

**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):	Leanne Crowe
Type of inspection	Unannounced
Number of residents on the date of inspection:	82
Number of vacancies on the date of inspection:	19

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:
12 December 2017 09:00	12 December 2017 18:30
13 December 2017 10:00	13 December 2017 17:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This report sets out the findings of a two day unannounced triggered inspection following receipt of unsolicited information of concern received by the Health Information and Quality Authority (HIQA). The concerns alleged issues on inadequate staffing and a poor quality of care provided to residents. Evidence found during this inspection did substantiate these concerns. The inspectors found that 28 members of staff (20 full time positions) had resigned since August and staffing levels were inadequate to meet the care and welfare needs of residents. As a result the provider nominee agreed to a temporary hold on all new admissions into the centre until such time that the management are reassured that the staffing compliment is stabilised and that the care delivered is safe, appropriate to residents' needs, consistent and effectively monitored.

The inspectors focused on care and welfare of residents and staffing, and also monitored progress on the actions required arising from the last inspection carried out on the 17th August 2017. The inspectors met with residents, relatives, the provider nominee, the person in charge, the deputy manager and staff members during the inspection. Practices were observed and documentation was reviewed such as policies and procedures, care plans, medication management and staff records. The centre's management team has undergone significant change over the

past nine months, and has had two changes to the person in charge. As a result of the change in frontline staff, the centre has put into place a recruitment plan and additional measures to minimise the impact on resident care needs. Despite these measures the inspectors found clear evidence that the turnover in staff is impacting negatively on resident care.

From the eight outcomes reviewed during this inspection, two outcomes were compliant and two outcomes were deemed to be substantially compliant. A moderate non-compliance was found in one outcome. A major non-compliance was found in three of the Outcomes inspected. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centers for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Since the previous inspection there has been a significant change in the management of the centre. The newly appointed person in charge displayed good knowledge of the regulations. She is supported by a deputy director of care and a team of clinical nurse managers. The person in charge has responsibility across two centres. The inspectors were informed that from mid-January 2018 the person in charge will be based full time in this centre. The residents who spoke with inspectors were aware of the changes and knew the new person in charge by name.

Throughout the two days, the inspectors spoke to both the person in charge and the deputy director of care. The inspectors noted that the person in charge has significant clinical and management experience in the care of older persons. The person in charge outlined the significant governance, processes and system changes that are planned for the centre. There was evidence of good consultation with residents and relatives from speaking to residents and visitors, and from a review of residents' committee meetings. The majority of residents and visitors to whom the inspectors spoke stated that they were happy with the service provided and they were satisfied that the management team and front line staff appropriately consulted and kept them informed.

A judgment of major non compliance was informed by cumulative findings. Two of the four actions under this outcome from the previous inspection that had not been adequately progressed and remained open. Firstly, the requirement to have all documentation under Schedule 2 in relation to Garda vetting disclosures. The second action was in relation to ensuring that the management systems were in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Additional non compliances in relation to governance and management include:

- the centre has been moving away from compliance as evidenced by non-compliances identified on this inspection. This inspection was a triggered inspection following receipt

of unsolicited information of concern. The inspectors found clear evidence that the significant changes to the clinical staff was having a direct negative impact on the care for residents

- the failure over an extended period of weeks to provide adequate staffing levels on each unit to deliver the care
- gaps in mandatory training records for fire and the detection, prevention and response to abuse
- the complete absence of nursing assessments and development of care plans for a high percentage of the resident's files reviewed. Each unit has one nurse on duty. However, the required documentation was not in place to guide nurses on the individual needs of residents in order to ensure that their medical and nursing needs are met. These gaps in documentation coupled with the high turnover of nursing and care staff posed a significant risk for residents.

The registered provider confirmed that resources were available to ensure the continuous professional development of staff. There was some progress made in the development of systems to ensure that the service provided was monitored and safe but significant improvement was required. Clear lines of accountability and authority were evident in the centre. The inspectors found that the new management team were collating monthly clinical data, and key clinical parameters were audited since the last inspection including resident falls, wound management, health and safety audits and infection control management. In addition, all data was easily retrieved by the person in charge. The data collated was analysed and action plans were developed to inform areas requiring improvement. Additionally, policies and procedures were in place to guide practice and service provision.

The new management support structure in place is comprehensive and the provider nominee is actively involved in the running of the centre. There is a monthly management meeting that has a rolling agenda. The inspectors reviewed the minutes of these meetings. The documentation evidenced that the management team have awareness of the issues identified throughout the inspection and that there is a willingness to ensure that the centre addresses all gaps to bring the centre into full compliancy with the regulations. An annual review of the quality and safety of care delivered to residents for 2017 was completed.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were systems in place to safeguard residents. However, inspectors found that improvement was required in relation to restrictive practices, care planning documentation and suitable training for staff. The gaps in care planning documentation are actioned under Outcome 11, Health and Social Care Needs. Two actions from the last inspection, relating to staff training and the management of residents' pensions, are restated in this inspection report.

There was a policy and procedures in place for the prevention, detection and response to abuse, which had been reviewed in October 2017. This policy outlined the systems in place to safeguard residents, and guided staff in their response to and management of allegations of abuse. Training records indicated that not all staff had completed up-to-date safeguarding training.

There was a policy and procedure in place for 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). Inspectors were informed by the centre's management team that there were no residents currently showing responsive behaviours.

There was a policy and procedures in place for restrictive practices, however, inspectors found that this did not support the implementation of an environmental restraint. A small number of residents were using wandering alarm bracelets to support their safe navigation within the centre. However, inspectors found that risk assessments had not been consistently completed for these residents. Where risk assessments had been completed, only some of these were reviewed regularly to ensure that the bracelet was still required. There was inconsistent practices in relation to consent for the use of wandering alarm bracelets. Inspectors advised that the centre's policy on the use of restraint is reviewed to include the use of wandering alarm bracelets.

A restraint register was maintained in the centre which outlined the number of residents using physical restraints such as bedrails and lap belts. On the day of the inspection, a total of 23 residents (28%) were using bedrails that restricted movement. Efforts were being made to reduce the use of bedrails, with records indicating that 30 low-low beds were being utilised across the centre. A sample of residents' files using bedrails were reviewed by inspectors and found that care plans were in place for these residents. Evidence of bedrail risk assessments, care plan reviews and consent forms signed by the resident or their next of kin were available in some files. However, for the remaining residents, gaps in this documentation were identified. While records relating to the release of restraint were available, gaps within this documentation were also identified in the records reviewed.

The provider was acting as a pension agent for a small number residents. An action relating to this had been identified at the last inspection. While inspectors acknowledged that efforts had been made to ensure the system was in line with the relevant guidelines and legislation, further improvement was required.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

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 actions from the last inspection had been included in the revised risk register. During the course of the inspection the management team further amended the risk register to include the risks identified during this inspection.

There were fire policies and procedures in place that were centre-specific. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Although fire training gaps were identified, each staff member spoken to during the inspection was familiar with evacuation requirements of residents and confirmed that they had attended fire evacuation drills. The centre had carried out drills that simulated staffing levels at day time and night time. Quarterly servicing was carried out and fire safety equipment was serviced on an annual basis. There were records of weekly fire safety checks.

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. All hand-washing facilities had liquid soap. There were policies in place on infection prevention and control. There was personal protective equipment such as latex gloves and plastic aprons available in all units. Staff interviewed demonstrated adequate knowledge of the correct procedures to be followed. Inspectors spoke with cleaning staff who were knowledgeable on the cleaning schedule and the colour-coded cloth system in place. However, inspectors were informed that cleaning cloths are used for multiple rooms (up to four rooms) before being discarded for washing. The incoming management team had recently allocated additional cleaning hours to support further general cleaning and deep-cleaning within the centre. Inspectors noted strong odours within one bathroom during both days of the inspection despite the cleaning schedule evidencing the room was cleaned three times a day.

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):

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

Findings:

There were written operational policies relating to the ordering, transcribing, prescribing, storing and administration of medicines. An action from the last inspection regarding unsafe practices in relation to the management of controlled drugs was completed at this inspection. Inspectors found that the processes in place in relation to the transcribing, administration, recording and review of controlled drugs were now in line with professional and regulatory requirements. Inspectors examined a sample of controlled medicines held in the centre and found that the balances of each medicine matched the relevant records. Inspectors were informed that the medicines management auditing programme had been revised since the last inspection. There were appropriate procedures in place for the handling and disposal of unused and out of date medicines, and inspectors found that these medicines had been returned to the pharmacy or disposed of.

Medication administration practice was observed by inspectors. Nurses were observed adopting a person-centred approach while administering medications. Administration records were appropriately completed and medicines to be administered in a crushed format were individually prescribed by a GP.

Pharmacists were facilitated to meet their obligations to residents.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

Comprehensive pre-admission assessments were carried out and recorded for all residents that were admitted to the centre. The person in charge communicates with the referring service and the option is given to all future residents to visit the centre. There were processes in place to ensure that when residents were admitted, 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.

Access to a general practitioner (GP) and allied healthcare professionals, including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and specialist palliative care services were made available when required.

A significant number of files were reviewed in search of clinical information. Inspectors followed lines of enquiry on the management of residents at risk of falls, wound management, weight and nutritional management and pain management. Four of the files reviewed did not have any nursing assessments carried out on admission. The daily progress notes for these residents referenced that they had been admitted to the centre and a comment on their general status was recorded. There was clear evidence that the gaps or absence of assessments had a direct negative impact on residents' wellbeing. For example, one resident that was admitted with a condition that required regular pain medication did not have any pain assessment on file or a care plan directing staff on how best to manage the pain when reported.

Care plan documentation was also reviewed. Inspectors found that the documentation on care planning and implementation required further development. For example, a resident with a history of seizures did not have any care plan to direct staff on how best to manage any seizure activity. This was discussed with the nursing management team who corrected the gaps during the inspection. From the review of the documentation there was some evidence that residents and relatives had been consulted with and were in agreement with the content of the care plans. In a number of the files reviewed there was no care plan developed in relation to specific needs. The centre has had significant turnover of nursing and care staff recently. The documentation in place does not guide new staff members on residents' preferences and specific care needs. The gaps in the residents' files were discussed with the nursing management team. The inspectors note that some gaps identified on specific files were rectified during the inspection. However, the risk associated with the poor documentation and the large number of new staff posed a high risk to residents. Inspectors found multiple examples that led to poor outcomes for residents. For example, the documentation within one file recorded that a resident had not had a bowel motion for four days. The resident was symptomatic of constipation but no follow up occurred for over nine days. A commitment was given that a full review of all files will be carried out. Education will be given to all new staff on the requirements that would ensure that resident care is not compromised and that the centre is brought into regulatory compliancy.

Judgment:

Non Compliant - Major

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):

Findings:

There was a policy and procedure in place for the management of complaints. The policy had been reviewed in October 2017. A summary of the complaints' process was displayed prominently in the centre and was also included in the centre's Statement of Purpose.

The centre's Director of Care was responsible for the management and recording of complaints. A complaints log recording all complaints received was maintained in the centre and was reviewed by inspectors. These records contained all of the information required by the regulations, including the details of the investigations into complaints and the actions taken to address the complaints. Complainants' satisfaction with the outcome of complaints was also recorded.

A second person was identified in the complaints' policy to ensure that all complaints were recorded and responded to appropriately, but there was no evidence that complaints were reviewed in this manner.

There was an independent appeals process in place for complainants, should they choose to use it.

Inspectors spoke with staff and residents about complaints or issues of concern. Residents were able to identify who they should make complaints to and staff could outline how they would respond to a complaint.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

Findings:

Systems were in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Inspectors found that residents were commenced on food and fluid balance charts for a number of days following admission to the centre. Residents were also visited by a member of catering staff following admission to ascertain their preferences in relation to food.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were closely monitored and checked routinely on a monthly basis or more frequently when clinically indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of allied health professionals where appropriate.

Residents had good access to a dietician, who visited every six weeks, and speech and language therapy services. These services were available to residents on referral; based on assessment of need or a change in a resident's condition. Inspectors found that the recommendations made by the dietician or speech and language therapist were promptly communicated to the centre's kitchens and staff.

Each day, the menu was displayed in the dining room and also on each table. Pictorial representations of the meals to be served were also included on these menus. Each morning, catering staff spoke with residents to outline the meals available and record their choices. Additionally, alternative meals were provided each day should residents change their minds.

Since the previous inspection, management had conducted an audit of the dining experience in one area of the building. While mostly positive, this had generated some actions that were being addressed at the time of this inspection. Inspectors observed the dining experiences of residents across the centre throughout the two days of the inspection. Mealtimes were found to be a cheerful, social occasion in all dining rooms. The rooms were spacious and accommodated residents using specialised equipment. There were sufficient numbers of staff in each dining room at mealtimes. Inspectors observed staff providing residents with assistance in a discreet and sensitive manner. Some residents with unintentional weight loss or weight gain were also prescribed specialist diets by the dietician. Staff preparing, serving and assisting with meals and drinks were familiar with residents' dietary requirements, needs and preferences. Inspectors asked that the presentation of one type of specialised diet be reviewed.

Snacks and refreshments were provided throughout the day and were available at night time if residents wished to have them. Inspectors spoke with a number of residents throughout the inspection. The majority of these residents spoke extremely positively of the food they were served.

A protected mealtime initiative was enforced throughout the centre and inspectors saw that this was respectfully observed by visitors to the centre on the days of the inspection.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Prior to this inspection, unsolicited information of concern had been received by HIQA in relation to alleged inadequate staffing to meet the needs of residents. As a result of the information received, the registered provider had been issued with a 'provider led investigation' report. Inspectors found that the registered provider's response was comprehensive: the centre has implemented a recruitment strategy to ensure that adequate staffing levels are in place at all times and that resident care is not compromised. On the days of the inspection, the inspectors found clear evidence to substantiate the concerns raised. The findings from the inspection strongly support that current staffing levels are not consistently adequate to ensure the delivery of quality care according to the residents' individualised care plans. This view was informed by the following:

- on three occasions the inspectors noted that large groups of residents sitting in communal areas were unsupervised for extended periods of time
- the vast majority of staff that the inspectors spoke with over the course of the two day inspection repeatedly highlighted the issue of healthcare staff shortages. The overwhelming majority stated that the recent turnover of staff was significantly impacting on staff members' ability to effectively meet residents' needs
- healthcare staff that inspectors spoke with informed the inspectors of occasions where cover was not provided for staff on unplanned leave. To counteract this issue the management team have implemented a new on call system. To date this system has not resolved the ongoing issue of providing cover when staff shortages occur.
- the inspectors were informed of and observed long periods of delay in responding to residents that requested assistance with care related issues
- the inspectors also noted that concerns about the high level of staff turnover had been recorded in the minutes of residents' meetings. In these minutes, reassurance was given

by the person in charge that all steps were being taken to address the issue of staffing to ensure continuity of care.

The recent staff resignations and the induction of new staff issue was also referenced under Outcome 2 of this report. In response to the above, the provider representative informed the inspector that a temporary hold on all new admissions will be in place until the staffing numbers are stabilised.

The inspectors observed warm interactions between staff and residents and observed staff chatting easily with residents. For the majority, residents spoke positively about staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. Throughout the inspection, inspectors observed the dignified and caring manner in which staff interacted and responded to residents.

An actual and planned roster was maintained in the centre. The inspectors were informed that all new staff have a three day supernumerary induction to familiarise themselves with the centre. The induction is supported by a policy last reviewed in October 2017. The inspectors noted that two newly recruited members of the team currently carrying out induction did not have Garda Vetting on their file. The two staff had been in direct contact with residents.

Records viewed by the inspector confirmed that overall there was a good level of training provided. Mandatory training in manual handling was in place for all staff. Fire training records evidenced that 12 members of the current staffing compliment are enrolled to attend training in January 2018. This action is restated from the last inspection. The training records on the prevention, detection and response to abuse were reviewed on day one of the inspection. Significant gaps were identified in the clinical care team. The management team addressed this gap during the inspection and reassurance was given that all staff will receive this mandatory training as a matter of priority. This is actioned under Outcome 7, Safeguarding and Safety. The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Apart from the Garda vetting disclosures as outlined above, all files met with regulatory requirements. Registration details with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2017 for nursing staff were seen by the inspector.

Judgment:

Non Compliant - Major

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:	12/12/2017
Date of response:	22/12/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored require review. This finding was evidenced by the culmination of the following:

- the centre has been moving away from compliance as evidenced by non-compliances identified on this inspection. This inspection was a triggered inspection following receipt of unsolicited information of concern. The inspectors found clear evidence that the

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

significant changes to the clinical staff was having a direct negative impact on the care for residents

- the failure over an extended period of weeks to provide adequate staffing levels on each unit to deliver the care
- gaps in mandatory training records for fire and the detection, prevention and response to abuse
- the complete absence of nursing assessments and development of care plans for a high percentage of the resident files reviewed. Each unit has one nurse on duty. However, the required documentation was not in place to guide nurses on the individual needs of residents in order to ensure that their medical and nursing needs are met. These gaps in documentation coupled with the high turnover of nursing and care staff posed a significant risk for residents.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Following the inspection, a comprehensive review of the management systems in place within the nursing home was undertaken, with a particular focus on staffing. This review has led to the following actions being taken:

- Additional training for Clinical staff has been organised to ensure that their knowledge of Legislation, Regulations, Policies and Procedures, Standards for Care, and Protection and Welfare of Residents is current and in line with best practice thereby ensuring excellence in care.
- The continued implementation of the nursing home's Recruitment Plan in order to ensure Adequate Staffing levels.
- The completion of Mandatory Training by all existing staff and a revision to internal structures which will ensure that any new Staff will have completed Mandatory Training within 2 weeks of commencement of employment.
- Additional Training and Education has been provided to every Nurse to ensure Person Centred Care plans are in place for all existing residents. On admission each resident following on from a Comprehensive Assessment will have a care plan developed which reflects their changing need and outlines the supports required to maximise their Quality of Life in accordance with their wishes.

Proposed Timescale: 22/12/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The provider was acting as a pension agent for a small number residents. An action relating to this had been identified at the last inspection. While inspectors acknowledged that efforts had been made to ensure the system was in line with the relevant guidelines and legislation, further improvement was required.

2. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

- Whilst the Registered Provider had been progressing this matter at the time of the inspection, no definitive solution had been identified which would be cost neutral to the residents (which was the outcome sought).
- The Register Provider will now contact the Department of Social Protection for its Guidance Re acting as a Pension agent for some residents and will implement this guidance.

Proposed Timescale: 26/01/2018

Theme:

Safe care and support

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

Training records indicated that not all staff had completed up-to-date safeguarding training.

3. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

- Following the inspection any member of staff whose safeguarding training was not up-to-date was identified. All existing staff are now trained in the detection and Prevention of, and Responses to Abuse.
- Going forward all new staff will have completed Safeguarding Training within 2 weeks of commencement of employment.
- The Policy & Procedure for Safeguarding of Vulnerable People at Risk of Abuse (and associated training records) will be on the agenda of all future staff meetings.

Proposed Timescale: 22/12/2017

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:

Inspectors were informed that cleaning cloths are used for multiple rooms (up to four rooms) before being discarded for washing. Inspectors noted strong odours within one bathroom during both days of the inspection, despite the cleaning schedule evidencing the room was cleaned three times a day.

4. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

- The PIC will ensure that best practice Infection Control and Prevention Measures are reinforced with all staff during training and supervisory inspections by management.
- Household Staff have been re-apprised of Policy number CE-010 whereby colour coding systems are in place for cleaning cloths in order to minimise the risk of cross contamination. Staff have also been guided regarding the use of individual cloths in each room.
- A double extractor fan along with a storage unit for incontinence wear are currently being installed into the bathroom/WC referenced above.
- Cleaning staff have been reminded of the importance of recording in the cleaning schedule and these records will be subject to greater management supervision.

Proposed Timescale: 22/12/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Evidence was found that some residents did not have any nursing assessments carried out on admission. The daily progress notes for these residents referenced that they had been admitted to the centre and a comment on their general status was recorded. There was clear evidence that the gaps or absence of assessments had a direct negative impact on residents' wellbeing.

5. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

- On the day immediately following the inspection a meeting of all nursing staff was convened to address this issue.
- Staff are now absolutely clear on the process that Comprehensive Assessments are devised within 24hours of admission to the Nursing Home. These Assessments will identify the Personal and Social Care needs of all new Residents and will record all this information in the resident's care plan.
- This aspect of resident care will be subject to additional management scrutiny going forward and the provider has put measures in place to allow the Deputy Director of Care to off-load some current administrative duties in order to focus additional supervisory time on this key aspect of resident care.

Proposed Timescale: 22/12/2017

Theme:

Effective care and support

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

Care plan documentation was also reviewed. Inspectors found that the documentation on care planning and implementation required further development. In a number of the files reviewed there was no care plan developed in relation to specific needs. The documentation in place does not guide new staff members on residents' preferences and specific care needs. A commitment was given that a full review of all files will be carried out. Education will be given to all new staff on the requirements that would ensure that resident care is not compromised and that the centre is brought into regulatory compliancy.

6. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

- Immediately following the inspection all resident care plans were reviewed and gaps in relation to any specific resident needs were identified.
- All staff have now been advised and trained as appropriate to ensure that following admission and the completion of a Comprehensive Assessment, each resident will have a care plan commenced within 48hours and that this care plan will reflect that residents changing needs, and outline the supports required to maximise his/her Quality of Life and Person-Centred Care in accordance with their wishes.
- Since the inspection all new Clinical Staff have received further Education, Training and Support in Devising, Implementing and Evaluating Care Plans thus ensuring that the 'care planning' underpinning resident care in the centre is of the highest standard. Special supervisory attention will be given to this aspect by the Deputy Director of Care too in her 'adjusted' duties.

Proposed Timescale: 22/12/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

A second person was identified in the complaints' policy to ensure that all complaints were recorded and responded to appropriately, but there was no evidence that complaints were reviewed in this manner.

7. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

- The person nominated to maintain a record of all Complaints has now been fully re-apprised of all duties associated with the role.
- Going forward, this person will ensure that Complaints are appropriately recorded and responded to in line with Regulations.

Proposed Timescale: 22/12/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The findings from this two day on site inspection strongly support that current staffing levels are not consistently adequate to ensure the delivery of quality care according to the residents' individualised care plans. This view was informed by the following:

- on three occasions the inspectors noted that large groups of residents sitting in communal areas were unsupervised for extended periods of time
- the vast majority of staff that the inspectors spoke with over the course of the two day inspection repeatedly highlighted the issue of healthcare staff shortages. The overwhelming majority stated that the recent turnover of staff was significantly impacting on staff members' ability to effectively meet residents' needs
- healthcare staff that inspectors spoke with informed the inspectors of occasions where cover was not provided for staff on unplanned leave. To counteract this issue the management team have implemented a new on call system. To date this system has not resolved the ongoing issue of providing cover when staff shortages occur.
- the inspectors were informed of and observed long periods of delay in responding to

residents that requested assistance with care related issues

- the inspectors also noted that concerns about the high level of staff turnover had been recorded in the minutes of residents' meetings. In these minutes, reassurance was given by the PIC that all steps were being taken to address the issue of staffing to ensure continuity of care.

8. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

- This matter has been subject to comprehensive review by the Management Team and measures have been put in place which will ensure that correct staffing numbers are in place and that the skill mix of staff is appropriate to meet the needs of the Residents taking into account size and layout of the Nursing Home.
- Safe and effective recruitment practices in line with the nursing home's Policy HR-001 are in place to recruit staff. Particular attention will be focused on ensuring that newly Recruited Care Staff will have the required skills and experience necessary to enable them to respond to the needs of the residents.
- Care staff have received further guidance and training regarding the Supervision of Communal areas and responding in a timely manner to resident that request assistance.
- The Nursing home continues to operate an 'On Call' system which works effectively. Recruitment, which continues, has returned to normal levels for a centre the size of Droimnín.
- The Management team along with the Clinical staff will focus particular attention on ensuring that care staff receive the necessary support and supervision to enable them preform their job to the best of their ability going forward.

Proposed Timescale: 22/12/2017

Theme:

Workforce

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

Fire training records evidenced that not all staff had completed up-to-date training.

9. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

- Fire training is scheduled for Tuesday 09/01/2018 for outstanding staff and further

fire training is scheduled for the end of January for any new staff employed by the nursing home.

- Fire safety is included in the induction training of all new staff by PIC.

09/01/2018 and 30/01/2017

Proposed Timescale: 09/01/2018

Theme:

Workforce

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

The inspectors noted that two newly recruited members of the team currently carrying out induction did not have Garda Vetting on their file. They were currently carrying out induction and had been in direct contact with residents.

10. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

- No new staff will carry out induction training nor will they have any contact with residents until vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 has been received by the Nursing Home.

Proposed Timescale: 22/12/2017