

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Droimnin Nursing Home
Centre ID:	OSV-0000702
Centre address:	Brockley Park, Stradbally, Laois.
Telephone number:	057 864 1002
Email address:	info@droimninnursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Droimnin Nursing Home Limited
Provider Nominee:	Gearoid Brennan
Lead inspector:	Una Fitzgerald
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	74
Number of vacancies on the date of inspection:	27

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 January 2018 08:30	09 January 2018 17:00
10 January 2018 08:00	10 January 2018 15:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced two day inspection to follow up on the non compliances from the last inspection carried out in December 2017. The management team has undergone significant change in 2017 and had two changes to the person in charge. There was also a significant turnover of frontline staff, which impacted on the service to residents. The provider nominee had volunteered to put a temporary hold on all new admissions in order to implement a compliance plan. Findings on this inspection evidenced that this strategy had yielded a positive impact on the overall service provided. The inspector followed up on the ten action plans from the previous inspection and found that nine had been completed and plans to change the pension agent arrangements had been significantly progressed. The seven outcomes monitored on this inspection were found to be compliant or substantially compliant and the centre is now open to new admissions.

During the course of the inspection, the inspector met with residents, staff, the provider nominee, the person in charge and the management team. The views of residents and staff were listened to, practices were observed and documentation was reviewed.

The inspector found that care was delivered to a high standard by staff who knew

the residents well and discharged their duties in a respectful and dignified way. The service was adequately resourced and the management team responsible for the governance, operational management and administration of services demonstrated good knowledge and an ability to meet regulatory requirements.

The management team and staff were striving to continuously improve outcomes for residents. A person-centered approach to care was observed. Residents appeared well cared for and expressed satisfaction with the care they received. There was good evidence that independence was promoted and residents have autonomy and freedom of choice. Residents spoke positively about the staff who cared for them.

The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

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

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the management team's roles and responsibilities for the provision of care are unambiguous. The nursing management team facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions. There was a focus on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

A new auditing schedule and review system was in place to capture statistical information in relation to resident quality outcomes, operational matters and staffing arrangements. Clinical audits were carried out that analysed falls management, medicine management, care plans and environmental audits. This information was available for inspection. All audits conducted had been reviewed by the person in charge and action plans to close out any gaps had been identified and were in progress. The management team are currently in progress of a full review of the Schedule 5 policies and procedures to ensure that they are centre specific and reflective of the practices in place.

The management support structure in place is comprehensive. The provider nominee is based within the centre three days a week. The person in charge works full time in the centre. There is a monthly management team meeting. The turnover of staff identified in the last inspection has been stabilised and any staff shortages were being filled by the on call roster.

An annual review of the quality and safety of care delivered to residents for 2017 was completed that informed the service plan and identified the Quality Improvement Initiatives planned for 2018.

The residents and relatives who met the inspector were knowledgeable about who the management team was and voiced that they would have no hesitation in bringing any issues to their attention. In addition, the relatives voiced confidence that any complaint made would be appropriately followed up.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

The provider nominee is acting as a pension agent for a small number of residents. Progress has been made to ensure that the centre is in line with the Department of Social Protection guidance. The inspector was shown documentation that evidenced that this action will be completed by the 26th January 2018 as outlined and accepted by HIQA within the previous report.

Measures were in place to protect residents from being harmed or abused. The centre policy was last reviewed in October 2017. The policy provided guidance for staff on the various types of abuse, assessment, reporting and management of allegations or incidents of abuse. Staff who spoke with inspectors were knowledgeable and were familiar with the reporting structures in place. The training matrix evidenced that all staff had received training on Safeguarding Vulnerable Adults.

The inspectors saw that measures had been taken to ensure that residents were protected and felt safe while at the same time had opportunities for maintaining independence. Communal areas were accessible to residents. There was a call bell facility in all rooms and within easy reach of residents. Residents told inspectors that they felt safe in the centre and spoke highly of the staff caring for them.

The systems in place to promote a restraint free environment in line with the national policy was described and demonstrated. A restraint policy, last updated in October 2017 was available. Following on from the previous inspection the management had met staff and guidance specific to promoting a restraint free environment had been provided. A monthly audit of restraint usage evidenced a decrease in the use of bedrails. Alternative

measures are also available for use. The inspector reviewed files. A consent form was in place. Assessment of the need for bedrails had been carried out. Records of the duration of restraint and safety checks or releases were recorded on an hourly basis.

The centre had a policy on and procedures in place to support staff with managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This policy dated October 2017 was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspector reviewed the documentation in use to guide staff. The care plans identified potential triggers and guided the clinical team on how best to manage any incidents. The guidance and system in place had templates of Activating Event, Behaviour and Consequences (ABC) assessment charts for recording any incidents. However, the inspector noted three instances within files reviewed that advice received from the multidisciplinary team specific to the management of responsive behavioral issues was not acted upon in a timely manner.

Judgment:

Substantially Compliant

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

Theme:

Safe care and support

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

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

Findings:

Actions required from the last inspection had been completed. A meeting was held with the household staff on 20th December 2017. Extra guidance and training was given on cleaning practices within the centre. Staff interviewed demonstrated adequate knowledge of the correct procedures to be followed. The staff were knowledgeable on the cleaning schedule and the colour-coded cloth system in place. An infection prevention and control audit had also been conducted on the 5th January 2018 as follow up to ensure that learning had occurred. Overall the premises, including the communal areas and bedrooms were found to be clean and there was an adequate standard of general hygiene maintained in the centre.

There were fire policies and procedures in place that were centre-specific. Quarterly servicing was carried out and fire safety equipment was serviced on an annual basis. There were records of weekly fire safety checks. There were fire safety notices for residents, visitors and staff appropriately placed throughout both buildings. Training records evidenced that all staff had received fire training. The inspector spoke with staff that was familiar with evacuation requirements of residents. The most recent fire drill was carried out on the 2nd January 2018 and records documented the scenario simulated, the length of time taken for evacuation of residents as well as learning

identified during the drill.

There was a centre specific safety statement dated July 2017. The risk management policy included items set out in regulation 26(1). The policy covered the identification and assessment of risks and the additional controls in place to minimise the risks identified. There was a risk register available in the centre which was kept under review by the management team. The risk register reviewed by the inspector was a detailed and comprehensive document which scored all risk according to impact and likelihood. However, the risk rate scoring was not compatible with the risk policy and required review.

Judgment:

Substantially Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Residents were protected by safe medicine management policies. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Practices in relation to prescribing and medicine reviews met with the legislation and regulatory requirements. The centre had conducted a full review of medication kardexes since the last inspection and the gaps identified had been addressed. Medication management practices had also been discussed at a staff nurse meeting to share learning. The inspector reviewed the documentation in place for the reporting and follows up on reported medication errors. The system was not sufficiently robust and required further analyses and review. The inspector found that all appropriate actions had not been taken in line with the policy. For example, a telephone call to the next of kin was not followed up.

Nursing staff were observed administering medicines to residents. The process was engaging and residents were not hurried. The inspector observed and staff confirmed that medications were not always administered to residents within a reasonable timeframe of the prescribed administration time.

Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage. The pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. There were procedures for the return of out-of-date or unused medications.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The last inspection had found major non compliance in Health and Social care needs. There had been no new resident's admitted into the centre as a management strategy to ensure that the required assessments and care plans were in place for current residents. The inspector found clear evidence that the required actions had all been addressed.

Residents' health care needs were met through access to medical services and appropriate treatment and therapies.

The files reviewed evidenced that the residents have access to a general practitioner and allied healthcare professionals.

Assessments and clinical care accorded with evidence based practice. Residents had been assessed to identify their individual needs and choices. The assessment process used validated tools to assess each resident's dependency level, risk of malnutrition, falls risk and their skin integrity. Clinical observations such as blood pressure, pulse and weight were assessed monthly. Each resident file reviewed had a comprehensive care plan in place. The care plans were person centered and the detail contained within the care plans evidenced that the staff were knowledgeable on the specific care needs of residents under their care. There was evidence that care plan reviews had occurred with all current residents in consultation with either the resident or their representative.

There was evidence within one file of a resident who declined assessment and follow up treatment. The care plan in place guided staff and the residents choice was supported and respected.

There were processes in place to ensure that when residents were transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services.

Judgment:

Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

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

Findings:

There were policies and procedures for the management of complaints. The complaints process was displayed strategically throughout the centre. The inspectors reviewed the complaints log. Records indicated that complaints were minimal. Residents were informed on admission of the complaints procedure and the detail is outlined within the statement of purpose.

The complaint log reviewed evidenced that all complaints received had been investigated promptly, a record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome.

Residents and staff spoken with during the inspection told the inspector that they would not hesitate to make a complaint if they had one. Residents told the inspector that they were satisfied with the care and were aware of who they could complain to if they needed to.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

Following on from the last inspection the management team had put into place systems and support measures for staff to ensure that the staffing numbers and skill mix employed in the centre are sufficient enough to ensure that resident needs are met. The staffing compliment had stabilized and all staff vacancies were filled. A comprehensive induction programme was put in place for new staff. As a result of the temporary hold on new admissions the staff had the opportunity to become familiar with the policies and procedures that ensure that person centered individualised care is delivered as evidenced in Outcome 11 Health and Social care needs. The management have also bedded down the on call system and any staff shortages have been covered to ensure that there is no negative impact on residents.

The actual and planned rosters for staff was reviewed. The inspector found that staffing levels and skill mix were sufficient to meet the needs of residents. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities and nurse managers explained the systems that will be actioned to supervise staff. Residents and the majority of relatives spoken to confirmed that they felt their care needs were met by staff. Residents felt that their call bell was always answered and felt safe in the centre. Staff spoken with felt supported by the management team.

Evidence of current professional registration for registered nurses was seen by the inspector. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Training included in house mandatory training on safeguarding and safety, patient moving and handling and fire safety. The training matrix evidenced that all mandatory training was up to date.

All documents as required by Schedule 2 of the regulations for staff were maintained.

The person in charge confirmed that there are no volunteers working within the centre.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Una Fitzgerald
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:	Droimnin Nursing Home
Centre ID:	OSV-0000702
Date of inspection:	09/01/2018
Date of response:	16/01/2018

Requirements

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

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

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The inspector noted three instances within files reviewed that advice received from the multidisciplinary team specific to the management of responsive behavioral issues was not acted upon in a timely manner.

1. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date

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

knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

- The PIC will ensure that all staff has up to date knowledge and skills to address Residents needs in relation to behavioural and psychological symptoms.
- The PIC will liaise with Allied Health Professionals and GP's to ensure recommendations are acted upon in a timely manner.

Proposed Timescale: Immediate

Proposed Timescale: 16/01/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk register reviewed by the inspector was a detailed and comprehensive document which scored all risk according to impact and likelihood. However, the risk rate scoring was not compatible with the risk policy and required review.

2. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

- The risk rate scoring in the risk register will be changed in line with the risk rate scoring in the risk policy document.

Proposed Timescale: 31/01/2018

Outcome 09: Medication Management

Theme:

Safe care and support

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

The inspector observed and staff confirmed that medications were not always administered to residents within a reasonable timeframe of the prescribed administration time.

3. Action Required:

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

regarding the appropriate use of the product.

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

- The PIC will Liaise with the GP and Pharmacist to change medication administration times on resident Kardex's/Mars to ensure residents receive their medications within a reasonable timeframe as outlined by NMBI Medication Management Guidance.

Proposed Timescale: 31/01/2018

Theme:

Safe care and support

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

The inspector reviewed the documentation in place for the reporting and follow up on reported medication errors. The system was not sufficiently robust and required further analyses and review.

4. Action Required:

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

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

The PIC will Carry out a Review and update of Medication Error book which will include:

- More detailed information with learning and reflection for all Nurses.
- In the event of error all Nurses made aware to contact GP/Midoc.

Proposed Timescale: Immediate

Proposed Timescale: 16/01/2018