporting residents living with a Dementia and/or cognitive decline. We strive to seek explanation and understand the need behind the behaviour, so that we can provide solutions and facilitate the resident to live free of unmet needs as far as possible. We aim to ensure we minimise incidents of behaviours that challenge, through preventative protocols such as engagement and meaningful occupation, and to safeguard the welfare of staff and residents who may potentially be affected by such incidences. Through training and coaching staff working with residents living with dementia, we strive to ensure there is an understanding of each individual resident, and enable all staff to facilitate residents to achieve their potential in life every day, irrespective of the resident's cognitive ability, being mindful of limiting the use of PRN medication.

In this context, the use of PRNs have decreased in October as compared to July. This evidence was provided to the Inspectors on the day of Inspection.

Staff continue to complete ABC charts and update care plans when required. All care plans reflect the behaviours displayed by residents along with de-escalation techniques and diversion techniques, used to manage behaviours that challenge. Where PRN's are required their use is clearly identified with very specific guidelines as to when and how they are used.

Where a resident has more than one PRN medication written up the care plan also now clearly reflects which one is to be used first and guides all nurses on what constitutes appropriate use of PRN medication.

The Home Manager maintains complete oversight on all care plans including those specific to the management of behaviours that challenge. A comprehensive review of all care plans has taken place by the Home Manager, and all clinical staff are fully aware of the national policy published by the Department of Health.

**Proposed Timescale:** 12/12/2017

## **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:**

Improvements were required to ensure residents were protected by safe medicine management procedures and practices.

The following unsafe practices found compromised residents' safety and wellbeing:

- the pre-admission nursing assessment influenced the transcribed prescription more than the doctors/medical prescription and discharge letter
- residents were prescribed up to eight p.r.n medicines that included psychotropic medicines which were not included in the medical prescription received in advance or on admission with the resident
- a nursing assessment that included details of medicines previously taken had incorrectly influenced the transcription, prescription and administration of medicines that were no longer prescribed on transfer of the resident to the centre due to a history and recent diagnosis of polypharmacy
- medicine administration records showed that a resident that was prescribed regular and p.r.n. psychotropic medicines had inappropriately received both the regular and p.r.n dose at the same time
- the rationale, alternative tried prior to the administration of p.r.n. psychotropic medicines and effect following administration was not sufficiently recorded as referenced in outcome 7
- antibiotic medicine was administered for over two days from a faxed prescription.

Management and nursing staff were requested to undertake a comprehensive audit and review of medicine management practices and protocols to bring about improvements in line with professional standards and national guidance.

### **6. 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:**

FirstCare continuously strive to ensure best practice protocols are adhered to through training and mentoring of all clinical staff. Plans were in place prior to the inspection to commence the use of an electronic medication management system in early 2018.

A comprehensive audit of the PRN medication usage within Beneavin Lodge identified;

- 2 Psychotropic,
- 1 Mild OTC analgesic,
- 3 different types of Moisturizing creams,
- 1 Laxatives,
- Oxygen,
- 1 medication for gastritis,
- 1 medication for diarrhoea,
- 1 antacid, and
- 1 cough syrup.

These were only given when required and in the case of an emergency. All new admissions are now reviewed by the CNM to ensure that the appropriate medications have been transcribed by the admitting nurse and the appropriate prescription has been adhered to, and sent to the pharmacy.

A multi-disciplinary review of all medications has been scheduled for week beginning December 11th.

As advised in Outcome 2, the admission procedure policy has been reviewed and amended to give clear direction to all staff involved in the admission process. The policy clearly outlines the process relating to transcription. Transcribing of Kardex will only be completed on the basis of hospital prescriptions and as per the Pre-admission Policy. The CNM responsible for the admission of any new resident, reviews the Kardex prior to it being sent to the pharmacy.

Changes to the admission policy (sent with this action plan) clearly guide all nursing staff in relation to the acceptable practices regarding a prescription for a new admission. These practices are monitored and audited by the Home Manager to ensure accountability and oversight.

All staff have received additional medication management training within the home. Nurses now report daily to CNM's/HM of the PRN's that are used, as well as the de-escalation techniques tried, and all efforts that are taken prior to the use of PRN medications. Beneavin Lodge are currently implementing the new computerised medication management which will also add more stringent oversight to the use of PRN. In the interim all PRN administrations are accompanied by an explanation for their use, an indication of the rationale for use, as well as a detailed description of the behaviour, de-escalation, and diversional techniques, for managing behaviours that challenge, used before the PRN was administered.

Care Plans and ABC charts are in place for all residents that may exhibit behaviours that are challenging. These careplans have all been reviewed and amended to include all de-escalation and diversional techniques, to manage behaviours that challenge.

Refresher care plan training is planned to take place January 15th, 2018. All nurses are informed of documenting in the progress notes, the alternatives that were tried prior to administering the PRNs. Usage of PRNs are reported daily to the Home Manager and

Clinical Nurse Managers. The Home Manager maintains complete oversight on all PRN usage in the Nursing Home.

CNM's oversee, monitor, and audit the administration of any new medication not limited to and including antibiotics.

A complete audit of the management system had taken place prior to the inspection with an agreed implementation plan put in place between the pharmacy and Beneavin Lodge management team, in respect of a computerised medication management system. This system will bring about improvements in the auditing and review of medication management within the nursing home. A comprehensive training program for all nursing staff is part of the implementation of this system, and will include refreshers on practices for all nursing staff.

On admission, the CNM will check all the medication and reconcile it with the prescription received from hospital/home. The pharmacy is due to complete a medication reconciliation audit for all residents in Beneavin Lodge week beginning December 11th, 2017.

The guidelines and procedures set out in FirstCare policy take into account the standards set out by the Health Information and Quality Authority (HIQA) in the National Standards for Residential Care Settings for Older People in Ireland (2016) and those laid down for nurses in An Bord Altranais Publications such as Guidance to Nurses and Midwives on Medication Management (An Bord Altranais) and the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais).

**Proposed Timescale:** 31/01/2018

## **Outcome 12: Safe and Suitable Premises**

### **Theme:**

Effective care and support

### **The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

A number of design and operational matters required review and improvement as follows:

1. The noise levels from the sensor alarm mats was heard constantly and alarms were seen in use by up to or over 50% of residents in units. The noise levels were extremely irritating, loud and distracting. However, staff working within units had not noticed, responded to or silenced the alarms that were heard constantly going. One alarm rang for over 20 minutes and when the inspector highlighted this to the staff member they confirmed that the resident was not within the bedroom where the alarm device was linked to. On examination of the alarm device it was signalling 'out of range'. The use, purpose and management of alarms required immediate attention.
2. The volume of the public tannoid/announcement system was also very loud
3. Periodically the noise levels increased in the communal day/dining room from routine

kitchen activities which was unnecessarily created by staff clearing away cutlery and plates after meals

4. Music playing on T.V screens was inappropriate and detracted from the intended ambience

5. A repeated news channel remained on the TV of one unit for the duration of the inspection

6. The location of nurse's station within residents communal day/dining rooms required review to ensure residents privacy was maintained and sensitive information was not overheard during telephone or face to face conversations or seen on the laptop in use by staff.

### **7. Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

### **Please state the actions you have taken or are planning to take:**

The location, design and layout of Beneavin Lodge is suitable for its stated purpose. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007.

Whilst a Posey Alarm is used to safeguard a resident from a fall, a review of usage has been completed by the Home Manager, Clinical Nurse Manager and Clinical Staff. In consultation with the GP and following trials to balance resident safety versus background noise, a reduction in Posey alarm usage of a third was achieved.

The public tannoy system is and should only be used in emergencies and to announce activities within the nursing home. Administration staff have been reminded of this policy. In the interim the tannoy system has been reviewed to ensure the volume level is appropriate for the environment it is used in and any issues that arose during that review have been addressed.

Pantry staff have been informed to collect cutlery in a mindful manner of their surroundings and respect the residents by keeping the noise level as low as possible. Alternative methods for cutlery collection are currently being discussed with our Catering Team to aid in addressing the issue of noise levels.

Staff have been reminded of the need to be mindful of the noise levels within each area, and to ensure tolerance levels of staff to same do not rise, to avoid them becoming immune to same. Staff have been reminded of the effect noise, particularly repeated or uncomfortable volumes can have on those of our residents that live with a dementia, and also on episodes of responsive behaviour. Dementia refresher training is due to take place on 4th and 5th of January, 2018, and responsive behaviour training (including MAPA Training), is scheduled for 10th to 12th, 18th to 19th January, and February 7th to 9th, in the home. These topics will be discussed and reiterated by the tutor to ensure staff understanding of same. A 'Managing Behaviours that Challenge Workshop' was facilitated by the Home Manager and Operations Team on December 13th for all staff.

Staff and activity personnel have been reminded that TVs and other devices should not be left on inappropriate channels and where possible all residents should be included in the choice of what is displayed. TVs and other such devices are monitored by the Home Managers and CNM's on the floor on an ongoing basis and staff are reminded daily of the need to review and discuss station choices with residents.

Nurses have been advised that the GP and Treatment Room are more appropriate areas for private conversations to ensure confidentiality, dignity and respect for our residents.

FirstCare strive for operational excellence and these minor operational matters have all been addressed and resolved.

**Proposed Timescale: 27/11/2017**