Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Firstcare Beneavin Lodge
Name of provider:	Firstcare Beneavin Lodge Limited
Address of centre:	Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	23 March 2023
Centre ID:	OSV-0000117
Fieldwork ID:	MON-0039686

About the designated centre

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

The centre offers long and short term care for adults and respite care and convalescence for adults over 18 years old including individuals with a diagnosis of dementia. The designated centre provides 70 beds in a purpose-built premises which is divided into two units: Botanic on the ground floor and Iona unit on the second floor. There is an enclosed courtyard garden which is accessible from the ground floor. The centre is located close to local amenities and public transport routes. There is a large car park at the front of the building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 23 March 2023	09:30hrs to 17:00hrs	Kathryn Hanly	Lead
Thursday 23 March 2023	09:30hrs to 17:00hrs	Geraldine Flannery	Support

What residents told us and what inspectors observed

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the centre. Inspectors observed residents partaking in activities such as bingo and artwork in the activity room and shared spaces throughout the centre. Inspectors spoke with six residents and one visitor. All were very complimentary in their feedback and expressed satisfaction about the standard of environmental hygiene.

It was evident that management and staff knew the residents well and were familiar with each residents' daily routine and preferences. There were good positive interactions between staff and residents observed during the inspection.

Overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared appeared well decorated and clean.

The kitchen provided was adequate in size to cater for resident's needs. The infrastructure of the onsite laundry which serviced the campus supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and tidy. However inspectors were informed that clean laundry was transported back through Beneavin Lodge en route to another unit on the campus. Findings in this regard are further discussed individual Regulation 27.

There was a dedicated clean utility room for the storage and preparation of medications, clean and sterile supplies such as needles, syringes and dressings on each unit. All units had access to dedicated housekeeping rooms for storage and preparation of cleaning trolleys and equipment and sluice rooms for the reprocessing of bedpans, urinals and commodes. However the design of the sluice rooms did not facilitate effective infection prevention and control measures, particularly during outbreaks.

There was a lack of appropriate storage space in the centre resulting in the inappropriate storage of supplies in the underground car park. Details of issues identified are set out under Regulation 27.

Equipment was generally clean with few exceptions. For example several portable fans were visibly dusty and three plastic urinals seen in en-suite bathrooms were unclean. There was a hydrotherapy (jacuzzi) bath available on each floor. While the external surfaces of the baths were cleaned after use, the pipes/ air jets did not receive routine disinfection. One of the two baths were designed and installed with an integrated cleaning and disinfection system. However, inspectors were informed that this system was not routinely used. Findings in this regard are further discussed individual Regulation 27.

Conveniently located alcohol-based product dispensers facilitated staff compliance

with hand hygiene requirements. Staff carried personal bottles of alcohol hand rub in areas of the building where there was an increased risk of ingestion of the alcohol-hand gel. However there were a limited number of clinical hand wash sinks available. The available clinical hand wash sinks did not comply with the recommended specifications for clinical hand wash basins. Inspectors were informed that replacement clinical hand washing sinks were scheduled to be installed on 05 April 2023.

The next two sections of the report present the findings of this inspection in relation to the governance and management of infection prevention and control in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control governance, environment and equipment management. Details of issues identified are set out under Regulation 27.

Firstcare Beneavin Lodge Limited is the registered provider for Firstcare Beneavin Lodge. The management team was established and consisted of the Chief Operating Officer, a Regional Director, an Associate Regional Director and the person in charge. The designated centre is part of Orpea Care Ireland and as a result, other management supports were available from this group such as Human Resources and Quality personnel.

Inspectors found that that there were clear lines of accountability and responsibility in relation to governance and management for the prevention and control of healthcare-associated infection. Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the Director of Nursing.

The nominated infection prevention and control link practitioner had recently resigned. Inspectors were informed that a replacement infection prevention and control link practitioner was to be nominated to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.

Two housekeeping staff were rostered on duty on the day of the inspection and all areas were cleaned each day. The provider had a number of effective assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and disposable cloths to reduce the chance of cross infection. Regular environmental hygiene audits were carried out. However, the design of two of the cleaning trolleys was not ideal from an infection

prevention and control perspective. Findings in this regard are further discussed under Regulation 27.

Infection prevention and control audits covered a range of topics including waste management, equipment hygiene and hand hygiene. Audits were scored, tracked and trended to monitor progress. High levels of compliance were consistently achieved in recent audits. However inspectors found that findings of recent audits did not align with the findings on this inspection. Details of issues identified are set out under Regulation 27.

Surveillance of healthcare associated infection (HCAI) and multi-drug resistant organism (MDRO) colonisation was routinely undertaken and recorded. However a review of acute hospital discharge letters and laboratory reports found that staff had failed to identify all residents colonised with MDROs. Findings in this regard are presented under regulation 27.

The volume of antibiotic use was also monitored each month. However, the overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to provide assurances regarding the quality of antibiotic usage in the centre. Findings in this regard are further discussed under Regulation 27.

Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that the majority of staff were up to date with mandatory infection prevention and control training. Inspectors were informed that nursing staff had also completed an antimicrobial stewardship e-learning course. However inspectors were informed that training was provided via video link and online. National guidelines advise that direct face-to-face training with opportunities for demonstration and questions is also required

Inspectors also identified, through talking with staff, that further training was required to ensure staff are knowledgeable and competent in the management of residents colonised with MDROs including Carbapenemase-Producing *Enterobacterales* (CPE).

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. There was a varied programme of activities that was facilitated by activity co-ordinators, nursing and care staff and was tailored on a daily basis to suit the expressed preferences of residents.

There were no visiting restrictions in place and public health guidelines on visiting

were being followed. Visits and social outings were encouraged with practical precautions were in place to manage any associated risks.

The layout of the building over two separately staffed floors lent itself to effective outbreak management. This meant that each area could operated as distinct cohort area with minimal movement of staff between zones to minimised the spread of infection should an outbreak develop in one area of the centre. The centre had effectively managed several small outbreaks and isolated cases of COVID-19. While it may be impossible to prevent all outbreaks, the early identification and careful management of these outbreaks had contained and limited the spread of infection among residents and staff.

However a recent gastroenteritis outbreak had spread extensively over both floors. All symptomatic residents had since fully recovered and a formal review of the management of the outbreak of had been completed. However the review had not identified issues identified on the day of the inspection that may have contributed to the outbreak.

Inspectors identified some examples of good practice in the prevention and control of infection. Ample supplies of personal protective equipment (PPE) were available. Appropriate use of PPE was observed during the course of the inspection with few exceptions. The provider had substituted traditional unprotected sharps/ needles with safer sharps devices. This practice reduced the risk of a needle stick injury. However four sharps bins were unlabelled and the temporary closure mechanism was not in place as recommended in the centres infection control guidelines.

A dressing trolley containing stocks of various wound dressing was observed to be brought into several resident's bedrooms without been cleaned and disinfected. This could lead to cross contamination. Findings in this regard are presented under regulation 27.

A review of care plans found that further work was also required to ensure that all resident files contained resident's current health-care associated infection status and history. Accurate information was not consistently recorded in resident care plans to effectively guide and direct the care residents colonised with MDROs.

Residents that had been identified as being colonised with MDROs were appropriately cared for with standard infection control precautions. However careplans for these residents did not detail the specific circumstances when transmission based precautions (contact precautions) may be required in additional to standard precautions. Details of issues identified are set out under Regulation 27.

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention

and control and antimicrobial stewardship. For example;

- While antibiotic usage was monitored, there was no evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives or guidelines.
- There was some ambiguity among staff and management regarding which residents were colonised with MDROs. This meant that appropriate precautions may not have been in place to prevent ongoing spread and potential infection when caring for residents that were colonised with MDROs.
- A review of four resident's care plans also found that accurate information was not recorded in resident care plans to effectively guide and direct the care residents colonised with MDROs.
- Inspectors identified through speaking with staff that they did not know which infection prevention and control measures were required to be used if caring for a resident that was colonised with Carbapenemase-Producing *Enterobacter* (CPE). Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the bacteria when caring for these residents.
- Disparities between the findings of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The sluice rooms were small sized and did not facilitate effective infection prevention and control measures. For example, there was insufficient space for cleaning and disinfecting equipment and there was no equipment cleaning sink. Unused janitorial units were observed within both sluice rooms.
- Parts of the centre were used as a thoroughfare for returning clean laundry to another centre on the campus. This arrangement posed a risk of cross contamination, particularly during outbreaks.
- Clean supplies including incontinence wear and PPE was stored in an open area of underground car park. Failure to appropriately segregate functional areas posed a risk of cross contamination.
- The specimen fridge was stored within a clinical room. This increased the risk of environmental contamination and cross infection.

Equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- A dressing trolley was not cleaned and disinfected at the end of each wound care procedure. This increased the risk of cross infection between residents.
- Two of the three cleaning trolleys observed did not have a physical partition between clean and soiled items. Cleaning carts were not equipped with a locked compartment for storage of chemicals. This increased the risk of cross contamination and ingestion of hazardous cleaning products.

- Several urinals observed within in en-suite bathrooms were visibly unclean. Inspectors were informed Inspectors were informed that the contents of urinals were manually emptied into en-suite toilets prior to being brought in the bedpan washer for decontamination. This practice will increase the risk of environmental contamination and cross infection.
- Resident's washbasins (used for personal hygiene) were observed to be washed in the bedpan washer with a urinal. This practice was not appropriate as bedpan washers are only validated for the decontamination of human waste receptacles such as urine bottles, bedpans and commode basins.
- The hydrotherapy baths were not effectively cleaned after and between uses. These baths are potentially a high-risk source of fungi and bacteria, including legionella. Failure to routinely decontaminate infrequently used baths can result in contamination of jets if not effectively decontaminated after use.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Infection control	Not compliant

Compliance Plan for Firstcare Beneavin Lodge OSV-0000117

Inspection ID: MON-0039686

Date of inspection: 23/03/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: • An Infection Prevention and Control Committee is in place since March 2023. By the end of May 2023, the terms of reference for this Committee will be revised to include monitoring of antibiotic usage and identifying quality improvement initiatives that harness AMRIC stewardship in the Centre. • In April 2023, the PIC introduced an enhanced antimicrobial register along with a new MDRO/HCAI register to improve governance of AMRIC in the centre. • This is further supported by a newly developed monthly AMS report to identify any trends and learning. Any learning will be shared with relevant MDT members. The AMS report and identified trends and learning will be discussed at monthly governance meetings. • By 7th of May 2023, all relevant care plans of residents with a colonised MDRO will have been updated to provide clear guidance to staff members. • The MDRO/HCAI Register in place enlists all residents with infection, and the precautions required to provide for their care and completion of relevant care plans. A CNM will update this register upon change and circulate to relevant staff. A CNM will also verify care plans when they complete this register. Additionally, care plan audits are completed monthly to ensure accuracy of information regarding residents colonised with MDRO's. • Staff Nurses will update handover sheets and where applicable place discreet signage on the door to alert staff of the residents' infection status. The management team will check on staff awareness and understanding of this signage and the precautions required to provide care on an ongoing basis. • Staff were made aware of the correct procedure to close a sharps bin. A CNM will monitor compliance through use of focused infection control audits and clinical supervision. • Focused Infection Control audits which include environment, hand hygiene, management of clinical waste and management of bodily fluids are in place. The management team have been provided coaching and guidance on the appropriate use of auditing to ensure compliance in line with national standards for infection prevention and	

control in community services.
• In May 2023, the IPC lead is scheduled to attend IPC link Practitioner Training. The PIC will oversee the audits to ensure that the IPC lead is identifying gaps in practice.
• A factsheet with information on CPE has been placed at each nurse's station for reference. The PIC has relayed this information to staff during staff meetings.
• The specimen fridge has been labelled and relocated to the reception. A daily cleaning schedule has been implemented and monitored by the PIC.
• The PIC has organised on-site training on antimicrobial stewardship in addition to the mandatory IPC training. This will be complete by end of June 2023.
• By the 31st of July 2023, a review of sluice rooms by the facilities team will have been completed ensure that they adequately meet the requirements.
• By the 31st of May 2023, a risk assessment will be carried out regarding laundry items transported through the centre particularly during outbreaks. Steps have been taken to mitigate movement of goods during outbreaks and alternate routes identified.
• Each floor has a designated area allocated to store incontinence wear. The PIC is in ongoing discussion to review supply with the HSE team and make amendments regularly to avoid any overstock. The PIC monitors the basement area weekly to ensure no inappropriate storage has taken place.
• Information sessions on the centre's decontamination policy have been completed with all staff. These sessions included decontamination of the hydrotherapy bath, personal wash basins and dressing trollies. Compliance with this policy is reviewed by clinical supervision and the audit programme.
• New housekeeping trollies are on order. These will allow for separate storage between clean and dirty items.
• A new SOP has been developed to inform and guide all staff in the disposal of bodily fluids and decontamination of urinals and bedpans, etc.
• Staff meetings were held to inform staff on single-use dressings. A CNM will monitor compliance daily by checking the clinical room.
• By 30th of June 2023, clinical hand washing sinks will be installed across the centre.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/07/2023