Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Beneavin Lodge
Centre ID:	0117
Centre address:	Beneavin Road Glasnevin Dublin 11
Telephone number:	01-8648577
Fax number:	01-8648576
Email address:	beneavin@firstcare.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Beneavin Lodge Ltd
Person in charge:	Brendan Coyne
Date of inspection:	17 and 18 June 2010
Time inspection took place:	**Day 1: Start:** 11:35 hours **Completion:** 18:05 hrs **Day 2: Start:** 07:25 hours **Completion:** 15:35 hrs
Lead inspector:	Nuala Rafferty
Support inspector(s):	Damien Woods
Type of inspection:	☒ **Registration** ☒ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland under the following topics:

1. Governance and leadership: how well the centre is organised.

2. The quality of the service.

3. How well the healthcare needs of residents are met.

4. Premises and equipment: appropriateness and adequacy.

5. Communication: information provided to residents, relatives and staff.

6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice - this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of

the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.
The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.higa.ie.

Acknowledgements
The inspectors wish to acknowledge the co-operation and assistance of the residents, relatives, provider and staff during the inspection.

About the centre

Description of services and premises

Beneavin Lodge is a purpose-built two-storey building. The centre can currently accommodate 62 residents and are seeking registration to accommodate 68.

The centre provides continuing care, respite and dementia care services.

The bedrooms with four exceptions are single with full shower en suite facilities. Two bedrooms on both the ground and first floor have the capacity to accommodate two beds. In addition to the en suite bathrooms, there are three communal assisted bath and/or shower rooms with toilets on each floor. Two hydrotherapy baths are also available.

Other facilities include a seated reception area and porch, two sitting rooms/lounges one dining room, two pantry kitchens, one treatment room, an activities room, oratory, snoezelen room hairdressing and smoking area.

Externally the centre is situated on a large site secured by a high wall and locked gates. Entrance to the site is monitored by CCTV and a password operated electronic gate system. Ample parking is available at the front entrance for staff and visitors. There are three disabled parking bays.

To the front, side and rear of the building there are enclosed gardens which are wheelchair accessible with seating and well maintained shrubberies for residents and visitors to enjoy.

Location

The centre is located on Beneavin Road Glasnevin, next door to the De La Salle College. The centre is serviced by the 19 and 19A bus routes and is within walking distance of shops and amenities.

Date centre was first established:	10 December 2004
Number of residents on the date of inspection	59 (+2 residents in acute services)
Number of vacancies on the date of inspection	1

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	0	38	13	8

Management structure

Brendan Coyne is the Person in Charge. The Person in Charge reports to the General Manager Finola Bell and Director of Operations Eilis Carroll. They subsequently report to Mervyn Smith and Anna McCabe who are Directors of the company Beneavin Lodge Limited which is the Registered Provider. There are two clinical nurse managers, who supervise all nursing and care staff. All staff report to the Person in Charge.

Catering is contracted to an external company and the catering manager liaises with the person in charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2 nurses*	13	4	5	1	**3

* Two clinical nurse managers

**Activities coordinator, maintenance, general manager

Summary of findings from this inspection

This was an announced inspection in response to an application by the provider for the centre to be registered under the Health Act 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009. As part of the registration process the provider had to satisfy the Chief Inspector of their fitness to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This registration inspection took place over two days.

As part of the registration process separate fit persons interviews were held with the person in charge and the provider. As part of the application for registration the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority) including completion of the Fit Person self assessment. This documentation was reviewed by the inspector to inform the inspection process.

The inspection found that the overall care delivered in the centre was of a good standard. Staffing levels and skill mix were appropriate to meet the needs of the current residents' profile.

Inspectors were satisfied that the medical and other healthcare needs of residents were catered for. Staff demonstrated knowledge of the residents' needs, likes, dislikes and preferences.

The centre is purpose-built and of a good standard. The inspectors found that the premises, fittings and equipment were very clean and well maintained. There was a good standard of décor throughout the centre.

While considerable preparations had been made by the provider for this registration application, this report identifies where some improvements are necessary to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

These include

- risk management
- complaints
- confidentiality of residents records

Comments by residents and relatives

Eleven questionnaires were returned by residents prior to inspection. Comments included:

- 'I am very content happy and well treated by staff'
- 'the staff are kind attentive and obliging'
- 'the staff are interested in what they are doing and a bonus, most of them smile!'

- ‘never need anything I get whatever I ask for’
- ‘staff and nurses are first class’.

Other comments were:
- ‘more thought given to selection of music at mealtimes’
- ‘sometimes there is quite a delay in answering bells’

Eleven questionnaires were also returned by relatives or carers prior to inspection Comments included:
- ‘we feel he is very safe and staff are very caring and helpful’
- ‘if there are any issues or problems we always get a phone call’
- ‘there is a care plan meeting every three months we attend with dad and any concerns or issues are dealt with then’
- ‘very good communication’
- ‘we had no doubts she would get the utmost care and attention, we have not been disappointed in one thing in 18 months’

Other comments were:
- ‘sometimes there are language difficulties which can cause communication problems’
- ‘we have ongoing concerns about her fluid intake’
- ‘maybe more opportunity for her to go outside to the garden’

Inspectors met and spoke with residents and relatives during the inspection and their comments included;
- ‘I like it here everyone is very nice and friendly’
- ‘ the chef who was off duty came in on Christmas morning to say hello to all the residents’
- ‘hairdressing is very expensive’

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

The provider and person in charge demonstrated knowledge and awareness of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

A clear organisational structure was available and this was included in the statement of purpose. Staff interviewed demonstrated a clear understanding of their role and responsibilities. They described the staff structure and reporting mechanisms in place.

A comprehensive list of centre-specific policies and procedures were available and found to be in compliance with relevant legislation. These had been reviewed and updated on a regular basis.

Comprehensive emergency plans were in place. Plans for medical and major incidents were reviewed by inspectors. An emergency plan detailing actions to be taken in the event of evacuation, resources, specific contact details and arrangements in place to manage such an emergency was available.

Fire policies and procedures were reviewed by inspectors and were found to meet legislative requirements. Fire records indicated that fire safety training took place regularly and fire escape routes and fire fighting equipment was checked in line with best practice.

Training records confirmed staff had received compulsory training including manual handling, fire drill and evacuation.

A health and safety policy and statement was available and a health and safety committee with staff representative was in place to take forward health and safety issues.

A competent person has confirmed that the centre complies with Statutory Fire Safety Requirements and regulation 32.

An insurance certificate was available indicating insurance cover as required by Regulation 26.

A contract of care was available and had been agreed with residents their families or advocate.

The policy and practices regarding the management of residents' accounts was inspected and found to be satisfactory.

Some improvements required

A record of all complaints was not maintained. Verbal complaints were not recorded. The person in charge explained that all written complaints were recorded but that none had been recently received, verbal complaints were dealt with on an individual basis and were not documented. Although a record of 'formal' complaints was available this record did not reference the investigation, outcome or satisfaction of the complainant further to the investigation.

A certificate confirming that the centre complies with the building Codes, planning and Development Act 2000-2006, further to recent renovations was not provided to Health Information and Quality Authority (the Authority).

A statement of purpose was available which did not meet all the requirements of the legislation. Specific admission criteria, range of needs, type of nursing care to be provided and age range of residents profile were not clarified.

A resident's guide was available which did not meet all the requirements of the legislation in relation to a summary of the statement of purpose, complaints procedure, contact details of the Chief Inspector of Social Services and contract of care.

Significant improvements required

A risk management committee to review, audit and manage risks was in place and met on a monthly basis and inspectors found good reporting of accidents and incidents however, on review of the records there were a high number of unwitnessed falls and skin tears noted. A process was in place whereby the person in charge reviewed all falls or incidents and entered guidance comments on the form. However, this process was not linked to individual residents care plans or review of risk assessments to determine alternative modes of reducing the risks. Neither did it reference the overall management, or dissemination of learning process to manage risks associated with falls, skin tears or other risks identified.

The assessment systems in place required improvement. An identification and assessment for risk such as the use of restraint, the use of psychotropic drugs, falls, or residents who spent most of their time in a chair or bed, had not been completed.

Minor issues to be addressed

It was noted that the daily checks of fire escape routes and fire fighting equipment was carried out by the person in charge and on enquiry inspectors learned that a person to deputise in his absence to ensure checks were maintained was not in place.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Iinspectors' found that residents received a good quality of service. They observed that the provider, person in charge, and all other staff were respectful to the residents and noted that the friendly caring attitude of staff created a relaxed and happy atmosphere.

Residents' privacy was respected and promoted by staff. Inspectors observed staff members knocking before entering residents' bedrooms and doors were closed and curtains pulled while staff attended to residents' needs. Inspectors heard residents being addressed in an appropriate and respectful manner. All residents were well groomed and smartly dressed.

Call bells were promptly responded to and were readily accessible throughout the centre.

Residents were provided with nutritional meals which offered them choice. Residents were asked prior to eating what they wanted and were encouraged to maintain their independence where possible and to those who needed any assistance were offered this in a respectful manner. Residents confirmed that "the food was very good here".

The dining rooms were clean and the tables were attractively set for the meal. The menu was displayed on the notice board in the dining room. Residents dined at round tables which were conducive to conversation. Choices to dine in the main dining room or residents own rooms were accommodated.

Snacks were available to residents outside of mealtimes and nutritional drink supplements and juices were available throughout the day.

The kitchen was well stocked and the chef informed the inspectors that food was delivered, prepared and served fresh each day. Residents' special dietary requirements were communicated to the kitchen by nursing staff.

Residents' religious and spiritual needs were met. An oratory was available where Mass was held regularly.

A hairdressing salon was provided and the hairdresser visited on a weekly basis.

Systems were in place to enable residents to fulfil their own potential and participate in events and activities based on individual interests and preferences. Inspectors examined a recent review of the activities programme and an individual assessment of each resident's interests and capabilities which was undertaken to improve the programme available to residents on a daily basis. Two musicians arrived to the centre on the evening of the first day of the inspection and played musical instruments and sang to entertain residents and their visiting relatives in the courtyard. Up to 21 residents and some relatives were enjoying the music and songs. It was a sunny evening and staff ensured all residents were provided with sunscreen and sunhats. Staff offered choice of drinks, tea or juices to everyone. Residents appeared to enjoy the session, singing and clapping along to the music.

Residents told inspectors of other recent events held in the centre. One lady spoke of the karaoke evening held a week or two earlier which she said was great fun and another lady talked of how much she enjoyed the bingo and exercise sessions.

A snoezelen room was available and ongoing training was being provided to staff on how to deliver this therapy to those residents who do not take part in other activities due to underlying dementia. The training includes an assessment of resident's interests and needs using body language cueing where residents may not have sufficient verbal communication. A daily assessment form is being completed over a six week period and an audit of changes in behaviour and or other benefits will then be carried out.

Staff had received training in the detection and reporting of elder abuse. Staff interviewed had appropriate knowledge of the topic and their responsibilities to report concerns.

Evidence of discussion with residents and their relatives was found on some of aspects of residents care plans. Consent was sought for use of bed rails for some residents and for palliative care inputs from the outreach team for another resident.

A staff allocation system was in place where two care staff were allocated to work with a group of residents on a certain corridor each day. Care practices were monitored by the staff nurse and clinical nurse manager on a daily basis.

Some improvements required

Evidence that residents were given the right of choice to have a key to their room was not found. This conflicts with statements made in the fit person entry programme self assessment provided prior to inspection. In conversation with several residents, inspectors found residents were not offered a key to their room or to the personal lockable space within their room. In discussions with staff inspectors were told that some residents would be at risk if given a key to their room. However, inspectors found that a risk assessment to determine the balance of choice and risk in this regard was not carried out.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Inspectors found that residents' had access to relevant health care services based on their assessed needs.

Residents were encouraged to retain their own general practitioner (GP) following admission and some residents had done so. Where this was not possible medical services were provided by a team of local GPs who visited the centre and reviewed the residents as required.

Physiotherapy, occupational therapy and dietetic services were available as required through GP referral to the health service executive community services and on a private basis. Chiropody, reflexology, audiology and optician services were also available and provided to residents on an as required basis. Access via an outreach community team to palliative care services was also available and were being accessed for one resident during the inspection.

Each resident was assessed prior to and on admission. Comprehensive assessments such as falls risk, pressure ulcers, wound care, dependency, nutritional assessment, manual handling assessment had been completed.

Identified risks were reflected in residents care plans which were reviewed on a monthly basis by nursing staff; this was confirmed by looking at residents charts and talking to staff members. Care plans were updated to reflect residents changing needs and staff were knowledgeable regarding residents current health status. Efforts to personalise the assessments and care plans were noted.

Residents looked well nourished and hydrated, on review of a sample number of residents nursing documents evidence of intake and output charts on those residents at risk of dehydration were in place, during handover one particular resident whose family were concerned regarding her fluid intake was discussed and a good urinary output over the previous 24 hours was noted.

Medication management was supported by specific policies and procedures reflected in practice. Controlled drugs were checked at the end of each shift and records confirmed this. Medication reviews were undertaken on a regular basis by nursing

staff and GP and at least three monthly. Medication administration was observed to be in line with best practice according to An Bord Altranais guidelines.

Some improvements required

The use of physical restraint practices such as lap belts and bed rails was observed. Evidence was found of discussion with and consent for use from residents themselves, their relatives and the general practitioner. The centre policy on use of restraint states that the use of restraint will be reviewed regularly. However, evidence of the policy being enacted in practice was not found. In addition the use of physical restraint practices found on inspection contradicts statements made in the fit person entry self assessment programme which states that physical restraint is not used in the centre.

Significant improvements required

Care plans were not consistently linked to evaluations of whether interventions in use were effective or implemented. Audit of the care planning process was not undertaken on a regular or structured basis by the clinical nurse manager or person in charge. This contributed to a delay in responding in a timely and proactive manner to one resident's healthcare needs in relation to health promotion and prevention of deterioration. The resident who had a history of frequent falls and had complained over a period of two months of hip pain had been reviewed by the GP. However evidence of a referral for further investigation was not found, care plans did not reference use of a falls diary, preventative measures in place or overall review of medications or condition to address the residents pain or reduce the frequency of falls.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The design and lay out of the environment was suitable for residents. It was spacious, brightly decorated and well maintained. Bedrooms were well furnished and decorated. Some residents had personalised their rooms with photographs, pictures and family mementos.

Externally there were several enclosed garden areas for residents to enjoy with seating and well maintained planted shrubberies. Plans for a sensory garden on the flat roofed area of the building are proposed and the provider has consulted with dementia support groups to ensure it meets residents' needs.

The door openings to the bedrooms and communal areas allowed for the easy access of beds and hoists. There was adequate communal, dinning and recreational space, and toilet facilities were strategically placed around these areas for ease of use by residents. Among the shower and bathing facilities a hydrotherapy bath is in place.

The dining room on the ground floor opened up onto a courtyard with shaded seating areas which residents were observed to sit with their visitors or reading the newspapers during the inspection.

There was a separate dedicated hairdressing room and a large bright recreational room was available for occupational interests and activities.

Treatment rooms were available for aromatherapy and allied health professionals' services to the residents in the centre.

Well equipped clinical rooms with secure drug cupboards and trolleys were observed.

A well maintained oratory was also available for residents.

Good emphasis was placed on residents' safety with a key pad operated lock on the front gates and door, a visitors book was situated in the reception area and visitors were asked to sign on entering and leaving the building. Hand rails were located in all the corridors. Residents interviewed confirmed that they felt safe.

Management provided equipment in response to the assessed needs of the residents. Such equipment included lifting hoists and walking aids, weighing scales, residents' call system, pressure relieving mattresses and profile beds. Servicing contracts for all equipment were in place and were reviewed by inspectors.

Clinical and domestic waste were appropriately separated and disposal contracts for same were viewed.

Adequate storage areas were available throughout the centre and a designated cleaners store appropriately equipped was noted.

All corridors are zoned for fire safety purposes and are wide enough to provide safe walking areas for residents.

A laundry also provided services for residents' personal clothing. A clear system for labelling clothing was in place and the laundry staff member was knowledgeable regarding the procedure for removing and returning residents' laundry and dealing with infected or soiled items.

There were many examples of the promotion of cleanliness. Positive indicators included a cleaning system which involved the use of different chemicals for cleaning and sanitising and separate cleaning cloths and mops for bathrooms and residents rooms. Good infection control measures were in place with alcohol gel dispensers strategically placed on all corridors which staff were observed to use. Cleaning staff spoken to were knowledgeable of infection control procedures around methicillin resistant staphylococcal aurous (mrsa).

A main kitchen prepared and cooked meals for lunch, diner and tea. It was well organised and stocked, and had safe and satisfactory systems in place such as Hazard Analysis Critical Control Point (HACCP). Breakfast and super were prepared and served from two separate kitchenettes; these were also used between meals if residents or relatives wished to have a meal or snack.

A visit in May 2010 by the health service executive environmental health officer was satisfactory. A good variety of food and menu choice was available and catering personnel were aware of residents' dietary requirements, likes and dislikes.

A record to verify regular checks on all water systems for the legionella virus was available.

Some improvements required

Room temperatures in all areas of the centre were extremely warm. The temperatures were reaching 25.3c at 8:20 hrs in the upstairs corridor, even with windows / doors open, 21c in the downstairs lounge and 25.5c in room 267.

Sluice rooms were found to be adequately equipped with bedpan washers and racks for storage. However, available mechanical extraction ventilation was not in use**.**

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Inspectors found that there were many good practices in respect of communication and information. Notices advertising the inspection visit were prominently displayed. Residents and staff told inspectors they were informed of the inspection. As a result, they made themselves available to inspectors for interviews and discussions.

The person in charge told inspectors that he tried to see all residents daily. This was confirmed in conversations with residents who told inspectors they chat to the person in charge regularly and knew him by name.

A list of advocacy services was available to residents and their relatives.

Notice boards were strategically placed throughout the centre and provided information on activities on a daily basis.

Opportunities for resident engagement and self expression were found to be actively promoted. Life history story books and a personal history profile for each resident were being compiled. A record of participation in activities was available for each resident.

Staff were respectful to residents in forms of address and inspectors observed many instances of lively banter between staff and residents which indicated staff's knowledge of residents in relation to their humour and personal preferences.

To assist residents navigate around the centre communal areas colour cueing which assisted residents with dementia recognise and differentiate between the door to bedrooms and toilets was in place. Handrails on the corridors were also painted in high visual colours to prompt residents to utilise them.

A suggestion box was available at the entrance to enable residents and staff make suggestions or raise issues.

Some improvements required

Communication difficulties were expressed in comments on some of the relatives and residents questionnaires provided to inspectors. The comments identified that poor language skills contributed to some staff being unable to communicate effectively with residents and relatives. Although inspectors found that the English speaking skills of the majority of staff were of a high level there were instances when staff did not understand questions inspectors were asking and were unable to respond appropriately.

Inspectors were told that residents' council meetings and staff meetings take place monthly. However, minutes available to inspectors did not detail whether issues raised previously had been revisited or addressed.

Residents' records were not securely stored. These records were stored at the nurses' station which was situated at a junction between two corridors' in a busy area where staff, residents and visitors pass frequently. Current records were stored on open shelving behind the desk. Although there are generally many people around the desk, the security of residents' information could not be fully assured and the station was observed to be vacated at times when staff were busy on a number of occasions during the inspection and records were easily accessible.

Significant improvements required

There was a handover at the start of each shift. Staff nurses and care assistants attended. This ensured that they were updated on any changes that had occurred. Not all grades of staff attend this handover and a system of how relevant information is transferred from nursing and care staff to household or catering staff was not evident. This lack of clear communication processes can lead to confusion in practice and this was evidenced when conflicting information was given to inspectors by different staff members and disciplines on the number of residents currently with methicillin resistant staphylococcal aureus (MRSA).

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Each staff grade were identifiable by their uniform, and all staff wore name badges. Many residents could identify staff by name.

Inspectors viewed a comprehensive staff training plan for 2010. It contained all the required mandatory training elements and included education on care practices specific to the residents' profiles.

Staff appraisal and personal development reviews were to be introduced to monitor staff performance, and were being developed initially for new staff to be included in the induction process.

Although a named nurse and key worker system is not in place, inspectors noted that staff were allocated to provide care to specific residents on a weekly allocation chart and this was observed to be in practice during the inspection.

Staff were supported and supervised in the delivery of care to residents by two clinical nurse managers' on the day shift one on each floor.

Staff were observed to be attentive and responsive to residents, they were knowledgeable about the likes and dislikes of residents and their preferred daily routine and activity. There was low turnover and staff told inspectors that they enjoyed working in the centre and felt supported by the person in charge. There were arrangements to cover annual leave, sickness and other unplanned absences.

On this inspection, the numbers of staff and skill mix were adequate to meet the needs of the current resident profile.

Of the staff spoken to they were familiar with the *National Quality Standards for Residential Care Settings for Older People* and copies were available at the nurses' station.

Inspectors found evidence of clear and robust disciplinary procedures in place which were verified by reference to a disciplinary record on file

Some improvements required

Inspectors looked at a sample of personnel files there was evidence of preparations to meet the requirements of the legislation. However, the records did not contain all the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 in that, evidence of references having been checked were not available. Application had been made for Garda Síochána vetting, however responses had not been received for all staff.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider person in charge and key senior managers to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the co-operation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:
Nuala Rafferty
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

16 August 2010

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Centre:	Beneavin Lodge Nursing Home
Centre ID:	0117
Date of inspection:	17 June 2010
Date of response: **DAY/MONTH/YEAR**	1 November 2010

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 *(*Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

1. The provider is failing to comply with a regulatory requirement in the following respect: Arrangements were not in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. A system of audit and review for the control of specified risk was not in place
Action required: Put in place precautions to control identified risks and ensure these are adhered to at all times
Action required: Revise the accident and incident reporting processes to incorporate more detailed and reliable sources of information
Action required: Ensure that the reporting and auditing systems established are linked to residents care plans to ensure risks are managed on both an individual and collective basis.

Reference: Health Act, 2007 Regulation 30 : Health and Safety Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: FirstCare is committed to developing processes and structures that are directed towards identifying and minimising actual or potential risk and as acknowledged had an Incident and Accident Policy in place at the time of the inspection. Monthly risk management meeting are held with a representative of each discipline working in the home. The findings and recommendations of the risk management committee are now having a traceable direct influence on goal setting, action plans and outcomes of care planning. Named people are responsible for each action required and a time scale is set for the action to be completed.	Completed

2. The provider is failing to comply with a regulatory requirement in the following respect: There were no formal auditing systems in place. An identification and assessment of risk had not been completed. There was no systems/procedure in place to identify learning from practice.
Action required: Develop a comprehensive audit for the purposes of ongoing quality monitoring and continuous improvement.
Reference: Health Act, 2007 Regulation 35: Review of the Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The following monthly audits were in place at the time of the inspection:	

▪ Care Plans ▪ Medication Management ▪ Falls ▪ Accidents/Incidents ▪ Tissue Viability ▪ Restraint ▪ Complaints ▪ Facilities ▪ The above audit systems will be reviewed and adjusted as required. FirstCare has commissioned a consultant to review and update: ▪ Risk Management Strategies ▪ Policies ▪ Risk Assessments ▪ Base line risk survey and update risk policies accordingly. The consultant has visited all FirstCare homes and provided a comprehensive plan of action to improve risk management and audit systems. This project is ongoing and draft documentation is available.	End December 2010

3. The provider has failed to comply with a regulatory requirement in the following respect:

Care practices where residents were encouraged and enabled to exercise choice and autonomy of decisions and which respected residents right of privacy and dignity were not always evidenced.

Action required:

Ensure care practices enable and protect residents' autonomy.

Action required:

Establish clear communication and information processes to facilitate each resident's right to exercise choice.

Action required:

Where residents' capacity to exercise choice is restricted, the reason is explained, documented and appropriate support provided.

Reference:

Health Act, 2007
Regulation 10: Residents Rights Dignity and Consultation
Standard 17 : Autonomy and Independence

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: FirstCare recognises and respects the resident's right to privacy, dignity, choice and autonomy. Each resident has a drawer with a lock in the bedside locker for personal effects and a procedure for the management of the locker key is in place. The availability of a key for the drawer is discussed on admission with the resident or their next off kin as appropriate and the outcome of that conversation is documented on the resident valuable record. The resident/next of kin's decision is reviewed by the staff nurse conducting the three monthly assessment.	Completed

4. The provider has failed to comply with a regulatory requirement in the following respect: Initial and continuous assessment, monitoring and evaluation of resident's changing needs are not reflected in the care plans. Care plans and risk assessments are not linked and are not consistent.	
Action required: Ensure each resident's needs are set out in an individual care plan developed and agreed with each resident. The interventions required to meet the changing needs of residents to be continuously assessed, monitored and evaluated on an as required basis and no less frequently than every three months	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As acknowledged each resident was assessed prior to and on admission and throughout their stay and comprehensive assessments completed. Identified risks were reflected in residents care plans which were reviewed on a monthly basis, or as clinically indicated. Care plans were reviewed monthly or more often as indicated and were	

updated to reflect residents changing needs. Additional training has been carried out by the Home Manager on a one to one with all the staff nurses to re-iterate the importance of ensuring there is a clear linkage between and learning from the risk assessments, clinical review and the planned care actions. This training was conducted within two weeks of receiving the feedback from the exit interview. The person in charge/clinical nurse manager conducts a comprehensive audit of 20% of the care plans each month and evidence of improved linkage is presenting in the audits. The report of this audit is discussed and reviewed by the general manager monthly.	Completed

5. The provider is failing to comply with a regulatory requirement in the following respect: The management of complaints and the complaints policy did not meet all of the requirements of the regulations.	
Action required: Review the management and recording of complaints so that all complaints are documented in a timely manner.	
Action required: Record all investigations, actions, outcomes and learning on each individual complaint and ensure that this record meets the requirements of the legislation.	
Action required: Put in place a written policy and procedure which meets the requirements of the legislation.	
Reference: Health Act, 2007 Regulation:39 Complaints Procedures Standard:6 Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There is a comprehensive written policy on dealing with Complaints which was reviewed and updated on 4 August 2009.	

Complaint management prior to that date will not have been as structured. The updated documentation includes: ▪ complaint log: complainant's details, ▪ complaint details and person responsible for investigating the complaint ▪ complaint process record ▪ complaint acknowledgement in writing, investigation, investigation summary, date of outcome meeting and written outcome of complaint to complainant This policy has been updated to explicitly include verbal complaints. We ensure that all complainants are satisfied with how the complaint was managed and the outcome of the complaint before closure of the process.	completed

6. The provider is failing to comply with a regulatory requirement in the following respect: The policies and procedures available in the centre to manage risks were not being implemented specifically in relation to restraint and communication.	
Action required: Ensure that all policies and procedures in place in the centre that identify, prevent, manage and control risks to residents meet regulatory requirements and are implemented in full.	
Action required: Ensure staff are aware of the policies and procedures and knowledgeable in relation to their responsibilities towards their implementation.	
Reference: Health Act, 2007 Regulation 31:Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The use of restraints (primarily bed rails) has always been discussed with the resident and/or next of kin. There is now documented evidence of this discussion with a signature of the resident/next of kin available to reflect this communication. Audit on the use of restraint is carried out formally by the centre manager on a monthly basis and as part of the care plan review process by the staff nurses	Completed

at least monthly or more often as indicated. Restraint use is also reviewed by the resident/next of kin during the three monthly assessment with the CNM/staff nurse.	

7. The provider is failing to comply with a regulatory requirement in the following respect: Clear operational communication procedures which facilities appropriate and timely communication within the centre and between staff and residents and other health service providers in relation to residents healthcare needs was not in place. A robust system of communication to be put in place for all staff to effectively deliver a quality learning and service driven environment	
Action required: Develop and implement an appropriate communication process and procedure which provides for seamless and appropriate communications which meets the health care needs of residents and ensures meaningful interactions between residents and staff on an ongoing basis	
Reference: Health Act, 2007 Regulation 11: Communication Standard: 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Firstcare has supported the development and implementation of clear operational communicational procedures, which form part of the Staff Induction Programme and ongoing training. Following feedback received during the inspection exit interview the Housekeeper reports to the staff nurse on each team at the time of the morning report and is informed of any change in the infection control status of the residents, or other relevant details such as admissions/discharge or transfers to from the nursing home. The housekeeper in turn communicates this information to the household staff. The catering supervisor continues to be informed of any change in the infection control status by the nursing staff at the time of diagnoses.	In place

The minutes of the residents' council meetings will reflect the outcome of previous issues raised.	

8. The provider is failing to comply with a regulatory requirement in the following respect:

The range of policies, procedures and guidelines available in the centre were not in compliance with schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.

Not all of the policies and procedures which were available met the requirements of the regulations.

Action required:

Put in place policies and procedures which meet the requirements of the legislation on all items listed in schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.(as amended)

Reference:

Health Act, 2007
Regulation 11: Communication
Standard 27: Operating Policies and Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As acknowledged there was a comprehensive list of centre-specific policies and procedures available and found to be in compliance with relevant legislation. As noted above the policy on risk management, complaints and Restraint have been reviewed and changes implemented. Further in dept review of risk management practices is in progress and may lead to further review of policies.	End December 2010

9.The provider is failing to comply with a regulatory requirement in the following respect:

All of the information contained in the statement of purpose is not accurate or sufficiently specific to meet the requirements of the current legislation.

Action required: Amend the statement to accurately and specifically reflect the requirements of the regulations and incorporate all matters as listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009, and the National Quality Standards for Residential Care Settings for Older People in Ireland.	
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An amended Statement of Purpose has been drawn up and furnished to the Authority.	Completed

10. The provider is failing to comply with a regulatory requirement in the following respect: The residents guide did not contain all of all of the information as required in the legislation.	
Action required: Compile a resident's guide which contains all of the information as required in the legislation.	
Reference: Health Act, 2007 Regulation 5: Provision of Information Standard 1:Information	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Resident's guide has been amended and furnished to the Authority.	Completed

11. The provider is failing to comply with a regulatory requirement in the following respect: Evidence of compliance with statutory building codes and planning and development legislation was not provided.	
Action required: Provide evidence that the provider is in compliance with all statutory legislation.	
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 29:Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Evidence of compliance with statutory building codes and planning and development legislation has been provided.	Completed

12. The provider is failing to comply with a regulatory requirement in the following respect: The personnel records of some staff did not contain all of the required documentation as required in schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended).	
Action required: Ensure that staff records contain all the requirements listed in schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Reference: Health Act, 2007 Regulation 24: Staffing records Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	
Provider's response: All staff records now contain the requirements as listed in Schedule 2 of the Health Act 2007.	Completed

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 26 Health and Safety	Ensure adequate precautions are in place to maintain daily checks of fire evacuation procedures including clear exits and fire fighting equipment by nominated personnel when the person in charge is absent. **Provider's response:** Procedures have been put in place to ensure that a daily check of the fire exits and fire equipment is carried out when the person in charge is on leave.

Any comments the provider may wish to make:

Provider's response:

The providers would like to thank the Health Information and Quality Authority's inspection team for the professional and courteous manner that they showed to everyone at Beneavin Lodge during the inspection.

We are pleased with the contents of the inspection report. We believe that the report highlights our understanding of the Health Act 2007 and *the National Quality Standards for Older People in Ireland* and how we are delivering quality person-centred care at Beneavin Lodge to all our residents on a daily basis. We believe that the report also highlights our commitment to continuous improvement.

We would like to thank all their colleagues working in Beneavin Lodge Nursing Home and all those who contributed to the Health Information and Quality Authority's inspection. We would also like to thank all the residents and their relatives and friends who proactively participated in the process.

Provider's name: Mervyn Smith

Date: 29 October 2010