Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Dunboyne Nursing Home
Name of provider:	Dunboyne Nursing Home Limited
Address of centre:	Waynestown, Summerhill Road, Dunboyne, Meath
Type of inspection:	Unannounced
Date of inspection:	13 March 2018
Centre ID:	OSV-0000185
Fieldwork ID:	MON-0020952

About the designated centre

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

Dunboyne Nursing Home Limited is the registered provider of Dunboyne Nursing Home. According to the statement of purpose, the nursing home provides residential care for long-term to short-term, respite and convalescence residents, as well as those with an intellectual disability, palliative care need, acquired brain injury and physical disability. The centre can accommodate a maximum of 61 residents. It is a mixed gender facility, catering for dependent persons aged 18 years and over. The centre was purpose built. There are 47 single and seven twin rooms. The centre has multiple communal rooms that are accessible to residents at all times. Residents also have access to a central enclosed courtyard. The centre provides 24-hour nursing care to residents with low to maximum dependency needs. Additional therapeutic services are provided on site at the request and in the best interest of the resident, subject to appropriate GP referral as necessary, and access to the required resources.

The following information outlines some additional data on this centre.

Current registration end date:	10/03/2020
Number of residents on the date of inspection:	54

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
13 March 2018	08:00hrs to 18:00hrs	Una Fitzgerald	Lead
13 March 2018	08:00hrs to 18:00hrs	Leanne Crowe	Support

Views of people who use the service

Residents who met with inspectors spoke positively about the staff in the centre and the care that they received. Residents felt that staff knew them well and told inspectors that the staff were very approachable. All residents said that they were safe in the centre. The atmosphere observed in the communal sitting areas was open and welcoming for residents and visitors to enjoy.

Some residents said they are very happy to be live there. Residents who were admitted for regular short-term stays stated that their experiences have always been positive.

Residents said that staff were kind and respectful towards them, and took care of their needs. They were complimentary of the food that they were served. Overall, residents were happy that the activities within the centre met their needs.

Capacity and capability

The governance and management of the centre needed to be strengthened and improved to ensure that there was sufficient monitoring and oversight of the service and care provided. While inspectors found that aspects of care were delivered to a good standard, audits were not consistently being carried out to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Inspectors were concerned about the oversight and management systems for the following reasons:

- Confidential resident files were not securely stored.
- Unsafe medication administration management practices were found on the day of inspection.
- Inspectors found significant gaps in the auditing of the clinical care and were not satisfied that the services provided were being effectively monitored. Inspectors were informed that due to senior staff turnover, the auditing of care had not been conducted since the end of 2017. The last monthly management report available for review was dated December 2017.
- Information requested at the opening of the inspection could not be easily retrieved or found. For example, the risk register, that identifies the risks and the control measures specific to this centre, was unavailable.
- The person in charge informed inspectors that they had carried out clinical data collection for January and February 2018, but there was no evidence that data was analysed or that action plans were developed in relation to areas requiring improvement.

- Two staff rostered for duty did not have completed Garda Síochána vetting disclosures on file. The provider confirmed that the vetting applications had been made. To ensure the safety of all residents, inspectors sought a commitment that these staff would be immediately taken off duty until the disclosures had been received. The management team complied with this request.
- The person representing the registered provider and the person in charge informed inspectors that the management team meet weekly to discuss all care and operational issues within the centre. However records of these meetings were not maintained. Therefore, inspectors could not ascertain if the issues identified during the inspection were known to the management team.

There were clear lines of accountability and authority in the centre. Policies and procedures were in place to guide practice and service provision. Since the previous inspection, there has been a change in the nursing management team. A full-time person in charge was newly appointed in May 2017. The residents who spoke with inspectors had a good rapport with the person in charge.

An annual review of the quality and safety of care delivered to residents in 2016 was completed, dated April 2017. The person in charge informed inspectors that the annual review for 2017 will be forwarded to HIQA in April 2018. The residents and visitors who spoke with inspectors stated that they were happy with the service provided and the level of consultation with them.

Inspectors found that there was a sufficient number of staff on duty on the day of the inspection. The skill-mix of staff could meet residents' assessed needs, for the most part. Mandatory training in moving and handling practices and the prevention, detection and response to abuse had been completed by all staff. Additionally, staff were supported to complete other training such as dementia care, care planning and infection control. Staff were knowledgeable of the training that they had completed. Staff meetings were held regularly and minutes of these were available for review. The person in charge undertook annual staff appraisals and evidence of these were reviewed by inspectors.

In the feedback meeting, the management team acknowledged and accepted the findings and inspectors observed a willingness to ensure that issues would be addressed to bring the centre into full compliance with the regulations. Prior to the inspection, a new deputy nurse manager was appointed to support the person in charge. Inspectors were informed that this additional resource should assist in addressing the findings of this inspection.

Regulation 14: Persons in charge

The person in charge was a suitably qualified registered nurse, who met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection, there was a sufficient number of staff on duty to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff availed of a comprehensive programme of training including dementia care, moving and handling practices and the prevention, detection and response to abuse. There was an induction process in place for newly recruited staff. The inspectors were not satisfied that these staff members were appropriately supervised while completing the induction process, particularly while providing care to residents. On the day of the inspection, there was an inadequate number of staff trained in basic life support to perform cardiopulmonary resuscitation (CPR) in the event of an emergency. Training in CPR was scheduled for 22 March 2018.

Judgment: Substantially compliant

Regulation 21: Records

There were a number of gaps identified in staff files required to be held in the centre, in line with Schedule 2 of the regulations. Of the sample of staff files reviewed by inspectors, Garda vetting disclosures had not been fully completed for two staff members who were recently employed by the centre. A file regarding another staff member did not contain two written references.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors were not satisfied that the systems in place provided a safe, appropriate, consistent and effectively monitored service.

Judgment: Not compliant

Regulation 30: Volunteers

There were a number of volunteers operating in the centre. All volunteers had Garda vetting disclosures on file, but their roles and responsibilities had not been set out in writing.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints process in place within the centre, including an appeals process. There was a person responsible for dealing with complaints, and inspectors found that they had maintained records of complaints appropriately. According to these records, all complaints raised had been addressed in a timely manner, and complainants were communicated with throughout this process. Residents and visitors who spoke with inspectors were aware of the complaints process.

Judgment: Compliant

Regulation 4: Written policies and procedures

All of the policies and procedures required by the regulations were available within the centre, and had been reviewed within the last three years. These documents were accessible to staff.

Judgment: Compliant

Quality and safety

Aspects of fire safety and risk management required improvement as they could potentially impact on the safety and welfare of residents. Multiple gaps were identified in the daily check list of fire exits. This action is restated from the last inspection. There were also gaps in the documentation on weekly fire alarm tests. The fire alarm system was triggered during the inspection at the inspectors'

request and found to be in working order. The details of fire drills were not recorded since July 2016. Staff spoken with on the day of inspection were able to tell inspectors what action they would take in the event of a fire.

Overall, care was found to be delivered to a high standard. Residents were provided with good quality, nutritious food and systems were in place for consultation with residents. There was evidence that any feedback from residents was acted upon by management.

Residents were involved in their assessments and care planning, and their wishes and views were sought to inform advance care planning for their future health care needs and end-of-life care.

Inspectors found that the assessment process and the development of care plans need to be reviewed to ensure that person-centred care is consistently delivered. The centre had a list of routine assessments that are carried out on all residents admitted to the centre. Care plans are then developed in line with the outcome of these assessments. Inspectors found multiple gaps in this process. For example, a resident who had returned to the centre following a period in hospital had no reassessment carried out for over six days. The resident's needs had changed and their care plan did not reflect these needs. In a number of the files reviewed, there was no care plan developed in relation to pain management. The gaps in the residents' files were discussed with the nursing management team as poor documentation posed a high risk to residents.

A number of residents in the centre had 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 reviewed these residents' files and found the detail recorded was comprehensive. Inspectors observed staff engaging with residents throughout the day and found that staff were patient and displayed good knowledge of individual residents and their needs.

There was a number of measures in place to protect residents from abuse. Staff had completed up-to-date training in the prevention, detection and response to abuse. Staff who spoke with inspectors knew the processes for reporting any concerns they might have, and emphasised that an open culture of reporting was promoted by management. Residents told inspectors that they felt safe in the centre.
The provider acted as a pension agent for a small number of residents. A new system for managing residents' pensions was being introduced at the time of the inspection. The provider stated that the new system in place is in line with the guidelines published by the Department of Social Protection.

The nursing team described how they promoted a restraint-free environment. However, a non-compliance from the previous inspection had not been addressed. Risk assessments and care plan documentation relating to restrictive practices needed further improvement, to safely guide practice, in line with national guidelines.

On the day of the inspection, inspectors observed poor administration of controlled

drugs that was not in line with best practice guidelines or the centre's own policy. The person in charge maintained records on medication errors and near misses. There was two reported medication errors relating to high-risk medicines. The previous inspection also identified poor practice in relation to administration of high-risk medications.

Management and staff within the centre respected residents' rights, choices and wishes, and supported them to maintain their independence where possible. Staff were also seen to be very positive and respectful in their interactions with residents. Residents were observed calling staff by their first names and interacting with them in a relaxed and friendly way. Residents were supported to practice their respective faiths and their spiritual needs were met. A prayer room was located within the centre, and various clergy visited residents. Residents had unrestricted access to telephones and wireless broadband. Televisions were installed in each bedroom, and additional channels could be provided if desired.

Residents were regularly updated about developments or changes within the centre. Residents' meetings were held regularly, which a large proportion of residents attended. Some sessions were attended by people representing residents who could not communicate their views or wishes. Staff were vigilant to gather feedback on a variety of issues if residents were unable to attend a meeting. There was evidence that residents' views and feedback was used to improve the service. A residents' newsletter, published every two months, provided a summary of recent events and news from the centre. Inspectors also spoke with visitors throughout the inspection, who were complimentary about the care and support provided by staff to their loved ones.

A programme of activities was carried out across the centre by two full-time activity co-ordinators. The activities schedule was informed by the interests and hobbies of the residents and included group activities and one to one sessions with residents. In addition, residents also attended events in the community, such as the St Patrick's Day parade. Activity staff also spoke with the inspectors about a number of outings that were planned for the coming months, including a coffee morning in the local town. A small bar with a working beer tap was located within the centre, and this was used during the recent screenings rugby matches.

Regulation 13: End of life

There were no residents receiving end-of-life care on the day of the inspection. There was good evidence of appropriate advanced care planning to ensure residents' physical, emotional, social, psychological and spiritual needs would be met. An end-of-life care plan was in place for each resident to guide staff. Family and friends would be suitably informed and facilitated to be with the resident at end of life.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were provided with a varied, wholesome and nutritious diet that was properly prepared, cooked and served. Residents' special dietary requirements and their personal preferences were complied with. Residents received assistance and support from staff when it was required. Fresh drinking water, snacks and other refreshments were available at all times.

Judgment: Compliant

Regulation 26: Risk management

A risk management policy was available. The person in charge informed inspectors that a risk register folder outlined the measures and actions in place to control all of the specific risks identified in the centre. However, on the day of the inspection, this folder could not be located.

Judgment: Not compliant

Regulation 27: Infection control

The procedures in place for managing the prevention and control of infection were in line with National Standards.

Judgment: Compliant

Regulation 28: Fire precautions

Records indicated that fire exit checks and testing of the alarm system were not always completed as required.

Training records showed three members of staff did not have up to date fire safety training.

Records of fire drills completed by staff did not provide assurance that staff were

aware of the procedure in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The systems in place for the management and administration of medication were not in line with national and professional guidelines.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

When reviewing documentation and residents' files inspectors found significant gaps in the timely assessment of residents' needs and development of care plans.

Care plans were not consistently reviewed every four months, or more frequently if required.

Judgment: Not compliant

Regulation 6: Health care

Residents had appropriate access to a GP and allied healthcare professionals. There was good evidence that advice received was acted upon in a timely manner.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors reviewed files and observed that residents who exhibited responsive behaviours received care that supported their physical, behavioural and psychological wellbeing.

The centre's management promoting a restraint-free environment. However, inspectors reviewed residents' care plans and found some gaps in the assessment process and the documentation in place.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to ensure that residents were protected from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights, privacy and dignity were respected by management and staff throughout the centre. Residents were aware of their rights, including, civil, political and religious rights. These rights were respected by staff, and residents were supported to exercise their choice as much as possible. Advocacy services were available to residents where required.

Residents were supported to engage in activities that aligned with their interests and capabilities, and facilities for these were available in the centre.

Residents' were regularly consulted with and their views were sought through regular residents' meetings.

Residents were facilitated to maintain their privacy and undertake any personal activities in private.

Residents' access to the community was maintained in so far as possible, and this was also supported by access to local media and aids such as telephones and broadband.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunboyne Nursing Home OSV-0000185

Inspection ID: MON-0020952

Date of inspection: 13/03/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The inspection report states that; "There was an inadequate number of staff trained in basic life support to perform cardiopulmonary resuscitation" Training had already been scheduled for 22/3/2018 which had resulted in an additional 5 staff members being trained in CPR. Completed 22/3/2018.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff files have been audited and are now complete with regards to the required documentation. The outstanding Garda Vettings were received dated 28/2/2018 (but not forwarded to us in a timely manner) and 21/3/2018 We have a compliant set of human resource policies and all will be followed going forward. Completed 23/3/2018	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All healthcare audits were completed on or before 24/4/2018. Management audits are being updated and a schedule for their completion for the full 2018 calendar year is in place. We have 8 management audits and each audit is scheduled to be completed 3 time per year.	

Healthcare audits completed 24/4/2018 Management Audits on-going through the calendar year 2018, 2 per month.	
Regulation 30: Volunteers	Substantially Compliant
Outline how you are going to come into compliance with Regulation 30: Volunteers: The roles and responsibilities for the volunteers are in place. 24/4/2018	
Regulation 26: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: The Health & Safety Statement and risk management policy in Dunboyne is in place. The identified and assessed risks are in the Health & Safety Statement folder. The individual and personal risks of the residents are assessed and form part of the residents files. These are located in the residents files as part of their care plans. Complete; 23/3/2018 and on-going.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: We have a compliant fire management policy in place All records for fire exit checks, testing of the alarms and fire drills conducted are up to date. All staff fire training is up to date following training on 4/4/2018. Completed; 4/4/2018	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Our Medication Management Policy is compliant with national and professional guidelines. A full medication management audit has been completed; 26/3/2018 and learnings actioned by 20/4/2018. Weekly checks are in place and showing very positive results. Complete; 5/4/2018. Checks and audits on-going	
Regulation 5: Individual assessment and care plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: A detailed care plan audit was completed; 13/4/2018.	

A detailed audit of pre-admission assessment procedures was completed; 30/3/2018
All care plans have now been updated.
Regular audits will ensure that this continues.

Complete; 20/4/2018 and on-going

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The residents care plans were fully audited and updated; 20/4/2018. All identified gaps were amended.
A detailed and compliant Restraint Policy is in place.
Restraint is a monthly audit and any and all identified improvements will be actioned as discovered through the audits.

Complete; 20/4/2018

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	22/3/2018
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	23/4/2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Yellow	24/4/2018
Regulation 26(1)(a)	The registered provider shall	Not Compliant	Orange	23/3/2018

	ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	23/3/2018
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	4/4/2018
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	4/4/2018
Regulation 29(5)	The person in charge shall 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	Not Compliant	Orange	5/4/2018

	appropriate use of the product.			
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	24/4/2018
Regulation 5(2)	The person in charge shall 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 a designated centre.	Not Compliant	Orange	30/3/2018
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/3/2018
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Not Compliant	Orange	20/4/2018

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	20/4/2018