Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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:	79
Number of vacancies on the date of inspection:	22

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
17 August 2017 09:00	17 August 2017 22:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a one day unannounced inspection that monitored eight outcomes. On arrival to the centre, inspectors met with the person in charge and the deputy director of care of the centre who were informed of the purpose of the inspection.

The inspectors met with residents and staff members. The case files of a number of residents within the service were tracked. Documentation such as care plans, medicine records, medical and clinical records, policies and procedures, and staff training records were examined.

Droimnin Nursing Home is a registered to provide care for a maximum of 101 residents. On the day of inspection there was a total of 79 residents. The inspectors observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. However, major non-compliance was found within Outcome 2 Governance and Management and Outcome 9 Medication Management practices which is discussed in detail within the body of the report.

The centre had significant changes to the governance and management over the past two months. A review and improvement plan in relation to the governance

arrangements is required to ensure effective delivery of care and protection of residents from potential harm related to medicine management practices.

Staff observed were courteous and responsive to residents and visitors during the inspection. The inspectors also noted that resident engagement was positive and staff interactions with residents promoted positive connective care. In general the living environment was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness.

Inspectors noted significant gaps in the monitoring of mandatory staff training records. There was appropriate staff on duty on the day of inspection. The centre is currently in the process of recruiting extra staff on the nurse management team to ensure appropriate governance, oversight, monitoring of quality care and supervision arrangements.

There were eight outcomes reviewed as part of this inspection, four of the eight outcomes were compliant or substantially compliant with the regulations. The two outcomes that were judged as moderate non compliance and two outcomes with major non compliance 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 Centres 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 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
There was a written statement of purpose that described the service and facilities that are provided in the centre. The statement of purpose consists of a statement of the aims, objectives and ethos of the designate centre. The management have kept the statement of purpose under review and revised the content at intervals of not less than one year.

As per the regulations, the statement of purpose had detailed the organizational structure of the designated centre. However, some minor changes to clarify the governance structure, job titles, specific roles and responsibilities are required.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
There was a defined management organizational structure. The management team within the centre had undergone significant change in the preceding two months. A new

person in charge had commenced within the centre in July 2017. There has also been a member of staff promoted to position of DDOC (Deputy Director of Care). A recruitment campaign is underway to appoint two new clinical nurse managers to support the current management team. Residents spoken to were familiar with the current management arrangements. The identified lines of authority, accountability and responsibilities for the areas of care provision required review. The senior nurse management team had agreed on areas of accountability within the centre and the inspector reviewed the documentation on this. However, findings on inspection did not align to what had been agreed. For example the DDOC carried out audits on monitoring of resident nutritional needs but did not have line management responsibility over the clinical team delivering the care.

The provider nominee had ensured that the incoming PIC had a period of handover of one month to ensure receipt of a comprehensive handover and smooth transition of changes. The registered provider had responsibility for two designated centres. The person in charge confirmed that the person nominated to represent the provider entity is available for consultation at all times. Inspectors were informed that since the commencement of the new person in charge and an internal promotion of newly appointed DDOC weekly management meetings occur. The meetings are not minuted and so were not available for the inspector to review.

Based on evidence gathered on inspection the inspectors concluded that the monitoring of practice and service delivered by staff was not sufficiently robust to ensure the service provided was safe, appropriate and consistent. Inspectors were informed prior to the inspection that a comprehensive hand hygiene audit had been conducted. On examination this audit showed that five out of 104 staff had participated in the audit. Inspectors were informed that monthly meetings occurs with senior management. However, the most up to date minutes available for inspection were dated March and April 2017.

Inspectors found significant issues on medication management practices around systems for the management and the documentation of controlled medications. Inspectors were concerned that members of the management team were aware of the poor practices found and had not taken effective action to address it. An external provider had completed an audit of the medication management dated 15/08/2017. The result of the audit reported full compliance with in house medicines management practices on controlled drugs. This is discussed further under Outcome 9 medication management.

The person in charge informed inspectors that a review of all policies required under Schedule 5 of the regulations is currently in progress. Inspectors were informed that a review of staff files had recently been carried out. However, inspectors found gaps in the four files reviewed. Although Garda Vetting was present in all the files examined the inspectors noted that the start date for two employees preceded the date when Garda Vetting was received. The person in charge confirmed that all staff had garda vetting clearance.

Inspectors read the annual review of the quality and safety of care delivered to residents for 2016. They were informed that the new management team plan to review the data collected that inform priorities for the following year. Inspectors were

concerned that monthly gathering of information that was in place has discontinued. There was no monthly data available for review on falls and the use of restraints for 2017. The inspectors were also concerned about the ability of the management team to retrieve data requested and provide information in a timely manner. For example, information requested by the inspectors at the introductory meeting at 09.00am was not made available until the feedback meeting at the end of inspection. There were no records available for inspectors to review on the day of inspection for training on safeguarding and safety. Staff training records examined highlighted significant gaps with in mandatory staff training on patient moving and handling and fire safety.

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

Findings:
Measures were in place to protect residents from being harmed or abused. The policy was reviewed July 2017 and it 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 about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were put in place to ensure the safety and welfare of residents. However, evidence that staff had completed safeguarding training could not be obtained by inspectors on the day of the inspection.

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. There was an enclosed garden that residents could access at multiple locations. Communal areas in all units were accessible to residents. The inspector saw that there were facilities and equipment available to support residents to retain their independence. For example mobility aids, hand rails on corridors and circulating areas. Free movement between floors of the building was facilitated by a lift. There was a call bell facility in all rooms that were occupied. The inspectors observed throughout inspection that the call bells were answered in a timely manner. Residents told inspectors that they felt safe in the centre and spoke highly of the staff caring for them.

There was a system in place for the safeguarding of residents' finances and property. Residents' money was held securely. Records were maintained for all transactions, and were signed by two staff members and the resident where possible. Inspectors checked a sample of balances and these were found to correspond with the recorded transactions. The provider was acting as a pension agent for a small number residents. The system in place to manage these payments required review to ensure that it was in line with the relevant guidelines and legislation.

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 July 2017 was available. The centre had a record of all restraint currently in use on each unit. Staff and records confirmed that in total 14 of the 79 residents (17%) was using bedrails that restricted movement. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. The inspector reviewed files. A consent form was signed by the resident or next of kin. Care plans and evaluation records included evidence of alternatives available such as low low beds and crash mats. Records of the duration of restraint and safety checks or releases were recorded.

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 was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspector reviewed care plans including some for residents who had responsive behaviour. 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. The inspector found that ABC charts were consistently updated when incidents occurred and this information was utilized to guide interventions. All interactions between staff and residents observed by inspectors on the days of this inspection were supportive, respectful and kind.

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):
No actions were required from the previous inspection.

Findings:

The centre had policies and procedures relating to health and safety within the centre. The centre has a risk management policy that includes items set out in Regulation 26(1). The centre had a current risk registrar dated June 2016 that identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. However, a further review of the policies last updated May 2017 was required to ensure that the practice in place is reflected within the policy. For example, the centre has implemented a wandering tag system to safeguard residents at risk from absconsion. This system is not outlined within the policy.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. Household staff spoken to were knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The standard of cleanliness throughout the building was of a good standard.

Suitable arrangements were in place in relation to promoting fire safety. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. Fire safety and response equipment was provided. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire evacuation procedures were prominently displayed throughout the building. Each resident room had a location map on the back of their bedroom door highlighting their nearest fire exit. While there were significant gaps identified within the training records on fire safety staff spoken to were knowledgeable about fire safety and evacuation procedures. The management team confirmed that four fire drills have been carried out in 2017. However, the detail of the drills was not available on the day of inspection.

Judgment:
Non Compliant - Moderate

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:
There were written operational policies relating to the ordering, transcribing, prescribing, storing and administration of medicines to residents. However, these policy documents had not been fully implemented as inspectors found unsafe practices in relation to the

transcribing, administration, recording and review of prescriptive medicines including controlled drugs.

Residents were not sufficiently protected by medicine management practices found during this inspection and the standards did not meet with professional or regulatory requirements as follows:
• inspectors found evidence that the medicines management policy had not been consistently implemented and controlled drugs which were discontinued and should have been returned to the pharmacy were retained and used for other residents who were later prescribed this medication. For example records showed that on 13 occasions controlled drugs prescribed for an individual resident and subsequently discontinued, were repeatedly administered to two other residents who had been prescribed this medication.
• on two occasions where a controlled drug had been taken from a resident's supply, records did not clearly indicate to whom the controlled drug had been administered. Records outlining who had received the controlled drug on these two occasions was later provided to inspectors by a member of senior management.
• records evidenced that on one occasion, only one staff member's signature was recorded on the controlled drug register, which does not meet professional requirements and is not in line with the centre's in house medicines management policy.
• the requirement of an original prescription by a resident's medical practitioner within 72 hours for faxed or transcribed medicines was not consistently adhered to or seen implemented in practice. Medicines transcribed on four residents' kardexes had not been signed by the GP but had been administered by staff in the centre
• a photograph for each resident was not evident for a number of residents with medicine or prescription records reviewed by inspectors, which may compromise resident safety
• the procedure for the safe handling or disposal of unused or out of date medicines required review. Of the documentation reviewed, inspectors found four examples of controlled drugs that had been discontinued and had not been returned to the pharmacy or disposed of in accordance with the policy.

Due to the significant concerns about the medicines management findings, inspectors presented their evidence to members of senior management during the inspection. It was confirmed that a senior nurse manager who was aware of the poor practices in relation to the management of controlled drugs had recently taken steps to address the matter but the practices were still evident at the time of inspection. Inspectors noted that an audit of the centre's medicine management practices on controlled drugs dated 15th August 2017 had found the centre to be fully compliant. Inspectors were concerned that the audit did not accurately reflect the practices within the centre, and also that the poor practices regarding controlled drugs had been allowed to continue in the centre for an extended period of time. As a result of these findings a major non-compliance judgement was communicated to the management team on the day of inspection.

Judgment:
Non Compliant - Major

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:
Residents' health care needs were met through timely access to medical services and appropriate treatment and therapies. Access to a general practitioner (GP) and allied healthcare professionals including psychiatry of later life, physiotherapy, dietetic, speech and language therapy, dental, ophthalmology and specialist palliative care were made available when required. There was good evidence within the files that advice from allied healthcare professionals was acted on in a timely manner. Care plans were updated to reflect any changes as a result of reviews.

Residents had good access to allied health care services. The care and services delivered encouraged health promotion and early detection of ill health facilitating residents to make healthy living choices. Arrangements were in place to meet the health and nutritional needs of residents. For example, the nurse manager had carried out a comprehensive nutritional audit. Finding highlighted some areas of improvement on nutritional content in the menu. A multidisciplinary team approach was taken and actions implemented have resulted in better outcomes for residents.

Pre-admission assessments were carried out and recorded. 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.

Assessments and clinical care accorded with evidence based practice. Residents had been assessed to identify their individual needs and choices. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Each resident had a comprehensive care plan developed with 48 hours of admission. The care plans were person centered and the detail contained within the care plans evidenced that the staff were knowledgeable on the residents under their care. Each care plan was reviewed and evaluated at intervals not exceeding four months or more frequently when required. There was clear evidence that care plans and treatment given is done in consultation with residents, and when appropriate the residents family was also actively involved.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Inspectors found that the centre promoted residents' capacity to exercise personal freedom and choice, and maximised their independence. A person-centred approach was evident, with several examples of residents being supported by staff to pursue their individual interests. Staff were observed providing care in a sensitive and discreet manner, and were respectful in their interactions with residents.

Work was ongoing since a previous inspection in 2016 to ensure that residents had opportunities to participate in meaningful activities in line with their interests and capabilities. An additional activity co-ordinator had been recruited and these two staff members were responsible for activity provision during the week. Rosters indicated that designated care staff were assigned to providing activities at weekends. Practice development in relation to activity provision was being facilitated, and this was being used to enhance the quality of the activity programme. For example, the documentation to record activity participation had been reviewed by the activity co-ordinators and new templates had been developed. One of the activity co-ordinators informed inspectors that, once implemented, these templates will record and evaluate the level of residents' engagement in each activity. A new assessment tool will also be implemented in line with this documentation.

A varied activities programme was being provided to residents in both buildings. On the day of the inspection, activities such as word games, painting, a newspaper review, chair-based exercise and skittles games were held. A period of time was also spent making room visits, where one-to-one activities were held with residents. While activities had previously been held on both floors of one building, this arrangement had recently been revised to accommodate all activities on the ground floor. Some staff and residents informed inspectors that this arrangement was not suitable for all residents in the building, and this was highlighted to management on the day of the inspection.

While the centre currently did not have access to specialised transport to facilitate outings for large groups of residents, management in the centre outlined to inspectors

that work was ongoing to facilitate transport for outings on a more regular basis. Staff outlined the efforts that were made to go out with residents on a more individual basis, such as walks to the local village. A bowls or skittles tournament was held between this centre and another nursing home every three months, and the location of the tournament alternated between these two centres. An outing to a local festival had also been organised for approximately 15 residents for the week after the inspection; transport was being supplied by an external service provider in this instance. In advance of this outing, a theatrical performance, developed by a member of staff working in the centre, was being held in the centre for all residents, and extensive decorations to support this performance had already been erected in the centre's foyer. Staff told inspectors that the performance had also been tailored to engage residents with dementia.

A summer party had been held in the centre the week prior to the inspection, consisting of a barbeque with live music also provided. Residents, their relatives and visitors had been invited, and a large number were in attendance on the day. Afternoon tea parties were held on a frequent basis, and alternated between both buildings to facilitate all residents that wished to attend. A number of external providers were involved in the provision of activities on a regular basis, including a musician and a exercise group that visited weekly. Two hairdressers also attended the centre weekly, and a hair salon in each building catered to residents' needs in this respect.

A residents' meeting had last been held on 4 April 2017, minutes of this meeting indicated that this had been attended by 17 residents. While actions had been identified in this meeting and subsequently addressed, it was not clear how frequently these meetings were held or when the next one would occur. On the day of the inspection, management staff agreed to revise this to ensure that feedback is sought from residents on a regular basis.

While visiting was not restricted in the centre, an initiative was in place at mealtimes to ensure that residents could take their meals undisturbed. A number of rooms were available throughout both buildings to facilitate residents to meet with visitors in private.

Residents were facilitated to exercise their civil, political and religious rights. An oratory was located in each building, which could be adapted to hold services for a number of different faiths. The deputy director of care outlined to inspectors how residents were supported to practice their respective faiths. Voting could be held in the centre, and residents could also vote in their electoral area.

A telephone was located in each resident's bedroom, and cordless handsets allowed residents to take calls in other areas if they so wished. Internet was available in the centre, and residents could avail of this if desired.

Residents' communication needs were outlined in care plans and these were reflected in practice by staff.

Residents had access to independent advocacy services, which could be contacted as required.

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:
Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Ongoing review of resident dependency and staffing levels were monitored to inform staffing levels and skill mix. Staff spoken to confirm that they had sufficient time to carry out their duties and responsibilities and nurse managers explained the systems in place to supervise staff. Staff spoken with felt supported by the management team.

Evidence of current professional registration for all registered nurses was seen by inspectors.

The training records highlighted significant gaps with in-house mandatory training on patient moving and handling and fire safety. There were no records available for inspectors to review on the day of inspection for training on Safeguarding and safety. All staff nurses had additional training requirements such as medication management and cardio pulmonary resuscitation. The training matrix that was available identified which staff had attended training and management had taken steps to address the gaps in current requirements. For example, a member of the current staffing compliment is now able to deliver the training requirement on moving and handling.

Recruitment and induction procedures were in place. The management team informed the inspectors that a recent staff audit had been conducted. However, not all documents required under Schedule 2 of the regulations are contained in the personnel files. This is actioned under Outcome 2 Governance and Management.

The provider had had completed Garda Vetting for the Legion of Mary volunteers

Judgment:
Non Compliant - Moderate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Droimnin Nursing Home
Centre ID:	OSV-0000702
Date of inspection:	17/08/2017
Date of response:	05/09/2017

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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As per the regulations, the statement of purpose had detailed the organizational structure of the designated centre. However, some minor changes to clarify the governance structure, job titles, specific roles and responsibilities are required.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Statement of Purpose has been altered to demonstrate a clear line management relationship between the Deputy Director of Care and the Clinical Team.

Proposed Timescale: 11/09/2017

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The identified lines of authority, accountability and responsibilities for the areas of care provision required review. The senior nurse management team had agreed on areas of accountability within the centre and the inspector reviewed the documentation on this. However, findings on inspection did not align to what had been agreed. For example the Deputy Director of Care carried out audits on monitoring of resident nutritional needs but did not have line management responsibility over the clinical staff nurses delivering the care.

2. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The Governance & Management structure within the statement of Purpose will be updated to include the roles and responsibility of the Deputy Director of Care as line Manager for the Clinical Teams.

Proposed Timescale: 11/09/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were informed that monthly meetings occur with senior management. However, the most up to date minutes available for inspection were dated March and April 2017.

Based on evidence gathered the inspectors concluded that the monitoring of practice and service delivered by staff was not sufficiently monitored to ensure the service provided was safe, appropriate and consistent.

Inspectors were concerned that monthly gathering of information that was in place has discontinued. There was no monthly data available for review on falls and the use of restraints for 2017.

3. 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:
The minutes of the last monthly management meeting held in August 2017 were gone to print on the date of the inspection; they have since been completed. The monthly data collections on Falls, Restraint, Dependency Levels, Weight Loss and Complaints have been updated by the PiC. Whilst the data from July -December 2016, and January-June 2017, was not made available on the day of the inspection due to administrative issues, it has since been located and is now available. Since the inspection all data is now contained in one location ensuring ease of retrieval when required.

Proposed Timescale: 11/09/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were informed that a review of staff files had recently been carried out. However, inspectors found gaps in all four files reviewed. Although Garda Vetting was present in all the files examined the inspectors noted that the start date for two employees preceded the date when Garda Vetting was received.

4. 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:
The Staff files identified as having gaps during the inspection are being reviewed and these gaps are currently being addressed. Going forward, no new employee will be rostered for duty until his/her Garda Vetting, Manual Handling, Safeguarding & Protection of Vulnerable adults, Infection control, is completed.

Proposed Timescale: 29/09/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were concerned about the ability of the management team to retrieve data requested and provide information in a timely manner. For example, information requested by the inspectors at the introductory meeting at 09.00am was not provided until the feedback meeting at the end of inspection.

5. 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:
The current data management system is being updated to ensure that all files can be more easily updated, and can be retrieved in a timely manner by staff. Both clinical and administrative staff will be involved in the process and each category will be made fully aware of the location of all files. A Control Folder containing all policies available for staff is also now available in the Learning Centre.

Proposed Timescale: 15/09/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was acting as a pension agent for a small number residents. The system in place to manage these payments required review to ensure that it was in line with the relevant guidelines and legislation.

6. 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:
This matter is currently being reviewed by the Provider and an appropriate system, which complies with the regulations and HIQA guidelines, will be implemented in the coming weeks.

Proposed Timescale: 29/09/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of the policies last updated May 2017 was required to ensure that the practice in place on risk management is reflected within the policies. For example, the centre has implemented a wandering tag system to safeguard residents at risk from absconsion. This system is not outlined within the policy.

7. Action Required:
Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

Please state the actions you have taken or are planning to take:
The nursing home's risk management policies will be reviewed and included in this will be Policy Number CE-025 (Management of Resident Absconsion). Care plans and risk assessments will be implemented for all residents who currently use of the wandering tag system.

Proposed Timescale: 15/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management team confirmed that four fire drills have been carried out in 2017. However, the detail of the drills was not available on the day of inspection.

8. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Scheduled fire drills (day and night) which will include, timings, location, participants, learning outcomes and action plans following the drills will be recorded and available for inspection at any time. This information will be discussed at all staff meetings to ensure that staff are familiar with the fire drill and also to improve the nursing home's Fire Management System.

Proposed Timescale: Immediate

Proposed Timescale: 05/09/2017

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:
Residents were not sufficiently protected by medicine management practices found during this inspection and the standards did not meet with professional or regulatory requirements as follows:

• on two occasions where a controlled drug had been taken from a resident's supply, records did not clearly indicate to whom the controlled drug had been administered. Records outlining who had received the controlled drug on these two occasions was later provided to inspectors by a member of senior management.
• records evidenced that on one occasion, only one staff member's signature was recorded on the controlled drug register, which does not meet professional requirements and is not in line with the centre's in house medicines management policy.
• the requirement of an original prescription by a resident's medical practitioner within 72 hours for faxed or transcribed medicines was not consistently adhered to or seen implemented in practice. Medicines transcribed on four residents' kardexes had not been signed by the GP but had been administered by staff in the centre
• a photograph for each resident was not evident for a number of residents with medicine or prescription records reviewed by inspectors, which may compromise resident safety

9. 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:
A) With immediate effect any Residents prescribed controlled drug medication will have his/her own supply available with their name clearly labelled and a valid prescription will be in place as per Droimnin Nursing Home Policy HS-006 Prescribing, Ordering, Storage and Disposal of Medications. Controlled drugs will to be ordered as part of the Residents monthly medications to ensure a sufficient stock availability for each identified Resident.

B) All Nurses have been advised by the PIC of their obligation to comply with their professional standards of responsibility for Medication Management of Controlled Drug Administration (NMBI) as per Droimnin Nursing Homes Policy HS-007. All staff Nurses have been advised to complete Medication management as per HSE-Land and present their certificate to PIC upon completion.

C) Photographs have been uploaded on the drug kardex's found to have been missing photographic identification during the inspection. Going forward the administration team will ensure this is carried out as part of the admission process.

Proposed Timescale: 05/09/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Significant improvements were required to ensure that medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

10. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
Following the inspection, a full review of all controlled Drugs stock in house has been carried out by the PIC and RGN's and all discontinued items were immediately removed and returned to pharmacy in accordance with Droimnin Nursing Homes Medication Policy HS-006 Prescribing, Ordering, Storage and Disposal of Medications. This practice, in accordance with professional or regulatory requirements, will be continued going forward.

New Controlled Drugs record registers are now in place in all three areas. Regular spot checks and audits of Medication Management practices will be carried out by the PIC, the Deputy Director of Care and the CNM's when in post.

Proposed Timescale: 05/09/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The training records highlighted significant gaps with in house mandatory training on patient moving and handling and fire safety.

Evidence that staff had completed safeguarding training could not be obtained by inspectors on the day of the inspection

11. 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:
A full review of staff training has been undertaken and any staff members whose mandatory training is not up to date have now been scheduled for training.

Proposed Timescale: 29/09/2017