

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Boyne Valley Nursing Home
Centre ID:	ORG-0000119
Centre address:	Dowth, Drogheda, Meath.
Telephone number:	041 983 6130
Email address:	niamhbvnh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Nemeco Limited
Provider Nominee:	Niamh Darcy
Person in charge:	Niamh Darcy
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

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 judgements 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.

Compliance with 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.

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

The inspection took place over the following dates and times

From: 11 March 2014 09:30 To: 11 March 2014 18:30

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

Outcome 01: Statement of Purpose
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was unannounced and was carried out to monitor ongoing compliance with the regulations.

During the inspection the inspector spoke with residents and staff members. The Inspector observed the delivery of care, reviewed documentation such as care plans, medical records, policies and procedures and aspects of the premises. The most recent monitoring inspection of the centre was carried out on the 15 May 2013.

While, no action plan was required following the last inspection of the centre in May 2013, this was not sustained and a number of non-compliances with the legislation were found on this inspection that posed minor and moderate risks to residents.

Fire safety procedures were not adequate and constituted a major risk to the health and wellbeing of residents. Individual risk assessed evacuation plans were not in place to ensure the needs of residents were met in terms of equipment and staff if their evacuation was necessary. A simulated fire drill to ensure that the staffing levels on night duty was adequate had not been carried out. The final fire exit doors

were locked and necessitated the use of a key to open. Not all staff had attended fire safety training.

Additional areas of non-compliance with the Legislation and standards during this inspection included risk management procedures in the centre regarding inadequate identification and documentation of risks and associated controls to mitigate same. While staff were knowledgeable, mandatory training of all staff was not achieved in the areas of fire safety, moving and handling and elder abuse recognition and management in line with regulatory requirements. Some improvements were necessary in medication management procedures to ensure all discontinued medications referenced signatory medical evidence. Care planning documentation was not adequately reflected in the care plans to inform care to meet all the needs of residents. Laundry facilities did not meet the requirements of the legislation and review of the quality and safety of care and the quality of life of residents was in place but was not adequate in all respects as discussed in Outcome 10 of this report.

The action plan at the end of this report identifies the areas where improvements are required to comply with 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.

Section 41(1)(c) of the Health Act 2007 Compliance with 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.

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:
Leadership, Governance and Management

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

Findings:
There was a written statement of purpose which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the statement of purpose was made available to the inspector. It was recently updated. The provider was aware of the need 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.

Judgement:

Compliant

Outcome 03: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Niamh Darcy is the provider and also the person in charge of the centre. She works full-time and is on-duty from Monday to Friday each week. She had completed mandatory training requirements and additional training in person centred assessment and care planning, continence promotion and falls management.

Deputising arrangements and on call out of hours arrangements were in place. A senior staff nurse deputises for the person in charge who is also a registered general with experience in older person nursing. The person in charge demonstrated good clinical knowledge and she was knowledgeable regarding the Regulations, the Authority's Standards and her statutory responsibilities. She was involved in the governance, operational management and administration activities in the centre. The person in charge is supported by a team of nursing staff, care assistants, catering, maintenance, and domestic staff.

She demonstrated that she had an in-depth knowledge of the residents and their individual needs. Residents said that they knew her well and referred to her as the person they would go to if they had a complaint and as being in charge of the centre.

Judgement:

Compliant

Outcome 04: Records and documentation to be kept at a designated centre

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Nurses' progress notes were not consistently linked to the care plans and required improvement to include comment on the psychosocial wellbeing of residents in some cases.

Judgement:

Non Compliant - Minor

Outcome 06: 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.

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There were systems in place to protect residents from being harmed or suffering abuse. There was a policy to advise staff on elder abuse management, due for review in February 2014. Although informative, it did not reference referral details for the elder abuse officer and did not adequately advise on the care on the immediate or short-term care of residents following an incident of abuse alleged or otherwise. Staff spoken with by the inspector was knowledgeable in protecting residents from abuse, recognising abuse and the procedures to follow in reporting disclosures. Training records reviewed by the inspector confirmed that elder abuse recognition and management training facilitated by an accredited trainer was not attended by all staff working in the centre over the past two years. Six staff working in the centre had not attended this mandatory training over the past two years.

Residents told inspectors that they felt safe in the centre and that staff were responsive and gentle in their approach to meeting their needs. The provider informed the inspector that she convened and led discussion groups with staff on protection of residents including the centre's procedures for managing elder abuse which assured her that staff were informed and knowledgeable in this area. Access by the public to the centre was controlled and was facilitated by staff on each occasion.

The provider was an agent for two residents' pensions. The residents concerned had named accounts within the centre's business account which was not in line with recommended best practice and although the transactions were transparent and were supported by invoices and signed receipts, there was inadequate evidence to confirm that all available options to set up a independent bank account or other on behalf of the residents concerned was explored.

The provider told the inspector that the centre did not maintain any residents expense accounts in safekeeping on their behalf and that as residents/relatives on behalf of the residents maintained and managed their own money for day to day expenses they were

afforded a lockable space in their bedrooms.

Judgement:

Non Compliant - Minor

Outcome 07: 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:

No actions were required from the previous inspection.

Findings:

This outcome was not satisfactorily met. While inspector observed that there was a risk management system in place which was supported by health and safety and risk management policies and procedures, it was not satisfactorily completed.

There was a risk management policy in place and a risk register which was reviewed annually, however the inspector was not satisfied that all risks within the centre had been identified and documented with controls established to mitigate potential impact to the health and safety of residents. On the day of inspection, the inspector observed a number of areas in the centre that were not assessed or documented to mitigate risk to residents.

- An alcove in an area of corridor from a central lobby area to the dining room was used to store hoists. The inspector observed that these hoists posed a trip risk to residents in addition to obstructing access to the only handrail fitted on this corridor.
- Car parking was located to the front of the centre. Some vehicular traffic entering the site passed by the front entrance for parking purposes. The risk posed by traffic entering the site was not assessed, no traffic calming measures were taken or appropriate warning signage displayed.
- While handrails were fitted both sides of a ramp up to the front door, handrails were fitted on one side only on a secured pedestrian ramp down from a patio area located at a higher level.
- One locked final fire exit from the centre exited immediately down two steps, there was no warning signage displayed that steps were in place on exiting this door or handrails in place.
- Ropes were extended across a stairway up to first floor accommodation which was used for the purposes of the provider and staff. In addition a rope was extended across a stairway down to staff facilities at a lower level than ground floor resident accommodation. A risk assessment had not been completed to assess the effectiveness of a rope as a control to prevent access by vulnerable residents.

There was a visitors record book maintained in the entrance hall of the building to monitor the persons in and out of the building to ensure the safety of residents and was completed by each person entering and leaving the centre. The risk management policy

did not meet the requirements of Regulation 31 in relation to arrangements for identification, recording, investigation and learning from serious incidents or adverse events involving residents. While a policy on managing residents absent without leave, accidental injury to residents or staff and challenging behaviour was in place, It also did not adequately advise on the management of aggression and violence, assault and resident self harm. The centre was secure and residents who were at risk of leaving the centre unaccompanied were identified and adequately supervised.

Equipment used by residents was serviced. Hoists were last serviced in September 2013 to mitigate any risk of injury to residents from same. A policy advising staff on how to manage emergencies was in place which included reference to a place of safe refuge in the event of residents requiring evacuation from the centre.

The Inspector assessed fire safety management in the centre. There were arrangements in place including checking procedures to protect residents from the risk of fire but were not adequate in all respects. Staff spoken with could describe the precautions in place to protect residents against the risk of fire, including the provision of suitable fire equipment, use of equipment and where it is located. There were training records of staff participation in fire drills which were reviewed with staff by the provider/person in charge three monthly to reinforce annual training however lacked a sufficient commentary record to include where the simulated fire was located and the evacuation time and staff response. In addition the Inspector was not satisfied that the fire drills completed to date accounted for the increased risk present at night given the staffing number and the current dependency level of residents. Two members of staff, one of which was employed in late 2013 had not completed annual mandatory fire safety training.

The fire doors were ajar to some residents' bedroom accommodation throughout the day of inspection, who were observed by the inspector to have physical conditions that severely hindered their independence. Some residents with reduced mobility had fire evacuation sheets fitted on their beds however, individual evacuation risk assessments were not documented for each resident to reference equipment and numbers of staff for evacuation if necessary.

External and internal directional signage was in place but required review internally to direct residents to the nearest final fire exit and externally to clearly direct pedestrians to the designated fire assembly point if evacuation of the centre was required. The inspector found that in addition to improvements being required to ensure safe placement of residents in the event of an evacuation being required, timely evacuation could also be hindered by the following;

- All final fire exits were locked with a key including the front door of the centre, a key was available in a break glass unit by each final exit door.
- One locked final fire exit from the centre exited immediately down two steps, there was no warning signage displayed that steps were in place on exiting this door.
- A fabric curtain was fitted over a final fire exit door, although not drawn over the door on the day of inspection.
- A communal toilet door opened into the corridor which blocked access to a final fire exit.

- External pathways surrounding the building which formed the route from the final fire exits to the external assembly area consisted of some steps and slopes. Passage up steps was required to access the assembly area from the back of the building.

There was a record maintained of all accidents and incidents and was reviewed by the inspector and found to reference nine incidents for the period 01 May 2013 to 01 March 2014. These records were noted to outline factual and substantiated information on the event and the actions taken by staff in response to ensure the well being of residents who fell including completion of neurological observations where falls were not witnessed to promptly identify changes in the residents' condition requiring intervention. Medical review was appropriately sought and completed in each case. There was also evidence of assessment by a physiotherapist and revision of residents' care plans and risk assessments post falls.

The Inspector also observed appropriate manual handling techniques in practice. Moving and handling practice observed by the inspector during the inspection was safe however, 16 (59%) of staff, two of which were employed in late 2013 had not completed accredited training in moving and safe handling procedures. Catering staff had completed training in food hygiene.

There were measures in place to control the spread of infection. These included provision of supplies for personal protective equipment, training for staff in infection control and the availability of policies and procedures relating to infection control. Hand hygiene procedures were carried out appropriately by staff. Additional measures in place to control and prevent infection, included arrangements for the segregation and disposal of waste, such as clinical waste however, waste disposal bins used to dispose clinical and non-clinical waste were not in line with health and safety best practice recommendations in that they did not have a hands free lid opening mechanism fitted, were not front opening to facilitate removal of waste bags safely by staff and did not have adequate signage in place to advise on appropriate waste segregation - whether for clinical or non-clinical waste collection purposes.

Judgement:

Non Compliant - Major

Outcome 08: Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Medication management policies and procedures were reviewed by the Authority as part

of this inspection and this document was overdue for review since June 2012. There were no medications observed that required disposal on the day of inspection. Prescribing and administration and recording practices and procedures were also reviewed. The following areas requiring improvement were identified;

- Documented pain assessments were completed with care plan development if a resident is receiving pain relief or end of life care however, pain assessment tools were not routinely used to assess and monitor level of pain and effect of pain relief administered.
- Numerous resident prescriptions did not have the resident's photograph attached to mitigate risk of administration error.
- Some medication prescriptions were not individually signed by a GP and were signed by a single signature in a vertical format which is not in line with best practice prescribing procedures including schedule two controlled medication prescribing procedures.
- Some residents medication prescriptions referenced discontinued medications which were not signed by a GP as required.

Many of the staff nurses in the centre had attended medication management training. Statement of maximum dosage that can be administered over a 24 hour period and 'crush' medication prescription met requirements. Residents who had difficulty swallowing oral tablets were provided with liquid preparations of the relevant medications.

Transcription of residents' medication prescriptions was undertaken by the person in charge and by staff in the centre. The person in charge transcribed regular prescriptions and staff nurses transcribed other prescriptions such as antibiotic prescriptions from faxed prescriptions. These were signed by transcribers and the residents GPs. Controlled medications were secured in a locked press in a locked room. Controlled medications were dispensed on a named resident basis only in line with the legislation governing controlled medication management in private nursing homes. A controlled drug register was maintained and complete. Prescription levels stored were checked twice every 24 hours by two registered nurses to ensure balances were accurately accounted for.

Judgement:

Non Compliant - Moderate

Outcome 10: Reviewing and improving the quality and safety of care

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:

Effective Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found on this inspection that there was a system in place to review, monitor and improve the quality and safety of care and the quality of life of residents. The provider/person in charge reviewed a large number of clinical and environmental practices to date in 2014 including meals and mealtimes, resident weights and BMI (body mass index) audit, moving and handling procedures, privacy and dignity, the external gardens and staff files. Although, there was evidence that deficits were addressed that were identified in information collated in the audits, this information was not consistently clearly analysed with associated documented quality improvement plan development. Therefore it was difficult to measure or evaluate quality improvement required or completed for the service in response to findings of audits or to develop a schedule to enhance the aspects of the service. In addition, the scope of the audits required improvement to ensure audit content captured all areas requiring improvement. For example, the audit on moving and handling did not highlight the finding by the inspector that 59% of staff did not attend training on safe moving and handling in the past two years.

This information had not been formulated into a report as required by Regulation 35 to date however, the provider/person in charge said that it was in progress.

The provider/person in charge told inspectors that she sought on-going service satisfaction and quality of life feedback from resident meetings and daily communication with residents and their family members when visiting. While feedback at residents meetings was recorded in meeting minutes, other feedback received was not documented.

Judgement:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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:

No actions were required from the previous inspection.

Findings:

This outcome was not satisfactorily met. There were eighteen residents, one of which was in hospital accommodated in the centre on the day of this inspection. These residents had varying assessed dependency levels and underlying medical conditions including a small number with mild dementia or cognitive disability care needs. On the day of inspection, seven (39%) of the resident group were assessed as having

maximum care needs, 3 (17%) had assessed high care needs, 8 (44%) had assessed medium and low needs. Assessment records, care plans and daily progress notes were maintained for each resident on a computerised document management system. The inspector found that the standard of care planning required improvement to ensure all residents care needs had an associated care plan in place. For example one resident with leg pain who was complaining of pain in the presence of the inspector was provided with pain relief but did not have an associated care plan to inform management of her pain. Assessment tools were utilised to risk assess each resident's vulnerability to falls, pressure related skin breakdown, nutritional deficits among others. Care plans reviewed were personalised and the resident needs they addressed were described in a personal and individualised way. Progress notes were not consistently linked to the care plans and required improvement to include comment on the psychosocial wellbeing of residents in some cases. Residents had access to allied health professionals as required and referrals with follow-up consultations were evidenced. Three monthly reviews of care plans reviewed by inspectors referenced no narrative in respect of what areas of each care plan was reviewed and while signed by a relative did not include evidence of involvement by the resident.

Residents' access to a social programme developed to suit their individual needs, capabilities and interests was not adequate and was identified by the inspectors as an area of resident care that required improvement. Life histories were not completed for all residents. A social care programme was in place and was co-ordinated by the general manager, however the general manager was on leave and there was not a designated member of staff who had overall responsibility for co-ordinating activities in her absence. Although staff were attentive to residents who remained in their rooms there was not adequate evidence that all residents had access to recreational activities that suited their needs and capabilities. For example, skittles were played on two days in the week and bird feeding was the recreational activity provided on the Friday, there were some residents in bed or who remained in their rooms therefore these group activities did not meet their needs. Inspector observed and spoke with two of three residents who remained in their bedrooms throughout the inspection. While they stated that they listened to their radios or watched television there was no individualised activity programme designed to meet their needs, capabilities and interests. Residents who were able also availed of a 'fit for life' exercise programme and reading of newspapers. Clergy from differing faiths visited the centre and could be contacted as required by residents. Religious services were held on a monthly basis.

The inspectors found that staff knew residents well and had a comprehensive knowledge of their care needs. Residents told the inspector in one to one conversations with them during the inspection that they valued the staff who cared for them and described areas of individual care activities that meant a lot to them including being able to get up when they liked in the mornings and staff always being available at night to assist them. Residents said that when they were up and about they could move freely around the centre and sit in the sitting rooms. Residents were observed to be adequately supervised by staff.

Some residents had bedrails fitted. Risk to residents who had bedrails fitted was assessed and release and review records were in place.

Judgement:

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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This outcome was not satisfactorily met. The centre is a storey and a half in design. The residents' accommodation was located on the ground floor only. The residents' accommodation consists of 1 single bedroom with ensuite facilities, thirteen single and two twin bedrooms without ensuite facilities. All bedrooms without ensuite facilities have sinks fitted. Each bed space had a call bell fitted so residents could alert staff if necessary.

In addition to bedrooms the inspector viewed, the communal areas used by residents, the sluice and laundry rooms. Not all communal toilets had assistive handrails fitted on both sides of the toilet bowl to assist residents with mobility deficits. Chair-type raisers were fitted over two communal toilets viewed on inspection. This equipment was not secured and posed a risk of instability if weight was not distributed evenly on both armrests.

The premises was found to be homely, warm, well maintained, decorated to a good standard and attractively and comfortably furnished. Residents were encouraged to personalise their bedrooms and many bedrooms had residents' personal photographs and ornaments displayed in addition to some items of personal furniture. The centre was visibly clean throughout. There was hand hygiene gel dispenser units fitted at convenient intervals with advisory hand hygiene procedure instructions displayed. A supply of personal protective equipment was available for staff use.

The sluice area was secured however, the bedpan washing machine was not operational and there was four bedpans awaiting decontamination placed on top of the machine. The rail for bedpan and urinal storage was not easily accessible.

Residents who were at risk of developing pressure related skin damage had appropriate mattresses in place. Some residents used assistive equipment which was made available to them following consultation with allied health professionals.

Judgement:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This outcome was satisfactorily met. The complaints procedure was reviewed by the inspector and was found to meet the requirements of the Legislation. The general manager is the nominated complaints officer for the centre, the person in charge/provider is the person independent of the complaints officer who is nominated to manage the complaint administration. An appeals process was stated and would be conducted by a person other than the provider/person in charge and the general manager. Advocate address and telephone details made available should residents wish to contact that service directly. The complaints log was reviewed and there were no complaints recorded for 2013/2014. Documentation of residents' or others' satisfaction with the outcome of the complaint was not assessed on this inspection as there were no complaints recorded. The procedure on how to make a complaint was displayed in the centre, documented in the residents' guide and available in policy format to inform staff of the procedure to be followed.

While there was no evidence of verbal complaints recorded in the documentation reviewed, the provider/person in charge told the inspector that they would be recorded should they occur.

Judgement:

Compliant

Outcome 16: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspectors found that arrangements were in place to ensure residents received dignified and respectful care throughout the day of inspection. Staff were observed to knock before entering residents' bedrooms and to maintain their privacy during personal care procedures by closing doors and bed screen curtains in twin rooms. Staff engaged with residents in a respectful and patient way during encounters with them. Residents were facilitated and encouraged to exercise personal choices and autonomy supported by many examples observed by inspector during the day of the inspections including choice of food, time of dining and time of getting up and going to bed.

The provider/person in charge and staff told the inspector how they valued and sought resident's feedback. Residents meetings were held on a monthly basis and were well attended with evidence from the minutes of much discussion including experiences of the service and suggestions where improvements could be made which included a decision was made where the chef checked residents' choice of dish for tea-time at their afternoon snack-time as opposed to after lunch as residents said they would not have an appetite for tea immediately after eating lunch. The provider/person in charge chaired the residents' meetings in the company of an advocate. A communication policy detailing communication guidelines and procedures for residents with impaired communication skills was in place.

Windows on two residents' bedrooms were located in the walls to the back of the patio area, while one resident did not wish to have net curtains fitted, there was no evidence that all options were explored to preserve these residents' privacy by obstructing view from the patio area into their bedrooms such as installing window glass that prevented view in without hindering view out.

Judgement:

Non Compliant - Moderate

Outcome 17: Residents clothing and personal property and possessions

Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Residents had adequate storage for personal belongings in their bedrooms. Clothing was labelled and was well looked after by the centre staff. Residents' personal clothing was stored neatly, hanging in wardrobes and folded on shelves and in drawers as appropriate. A record of property and clothing was compiled when residents were admitted and kept updated by nurses and care staff as new personal items were added or discarded by residents or relatives.

The laundry was adequately equipped but lacked sufficient floor space for ease of manoeuvre around machines and lacked worktop space for sorting clothing and segregation of potentially hazardous linen.

Judgement:

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.

Theme:

Workforce

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that the centre was well organised with an appropriate skill mix of staff available to meet residents care needs on the day of inspection. The inspectors were provided with copies of the staff rotas, training records and staff files as requested which were reviewed to assess compliance with the legislation in each case. In addition, the inspector was told that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of residents who were assessed as requiring high levels of care. For example, an additional carer was rostered until 11:00hrs each morning to assist residents.

There was evidence that staff had undertaken training on a range of healthcare topics relevant to their roles for example, medication management, continence promotion, falls prevention and crisis prevention intervention among others. However, training records evidenced that not all staff had attended required mandatory training in protection, safe moving and handling and fire safety.

The duty rotas given to the inspectors referenced hours of duty of all staff working in the centre including the provider/person in charge. Three staff files reviewed contained all records in line with the legislative requirements.

The inspector found that the staff numbers and skill mix on the day of inspection were appropriate to meet the needs of residents accommodated in the centre. However, there was two staff on night duty and as a simulated night-time fire drill was not completed, there was no assurances that this number of staff was adequate to evacuate residents safely in the event of a fire, given the layout of the premises and the assessed needs of residents. Inspectors observed that staff grades were adequately supervised and staff nurses worked closely with care staff in care delivery procedures. Residents spoken with spoke positively in relation to staff competence and skill in meeting their needs.

Judgement: Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
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 report¹

Centre name:	Boyne Valley Nursing Home
Centre ID:	ORG-0000119
Date of inspection:	11/03/2014
Date of response:	11/06/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with 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.

Outcome 04: Records and documentation to be kept at a designated centre

Theme:

Leadership, Governance and Management

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

Progress notes were not consistently linked to the care plans and required improvement to include comment on the psychosocial wellbeing of residents in some cases.

Action Required:

Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

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

Emotional wellbeing to be reviewed and updated in all care plans to reflect progress reports.

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

Proposed Timescale: 31/07/2014

Outcome 06: Safeguarding and Safety

Theme:

Safe Care and Support

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

The provider was an agent for two residents' pensions, there was inadequate evidence to confirm that all available options to set up a independent bank account or other on behalf of the residents concerned was explored.

Action Required:

Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

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

Bank has been contacted re opening individual accounts for the relevant residents. However this would necessitate the resident going to the bank. When told of this, the residents stated that they were happy with the current arrangement and did not want to open separate accounts. Following discussion with them the company is going to open one separate account for residents' money. Documented details of all income and expenditure will be maintained and made available to each resident when requested. The relevant residents are happy with this arrangement

Proposed Timescale: 31/07/2014

Theme:

Safe Care and Support

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

There was a policy to advise staff on elder abuse management, due for review in February 2014. Although informative, it did not reference referral details for the elder abuse officer and did not adequately advise on the care on the immediate or short-term care of residents following an incident of abuse alleged or otherwise.

Action Required:

Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

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

The policy document on Elder Abuse has been updated to include the referral details of the Elder Abuse Officer, HSE. and to advise on the care of residents following any incidents of suspected or actual abuse. All staff have signed to say they have read the update.

Proposed Timescale: 11/06/2014

Outcome 07: Health and Safety and Risk Management

Theme:

Safe Care and Support

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

Some waste disposal bins used to dispose clinical and non-clinical waste were not in line with health and safety best practice recommendations in that they did not have a hands free lid opening mechanism fitted, were not front opening to facilitate removal of waste bags safely by staff and did not have adequate signage in place to advise on appropriate waste segregation - whether for clinical or non-clinical waste collection purposes.

Action Required:

Under Regulation 30 you are required to: Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

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

New pedal bin now in use. 'Clinical Waste' and 'Non-Clinical Waste' signage in place

Proposed Timescale: 11/06/2014

Theme:

Safe Care and Support

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

There was a number of risks in the centre that were not assessed or had documented controls in place.

- An alcove in an area of corridor from a central lobby area to the dining room was used to store hoists. The inspector observed that these hoists posed a trip risk to residents in addition to obstructing access to the only handrail fitted on this corridor.
- Car parking was located to the front of the centre. Some vehicular traffic entering the site passed by the front entrance for parking purposes. The risk posed by traffic entering the site was not assessed, no traffic calming measures were taken or appropriate warning signage displayed.
- While handrails were fitted both sides of a ramp up to the front door, handrails were fitted on one side only on a secured pedestrian ramp down from a patio area located at a higher level.
- Ropes were extended across a stairway up to first floor accommodation which was used for the purposes of the provider and staff. In addition a rope was extended across a short stairway down to staff facilities at a lower level than ground floor resident accommodation. A risk assessment had not been completed to assess the effectiveness of a rope as a control to prevent access by vulnerable residents.

Action Required:

Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

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

- 1) Alternative hoist storage area now in use with appropriate signage
- 2) Speed limit sign and cautionary sign now in place at entrance to Nursing Home
- 3) This exit ramp will be closed off when the alternative exit ramp from patio is constructed which will have appropriate hand rails. At present the foundations have been laid for same.
- 4) The Risk Assessment Register has been updated to include the effectiveness of the precautions taken to reduce identified risks. Extra safety signage is now in place at the relevant areas.

Proposed Timescale: 1) Done. 2) Done. 3) 31-Aug-2014. 4) Done

Theme:

Safe Care and Support

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

The risk management policy did not meet the requirements of Regulation 31 in relation to arrangements for identification, recording, investigation and learning from serious incidents or adverse events involving residents. While a policy on managing residents absent without leave, accidental injury to residents or staff and challenging behaviour was in place, It also did not adequately advise on the management of aggression and violence, assault and resident self harm.

Action Required:

Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

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

The Risk Management policy will be updated to advise on management of aggression and violence, assault and resident self-harm.

Proposed Timescale: 31/07/2014

Theme:

Safe Care and Support

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

Sixteen (59%) of staff, two of which were employed in late 2013 had not completed

accredited training in moving and safe handling procedures.

Action Required:

Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

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

All staff bar 2 (1 on annual leave and 1 pregnant at time of training) have completed their Manual Handling training. ECL Consultants are to facilitate these 2 staff members at another venue within the next few weeks.

Proposed Timescale: 31/08/2014

Theme:

Safe Care and Support

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

Timely escape could also be hindered by the following inadequate findings;

- All final fire exits were locked with a key including the front door of the centre, a key was available in a break glass unit by each final exit door.
- One locked final fire exit from the centre exited immediately down two steps, there was no warning signage displayed that steps were in place on exiting this door or handrails in place.
- A fabric curtain was fitted over a final fire exit door, although not drawn over the door on the day of inspection.
- A communal toilet door opened into the corridor which blocked access to a final fire exit.
- External pathways surrounding the building which formed the route from the final fire exits to the external assembly area consisted of some steps and slopes. Passage up steps was required to access the assembly area from the back of the building.

Action Required:

Under Regulation 32 (1) (b) you are required to: Provide adequate means of escape in the event of fire.

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

- 1) Masterfire Consultants are at present attaching magnet locks and key pads to external doors
- 2) This curtain has been removed
- 3) This door now opens inward
- 4) A step-free route around the building is now under construction.

Proposed Timescale: 1) 31-Aug-2014. 2) Done. 3) Done. 4) 31-Aug-2014

Theme:

Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The fire doors were ajar to some residents' bedroom accommodation throughout the day of inspection, who were observed by the inspector to have physical conditions that severely hindered their independence. Some residents with reduced independence had fire evacuation sheets fitted on their beds however, individual evacuation risk assessments were not documented for each resident to reference equipment and numbers of staff for evacuation if necessary.

External and internal directional signage was in place but required review internally to direct residents to the nearest final fire exit and externally to clearly direct pedestrians to the designated fire assembly point if evacuation of the centre was required.

Action Required:

Under Regulation 32 (1) (c) (iii) you are required to: Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

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

1) All residents now have an evacuation plan on Epicare and in the Mobility and Safe Environment section of their ADL Care Plan which identifies the equipment and numbers of staff needed for evacuation if necessary.

There is also an updated list of residents and their requirements in the Nurses Diary. A floor plan with mobility identification stickers on each room is on display in the nurses' office.

2) Masterfire have updated current and installed new exit signs at appropriate areas.

Proposed Timescale: 11/06/2014

Theme:

Safe Care and Support

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

Two members of staff, one of which was employed in late 2013 had not completed annual mandatory fire safety training.

Action Required:

Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

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

Sean Kavanagh Fire Safety has been contacted and he is to do fire safety training with these 2 staff members. See below.

Proposed Timescale: 31/08/2014

Theme:

Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Records of staff participation in fire drills lacked a sufficient commentary record to include where the simulated fire was located and the evacuation time and staff response. In addition the Inspector was not satisfied that the fire drills completed to date accounted for the increased risk present at night given the staffing number and the current dependency level of residents.

Action Required:

Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

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

I discussed this issue with Sean Kavanagh, Fire Safety Consultant and he has agreed to do a simulated evacuation with the night staff. A date has to be arranged for same. Due to the holiday season this may take a few weeks. He has also said that he will document in greater detail the content of the fire training to include where the simulated fire was located and the evacuation time and staff response.

Proposed Timescale: 31/08/2014

Outcome 08: Medication Management**Theme:**

Safe Care and Support

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

The following areas requiring improvement were identified;

- Documented pain assessments were completed with care plan development if a resident is receiving pain relief or end of life care however, pain assessment tools were not routinely used to assess and monitor level of pain and effect of pain relief administered.
- Numerous resident prescriptions did not have the resident's photograph attached to mitigate risk of administration error.
- Some medication prescriptions were not individually signed by a GP and were signed by a single signature in a vertical format which is not in line with best practice prescribing procedures including schedule two controlled medication prescribing procedures.
- Some residents medication prescriptions referenced discontinued medications which were not signed by a GP as required.

Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

- 1) Pain assessment to be carried out on residents on long-term analgesia which will be reviewed 3 monthly or more often if necessary. When Prn analgesia is given a pain scale will be carried out. The effect of the analgesia is documented in the progress report.
- 2) All residents now have photo identity on their Kardex. GPs to sign same on their next visit.
- 3) This refers to 1 GP who has 1 resident in the Nursing Home. I have on numerous occasions explained best practice to him and requested his compliance. I will do so again on his next visit.
- 4) I will request GPs to sign discontinued drugs on their next visit.

Proposed Timescale: 31/08/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme:

Effective Care and Support

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

Although, there was evidence that deficits were addressed that were identified in information collated in the audits, this information was not consistently clearly analysed with associated documented quality improvement plan development. The scope of the audits required improvement to ensure audit content captured all areas requiring improvement. For example, the audit on moving and handling did not highlight the finding by the inspector that 59% of staff did not attend training on safe moving and handling in the past two years.

Action Required:

Under Regulation 35 (1) (a) you are required to: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

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

Review of quality and an Improvement Plan to be included as part of the audit process

Proposed Timescale: 30/09/2014

Theme:

Effective Care and Support

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

This information in respect of reviews conducted for the purposes of Regulation 35(1) had not been formulated into a report as required by Regulation 35 to date.

Action Required:

Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a

copy of the report available to residents and, if requested, to the Chief Inspector.

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

An annual report will be completed yearly to comply with this regulation.

Proposed Timescale: 30/09/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective Care and Support

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

Not all residents had access to a social programme developed to suit their individual needs, capabilities and interests.

Action Required:

Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

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

All residents are informed on the day of the activity to be provided. Some choose not to attend and staff spend time with them on an individual basis giving massages, manicures etc. Our Activities and Social Programme is under review and a questionnaire being compiled for residents to establish their wishes and preferences in this area.

Proposed Timescale: 30/09/2014

Theme:

Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The inspector found that the standard of care planning required improvement to ensure all residents care needs had an associated care plan in place. For example one resident with leg pain who was complaining of pain did not have an associated care plan to inform management of her pain.

Action Required:

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

All residents on long-term analgesia will have their care plans updated to reflect their pain management. These will be reviewed 3 monthly or more often if necessary

Proposed Timescale: 31/07/2014

Theme:

Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Three monthly reviews of care plans reviewed by inspectors referenced no narrative in respect of what areas of each care plan was reviewed and while signed by a relative did not include evidence of involvement by the resident.

Action Required:

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

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

All areas of the care plans are reviewed 3 monthly. In future a narrative will be included in the Notes section of the care plan and documented evidence of the residents involvement will be included

Proposed Timescale: 31/08/2014

Outcome 12: Safe and Suitable Premises

Theme:

Effective Care and Support

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

The bedpan washing machine was not operational on the day of inspection and there was four bedpans awaiting decontamination placed on top of the machine. The rail for bedpan and urinal storage was not easily accessible.

Action Required:

Under Regulation 19 (3) (c) you are required to: Maintain the equipment for use by residents or people who work at the designated centre in good working order.

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

Bed pan washer is now in use and due for a service in Jun 2014. This storage rail has been moved to a more accessible area.

Proposed Timescale: 11/06/2014

Theme:

Effective Care and Support

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

Not all communal toilets had assistive handrails fitted on both sides of the toilet bowl to assist residents with mobility deficits. Chair-type raisers were fitted over two communal

toilets viewed on inspection. This equipment was not secured and posed a risk of instability if weight was not distributed evenly on both armrests.

Action Required:

Under Regulation 19 (3) (n) you are required to: Make suitable adaptations, and provide such support, equipment and facilities, including passenger lifts for residents, as may be required.

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

2 new disability toilets have been fitted with the appropriate hand rails

Proposed Timescale: 11/06/2014

Outcome 16: Residents Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Windows on two residents' bedrooms were located in the walls to the back of the patio area, while one resident did not wish to have net curtains fitted, there was no evidence that all options were explored to preserve these residents' privacy by obstructing view from the patio area into their bedrooms such as installing window glass that prevented view in without hindering view out.

Action Required:

Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

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

I spoke with both these residents and gave them the options as suggested. They did not want any changes and are happy with the windows as they are.

Proposed Timescale: 11/06/2014

Outcome 17: Residents clothing and personal property and possessions

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The laundry was adequately equipped but lacked sufficient floor space for ease of manoeuvre around machines and lacked worktop space for sorting clothing and segregation of potentially hazardous linen.

Action Required:

Under Regulation 13 (a) you are required to: Arrange for the regular laundering of

residents linen and clothing.

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

More shelving has been installed in the laundry

Proposed Timescale: 11/06/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was two staff on night duty and as a simulated night-time fire drill was not completed, there was no assurances that this number of staff was adequate to evacuate residents safely in the event of a fire, given the layout of the premises and the assessed needs of residents.

Action Required:

Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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

I discussed this issue with Sean Kavanagh, Fire Safety Consultant and he has agreed to do a simulated evacuation with the night staff. A date has to be arranged for same. Due to the holiday season this may take a few weeks.

Proposed Timescale: 31/08/2014

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Training records evidenced that not all staff had attended required mandatory training in protection, safe moving and handling and fire safety.

Action Required:

Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

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

- 1) All staff bar 2 (1 on annual leave and 1 pregnant at time of training) have completed their Manual Handling training. ECL Consultants are to facilitate these 2 staff members at another venue within the next few weeks.
- 2) Sean Kavanagh Fire Safety has been contacted and he is to fire safety training with

these 2 staff members.

Proposed Timescale: 31/08/2014