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:	Drumbear Lodge Nursing Home
Centre ID:	OSV-0000132
Centre address:	Cootehill Road, Monaghan.
Telephone number:	047 84 800
Email address:	info@drumbearnursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Drumbear Lodge Limited
Provider Nominee:	Dymphna MacMahon
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make 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.

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.

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:
07 August 2014 09:30	07 August 2014 18:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was unannounced and was the sixth inspection of the centre. The inspector spoke with residents, the provider, person in charge and staff members. The inspector observed practices and reviewed a sample of residents' documentation such as care plans, medical records, some policies and procedures, incident log, directory of residents and staff training records and duty rotas. A general walk-around inspection of the nursing home environment was also undertaken facilitated by the provider.

Resident accommodation is located at ground floor level. The centre was visibly clean and well decorated throughout. Arrangements were in place to ensure infection control and prevention responsibilities were met. Residents spoken with were complimentary of the staff team and expressed satisfaction with the care they received to support their needs. The external pathways and gardens were maintained to a good standard.

During the course of the inspection, the inspector discussed the arrangements and layout of areas of the environment including a multi occupancy room and some twin room accommodation with the provider in respect of adequacy to meet the needs of residents as described in the centre's statement of purpose. The provider advised

that she was preparing plans to address same. The inspector reiterated the guidance issued by the Authority to providers in relation to ensuring facilities meet 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 by July 2015.

Clinical governance arrangements were required improvement and fire safety management in respect of procedures for safe evacuation of residents and the absence of clear policy documentation to inform all aspects of risk management in the centre as required by the regulations.
Staffing levels and skill mix required review to ensure adequacy to meet the needs of residents who reside in the 'high dependency area' to facilitate '24hr high nursing support' as described by the National Standards. While staff were informed, training records did not evidence that all staff had attended mandatory training requirements including protection of vulnerable persons and fire safety procedures including participation in fire drills.

Transcription and crushing of medication procedures did not meet all professional and legislative requirements on this inspection. A number of policies to inform practice in the centre were not adequate and require revision to include missing information and to ensure they are reflected in practice.

Review of a sample of residents' care documentation did not provide adequate evidence to support the level of some residents' participation in the social programme and whether positive outcomes for residents were achieved in meeting recreation/occupational needs. While, allied health professional expertise was available to support resident needs, there was evidence that recommendations made following some consultations were not carried out. There was inadequate information to support the involvement of residents and/or their significant other in the care plan reviewing process.

Other areas requiring improvement included aspects of the reviewing the quality and safety of care process and complaints management in terms of information to inform practice.

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

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
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 which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents, reflected practice in the centre and contained information in relation to the matters listed in Schedule 1 of the Regulations. A copy of the statement of purpose was made available on inspection and following minor revision to include further information on the complaints procedure in the centre dated 19 August 2014 was and forwarded to the Authority. However details of the deputising arrangements for the Person in Charge including their details as a person participating in the management of the centre were not included. The arrangements including the purpose, criteria for admission and staffing support for the high dependency unit were not stated. The provider was aware of the need to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Judgment:
Non Compliant - Moderate

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 were sufficient resources in terms of staffing, skills and equipment to ensure effective delivery of care in accordance with the centre's statement of purpose. There was a clearly defined management structure that identified the lines of accountability and authority. The provider and person in charge worked full-time in the centre and managed its day to day operation together. Aspects of the quality and safety of care and the quality of the residents' experience in the centre were monitored. The inspector reviewed evidence of safety audits, monthly accident and incident review, maintenance audits, an annual pharmacy audit and an end of life audit among others. While key information was collated in data collection, not all information analysed informed improvement, for example; an analysis of resident fall did not highlight that 50% of falls occurred between 21:30 and 02:30hrs, one of which resulted in a serious injury to a resident. In addition, concomitant quality improvement plans were not developed as part of the quality improvement process to include details of the actions to be taken, completion timescales and delegation of a designated person with responsibility for completion to ensure there was timely resolution of deficits identified from analysis of audit data collated. However, there was some evidence of quality improvement following monitoring reviews. For example, incident report templates were recently reviewed and reformatted to improve collection of clinical information including neurological observations following resident falls where appropriate. A summary log of each incident and the resident involved was compiled to assist with tracking of recurrent resident falls. The inspector was told by the provider that a summary report of quality and safety reviews was being developed for availability at the end of the year.

Judgment:
Non Compliant - Moderate

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:
It was noted that all beds in the centre were fitted with integral bedrails and these were in use for a number of residents' beds. The National Restraint policy and procedure was referenced to inform restraint management. However, the inspector observed that this

policy continues to refer staff to other Health Service Executive policies not in use in the centre and therefore not available to inform practice in the centre. This finding was the subject of an action plan of the inspection in June 2013. Bedrail risk assessments were completed for residents using same.

The medication management policy document did not adequately inform practice for prescribing or administering crushed medications. The inspector noted that a 'controlled release' medication prescribed for treatment of symptoms of Parkinson's disease was being administered crushed. The transcription of medications procedure requires review to reflect the instruction in the policy to include the signatures of transcribers and checking nurse on the prescription.

The staff duty rota did not include designated hand-over time at the start and end of each work shift to ensure ongoing communication of residents needs was in place. The off duty rota did not include the hours of night-duty actually worked by staff.

The directory of residents contained all required information as described in schedule 3 of the Regulations.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
The centre was found to be safe and secure. The entrance and exit doors were secure yet accessible to residents. A visitors log was in use to monitor the movement of persons in and out of the building which the inspector observed to be in use.

There were no allegations of abuse disclosed as reported by the provider and person in charge. There was a suite of policies informing protection of residents' policy on protection of residents from abuse including responding to allegations of abuse dated 01 May 2014. However, the policy informing response to allegations of abuse did not include referral details for the elder abuse social worker. In addition the policy did not inform the procedures to take if an allegation was made against a senior member of staff.
In conversation with some members of staff, the inspector found they were aware of

their responsibilities in relation to reporting allegations or suspected instances of abuse and were knowledgeable of the signs of potential abuse to residents. However, 16(26%) of staff had not attended protection of vulnerable persons training according to the training records given to the inspector and staff spoken with were not aware of the elder abuse social worker role or referral process. Residents spoken with by the inspector said they felt 'safe' and were complimentary of how the staff cared for them and their interactions with them. Staff interactions with residents was observed by the inspector and found to be respectful and patient in all respects. Residents were aware of the complaints process in the centre and reported that they could talk to staff including the person in charge and the provider about any concerns or areas of dissatisfaction they had.

Management of residents' finances was reviewed on this inspection. A policy on security of residents' accounts and personal property was available to inform practice. The provider facilitates safekeeping six residents' day to day expense accounts and is an agent for collection of one resident's social welfare pension. The inspector viewed the transactions of these accounts and found them to be transparent with concomitant accurate balances. All transactions were receipted and double -signed. However, the arrangement as appointed agent on behalf of one resident was not recorded as part of the residency agreement.

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

Findings:
The inspector found on this inspection that health and safety of residents, visitors and staff was generally protected with the exception of evacuation of residents in the event of a fire occurring in the centre. There was a policy informing fire safety management dated 01 May 2014. All final fire exits were unobstructed. A comprehensive fire prevention checking procedure was in place. Evacuation sheets were fitted on each resident's bed to assist with evacuation if required. However, personal evacuation assessments were not completed for each resident to determine personnel and equipment requirements for their safe evacuation in the event of a fire in the centre. The policy describes two techniques for evacuation that may pose a risk of injury to residents and does not clearly inform the evacuation procedure for example, whether from one zone to another or external to the building. There was an inadequate commentary record of fire evacuation drills completed and although the inspector was

informed that a simulated night-time fire drill had taken place on the 02 April 2014, there was no documented evidence of this drill having taken place to ensure night-time staffing levels were adequate to complete timely evacuation of residents.
The inspector reviewed the staff fire training records and found that seven staff were not referenced as having attended this training to date for 2014.

A weekly safety audit was completed that included, for example, review of fire prevention and safety and infection control and prevention procedures. While a comprehensive analysis was completed in each case and actions to address deficits found were entered on the page referencing analysis, quality improvement plans were not formulated that specified completion timescales and assigned responsibility for completion to ensure address of all deficits found were timely. The risk management policy referenced as the 'organisational risk assessment' in the centre was dated 26 March 2014. However, there was also inadequate information to inform incident identification, reporting, investigation and learning from outcomes. This finding was the subject of action plans developed from findings of the last inspection of the centre in June 2013 and are restated in the action plan developed from this inspection. Risk assessments were completed with concomitant mitigating controls in place with the exception of unscheduled floor buffing as a procedure completed following fluid spillage.

All resident accidents and incidents were recorded. Each resident had a falls risk assessment completed While a resident falls management policy was available, it did not evidence appropriate completion of neurological observations and monitoring of residents who sustained a head injury or had an unwitnessed fall. The inspector reviewed the accidents to residents since January 2014 and found that 50% occurred between 21:30 and 02:30hrs, one of which included a serious injury to a resident. There was inadequate evidence to support active management of this finding.

The centre environment was observed to be clean and clutter free and there were measures in place to control and prevent infection including hand hygiene gel dispensing units at convenient locations throughout. The majority of staff had received training in infection control and prevention as evidenced by staff training records. However, the inspector observed unscheduled floor buffing in progress while residents were returning to the day-room following lunch. While, the member of cleaning staff was gathering up loose electric cable to prevent accidents, the floor buffing procedure to clean up spillages required review to ensure risk of resident trips and falls was documented and mitigated with appropriate controls.
The inspector was told that all staff had attended mandatory moving and handling training and observed safe moving and handling procedures with residents.

Judgment:
Non Compliant - Major

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:
Written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents were in place which was updated in May 2014. Adequate procedures were in place for management of controlled medications as required. Controlled medications were stored in a locked cupboard within a locked cupboard and separate from other medications. A twice daily checking schedule was recorded by two staff on each occasion. Controlled medications were dispensed on a named person basis only as required. All discontinued medications were signed and dated by the residents' GP. Administration record times matched the prescription times as 'breakfast, lunch, tea and bed-time'. Maximum dosage of 'as required' (PRN) medications were stated but required clarity in the policy document to inform practice. One resident was receiving medications in crushed format. The medication management policy document did not adequately inform practice on this administration format as administration procedures were prescribed as a general order 'meds can be crushed as per GP'. The inspector noted that a 'controlled release' medication prescribed for treatment of symptoms of Parkinsons disease was being administered in crushed format.

Transcription of medications was undertaken by registered nurses in the centre. This procedure requires review to reflect the instruction in the policy to include the signatures of transcriber and checking nurse on the prescription. The inspector found that each resident's medication was reviewed regularly by the medical team on this inspection. Residents' photographs were clear and fixed on each prescription for the purposes of checking procedures during medication administration. Drug allergies, date of birth and each resident's GP details were recorded. The deficits in the medication policy and findings that it was also not reflected in medication transcription practice in the centre are discussed in outcome 4 of this report.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:

Quarterly notifications and notifications of serious injury had been submitted to the Authority as required and within the appropriate timeframe. The person in charge was aware that she was legally obliged to notify the Chief Inspector of incidents such as serious injury to a resident or an outbreak of infection. Failure to forward notification of serious injuries to two residents was a finding of inspection in June 2013 and the subject of an action plan found to be completed on this inspection.

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:
Each resident had a care plan developed from assessment to meet their needs. The inspector reviewed a sample of care plans and care documentation. A variety of assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration. For example, vulnerability to falls with corresponding actions to take to level of assessed risk, dependency levels, nutritional risk assessment, pressure related skin damage risk assessment and moving and handling assessments which were updated every three months thereafter. While, there was evidence that care plans were reviewed by staff, there was inadequate evidence of involvement of the resident or their significant other and a record of which, if any care plans were amended following this consultation process. Residents had adequate documented access to general practitioner (GP) services in addition to specialist services to support their mental health needs where required. Access to allied health care services was reported as available and in place to meet the diverse care needs of residents. In a sample of records reviewed, the inspector noted that consultations and assessments with care recommendations were recorded to support referral in most cases as appropriate. However, there was evidence in two residents' documentation reviewed that recommendations were not implemented or evaluated to ensure they were effective. For example, a resident admitted to the centre in March 2014 having percutaneous endoscopic gastronomy (PEG) nutrition. This resident was reviewed by a dietician in the hospital setting with a documented discharge recommendation that follow-up by a dietician was required; however, no record was available to support dietetic review since admission to the centre in March 2014. Another resident was on a recommended weight reducing diet with a 5 to 10% weight loss target recommended following assessment,

however weight monitoring records evidenced a weight gain of 3kg. Access to palliative care services was also reported. A resident recently admitted was in receipt of end of life care and urgent referral processes were completed to ensure palliative care input. The inspector observed that not all residents' end of life care wishes were documented to ensure they receive end of life care in a way that meets their individual needs and wishes and respects their dignity and autonomy. This finding was discussed in the report following inspection in June 2013 where the person in charge stated staff were receiving education and support in ensuring residents were facilitated to make decisions about their end of life care. Five staff had attended end of life care training in 2013 and seven staff attended in June 2014. In addition six staff attended training on management of medication pumps for administration of medication in palliative care.

The inspector observed the activity co-ordinator preparing to facilitate a scheduled activity while background music was playing. While twenty six of the fifty one residents residing in the centre were in the sitting room at this time, not all participated. Residents spoken with by the inspector said they preferred to listen rather than participate in some activities. One resident told the inspector that while she attended the activity and didn't participate, she planned to participate in the scheduled afternoon activity as it was her favourite. The weekly activity programme was displayed. Another resident with reduced mobility function told the inspector that she wasn't able to engage in the activities she used to do to relax at home due to her medical condition. Staff were knowledgeable regarding her past interests and hobbies. However, the inspector found that inadequate records were available evaluating whether participation in scheduled activities resulted in positive outcomes for individual residents. Although the inspector was told that the activity co-ordinator attended residents who remained in bed or in their bedrooms, an activity/recreation care plan was not present in one resident's documentation reviewed.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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' accommodation is provided at ground floor level throughout. The inspector observed that refurbishment work providing two offices and change of purpose of a room used previously as an office back to its original use as a single bedroom was

completed. The location of the new offices facilitated management to ensure improved service delivery and enhanced monitoring of the entrance to the centre.

A review of residents' accommodation in a six bedded multi occupancy room and some twin rooms using the guidance of the requirements of the Regulations and minimum standards as set out in the National Standards is required to determine how these rooms will meet residents' needs. During the course of this inspection the inspector discussed an existing six bedded, multi occupancy room and the layout of some twin rooms with the provider and person in charge and re iterated the guidance issued by the Authority to providers in relation to ensuring facilities meet the Regulations and the Authority's Standards by July 2015. The provider told the inspector that plans were under development to ensure the accommodation provided met the needs of residents as described in the centre's statement of purpose document. Room 17 is a multi occupancy room accommodating six residents with an en suite shower, toilet and wash basin provided. Glass window panels are fitted in the adjoining wall with a circulating corridor on each side of the entrance door to the room. While, the inspector observed that curtains were fitted and were drawn closed during residents' personal care activities on the day of inspection, this finding did not ensure the privacy needs of residents were assured. In addition, the layout of this accommodation was clinical in style and did not ensure residents had adequate private space which they could personalise. Most residents in this area had no personal shelf space other than the top of their lockers or wardrobe for displaying their personal items. One television was available for viewing by the six residents which did not promote personal choice or autonomy. However, arrangements as required for a high dependency facility as defined by the National Standards in terms of staffing levels and the level of dependency of those residing there were not clearly evidenced as meeting same. Five of the six residents attended the day room and dining room on the day of inspection and none of the residents in this area were assessed as having maximum dependency needs.

In addition the inspector discussed the layout of some twin bedrooms which required review to ensure they meet the needs of residents and are in compliance with the Regulations and Standards. The inspector observed that the space available inside bed screens to provide appropriate care for residents using assistive equipment such as chairs and/or hoists was limited. In addition, residents could not access en-suite facilities in some twin rooms without encroaching into the personal space of the other especially when bed screening was closed for privacy or/and personal care activities. The provider stated that she was reviewing these arrangements.

The premises were visibly clean. As discussed in Outcome 7 of this report, cleaning of communal rooms required review to promote resident comfort and to reduce risk posed to residents of trip or fall. Adequate cleaning, sluicing and laundry facilities were provided with access controlled by keypad locks. There were two sitting rooms and one dining room, all of which were used by residents. Residents had access to a secure courtyard. Assistive equipment was provided to meet the assessed needs of the residents including standing and lifting hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames.

Maintenance arrangements were reviewed on this inspection. A full-time member of staff carried out maintenance of the centre. There was a procedure in place for

identifying maintenance issues including faults which was signed-off on completion. This arrangement facilitated quality assurance and identification areas requiring review.

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):
No actions were required from the previous inspection.

Findings:
There was a complaints procedure in place in the centre; informed by a complaints policy dated 01 May 2014. However, the complaints policy information did not meet all the requirements of the Regulations. Missing information included identification of the centre's designated complaints officer and details as required by Regulation 34 (3) for a person other than the designated complaints officer and appeal arrangements to ensure the requirements, including documentation and timescales were met as stated. An independent appeal process was in place but details were not stated in the statement of purpose document which was corrected before the end of the inspection.

The inspector reviewed the centre's complaints log and observed that there were no written or verbal complaints referenced for 2014. The provider and person in charge confirmed this information was correct on enquiry by the inspector.
As there were no verbal or written complaints logged, the complaints process was not a subject of audit in the centre. Residents spoken with in relation to their satisfaction with the complaints process confirmed that they knew who to make a complaint to, Others confirmed their satisfaction with their care and the facility they were residing in.

Judgment:
Non Compliant - Minor

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):
No actions were required from the previous inspection.

Findings:
The inspector found that staffing levels required review to ensure the needs of residents were met. Arrangements as required for a high dependency facility as defined by the National Standards in terms of staffing levels and the level of dependency of those residing there were not clearly evidenced as meeting same. There were 52 residents in the centre of which 27 had high dependency needs, 1 had maximum dependency needs, 14 had medium and 10 had low dependency needs. The centre has a high dependency facility accommodating six residents. However, the inspector observed that the staffing levels found did not reflect an adequate staffing level/skill mix to provide for the required '24 hour high support nursing care' in the area referenced as a high dependency unit, as described by the National Standards. The inspector reviewed the resident falls for 2014 to date and found that (5)41% of falls occurred between 21.15 and 02.25hrs. In addition, a report of serious injury to a resident forwarded to the Authority referenced a resident falling twice between 18:30 and 22.30hrs on the same date.

On the day of inspection, the inspector reviewed the staffing rota and found that a senior carer grade was rostered to work on each day shift with the exception of one Sunday. This finding provided additional support for the carer team. The provider and person in charge both registered nurses worked Monday to Friday. The inspector noted that one staff nurse was on duty from 16:00hrs to 08:00hrs each 24hr period which may not be adequate to meet the high support nursing care needs of residents in the high dependency unit. Annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement and with the support of an identified 'relief' team which provided continuity for residents. While the inspector confirmed that there was a staff handover, there was no lap-over of the shift start and finish times to include this activity into the structure of the staff schedule. This finding is discussed in outcome 4 of this report.

Residents interviewed were complimentary of the staff team and expressed satisfaction with the care they received to support their needs. The inspector found staff spoken with to be knowledgeable of their roles and responsibilities regarding residents' care and preferences.

Staff were observed to practice safe moving and handling procedures and the person in charge told the inspector that all staff had completed mandatory training in this area. However, not all mandatory training was completed by staff. The training records evidenced that 16 staff had not completed elder abuse training and seven staff had not completed fire safety/drill training.

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:

Catherine Rose Connolly Gargan
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:	Drumbear Lodge Nursing Home
Centre ID:	OSV-0000132
Date of inspection:	07/08/2014
Date of response:	17/11/2014

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:
Details of the deputising arrangements for the Person in Charge including their details as a person participating in the management of the centre were not included in the Statement of Purpose document.

The arrangements including the purpose, criteria for admission and staffing support for the high dependency unit were not stated.

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

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 Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The deputising arrangements and details of same for absence of the PIC have been added into the Statement of Purpose. Please find copy of revised SOP to reflect these changes.

Proposed Timescale: 17/10/2014

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:
While key information was collated in data collection, not all information analysed informed improvement.

Quality improvement plans were not developed to include details of the actions to be taken, completion timescales and delegation of a designated person with responsibility for completion to ensure there was timely resolution of deficits identified from analysis of audit data collated.

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:
Weekly and Monthly Safety inspections have been reviewed and now include the following:
Details of the actions taken, completion timescales, outcomes and delegation of a person responsible for these have been added to the weekly and monthly Health & Safety inspections.

Proposed Timescale: 17/10/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

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

the following respect:
The restraint policy continues to refer staff to other Health Service Executive policies not in use in the centre and therefore not available to inform practice in the centre.

The medication management policy document did not adequately inform practice for prescribing or administering crushed medications. The transcription of medications procedure requires review to reflect the instruction in the policy to include the signatures of transcribers' and checking nurse on the prescription.

Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
a) HSE policies have been removed from Nursing Home Restraint Policy. Completed.
b) Plan: Medication Management Policy document will be reviewed with a view to inform practice for prescribing and the administration of crushed medications.
c) The transcription of medicines procedure will be reviewed to reflect practice.
Timescale for b) and c) 8th December 2014. However I will endeavour to address b) and c) sooner if possible.

Proposed Timescale: 08/12/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff duty rota did not include designated hand-over time at the start and end of each work shift to ensure ongoing communication of residents needs was in place. In addition the duty rota did not include the hours of night duty actually worked by staff rostered for same.

Action Required:
Under Regulation 21(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
The off duty now contains details of the designated handover times and hours of night duty actually worked.

Proposed Timescale: 17/10/2014

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 policy informing response to allegations of abuse did not include referral details for the elder abuse social worker. The policy did not inform the procedures to take if an allegation was made against a senior member of staff.

The arrangement as appointed agent on behalf of one resident was not recorded as part of the residency agreement.

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:
a) The Policy informing response to allegations of abuse now contains details of the elder abuse social worker allocated to the Nursing Home area and how staff can contact him and all staff are aware of same.
b) The policy also has been revised to include procedures for staff to take if an allegation is made against a senior member of staff.

Proposed Timescale: 17/10/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
16 (26%) of staff had not attended protection of vulnerable persons training according to the training records given to the inspector and staff spoken with were not aware of the elder abuse social worker role or referral process.

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:
a) Staff are now all fully aware of the Elder Abuse Social Workers role and the referral process for same.

Proposed Timescale: 17/10/2014

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:
The risk management policy referenced as the 'organisational risk assessment' did not provide adequate information to inform incident identification, reporting, investigation and learning from outcomes.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The "Organisational Risk Assessment s" Policy will now be referred to as "The Risk Assessment Policy" in this Nursing Home.

The following areas were risk assessed, hazards identified, Control measures in place and person responsible on the 26/03/2014. This information is included in the Risk assessment Policy for all staff to read and a copy is held in the Health & Safety file. Areas assessed on the 26/3/2014 are as follows: Residents, Catering Staff, Maintenance, Direct Care Workers (Nurses & Care Assistants), Visitors, Doctors and MDT members, Laundry Staff.

Proposed Timescale: 17/10/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unscheduled floor buffing to clean up spillages required review to ensure risk of resident trips and falls was mitigated.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
As per Cleaning Policy any hoovering of mats/carpet is carried out in the morning time before the residents go to the dining room for breakfast.

Mats are located at all exit doors and the "Reading room" is the only reception room carpeted in the home.

On the day of inspection there was a spill on the floor of the back sitting room. A member of housekeeping was asked by the Home Manger to spot clean this area following an on the spot risk assessment due to the spill to avoid slips and falls.

A member of nursing staff was present in the sitting room at this time and explained to the inspector that there was a spill and it was being attended to. This action only took minutes to complete. This was a necessary action to prevent the risk of slips and falls. At all times throughout this action the member of housekeeping and the nurse was aware of the resident's safety and remained in the room.

Proposed Timescale: 17/10/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector reviewed the staff fire training records and found that seven staff were not referenced as having attended fire safety training/evacuation drill training to date for 2014.

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:
On review of the Fire Training records 1 staff member was on Maternity leave.
The remaining new staff members received training on Fire Safety on induction; however they are scheduled for full Training on Fire Safety and Evacuation in November 2014.

Proposed Timescale: 17/10/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal evacuation assessments were not completed for each resident to determine personnel and equipment requirements for their safe evacuation in the event of a fire in the centre.

The policy describes two techniques for evacuation that may pose a risk of injury to residents and does not clearly inform the evacuation procedure for example, whether from one zone to another or external to the building.

There was inadequate commentary records of fire evacuation drills completed.

There was no documented evidence of a drill having taken place to ensure night-time staffing levels and skills were adequate to complete timely evacuation of residents.

Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
a) PEPS: Nursing home management were unaware that PEPS were a requirement in the Regulations. However on the day of this unannounced inspection the home manager had the PEP forms ready to be completed on all residents and then put in place. The manager showed these to the inspector and she was made aware of the plans to implement this. PEPS are now in place for every resident in the home.
b) All residents have an evacuation blanket on their beds; however the Fire Management Policy does not adequately reflect fire procedures in the home. The Fire Policy will be reviewed to reflect practice.
c) Commentary records for Fire Drills will be documented going forward. Fire drill and staff training in the use of fire extinguishers carried out on the 3rd, 4th and 5th of November. Full commentary completed on same.
d) Documented mock evacuations will take place to ensure night staff levels and skill mix are adequate to ensure timely and safe evacuations.

Proposed Timescale: 17/10/2014

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:
Crushing of a slow-release medication for administration in crushed format was not appropriate.

Action Required:
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

Please state the actions you have taken or are planning to take:
There is a reference document to advise what medications can /cannot be crushed and whether such crushed medications can be safely administered together without changing their pharmacological actions. This is kept in the Clinical treatment room. Staff constantly liaise with the Pharmacist and the residents GPs re medication management.

Since our inspection we have purchased two "Silent Knight" tablet crushers in order to

prevent cross contamination of crushed medications residue.

Plan: To remind staff Nurses that there is adequate documentation to refer to in relation to crushing of medications. These documents are kept in the clinical room.

Proposed Timescale: 17/10/2014

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An activity/recreation care plan was not present in one resident's documentation reviewed. There were inadequate records available evaluating whether resident participation in scheduled activities resulted in positive outcomes for individual residents.

Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
All residents care plans have been reviewed and personalised and all residents currently have activity/recreation care plans.

Recorded documentation is currently in place to show what activity each resident participates in. However this will be reviewed to include measures to record outcomes of resident's participation and feedback in these activities.

Proposed Timescale: 17/10/2014

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While, there was evidence that care plans were reviewed by staff, there was inadequate evidence of involvement of the resident or their significant other and a record of which, if any care plans were amended following this consultation process.

Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
Plan:
All nurses reminded to involve the resident and or their significant other/nok when they are reviewing the residents care plans.

Proposed Timescale: 17/10/2014

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence in two residents' documentation reviewed that recommendations from specialist services were not implemented or evaluated to ensure they were effective.

Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
In relation to the above two residents highlighted in the report we have conducted a full review of all residents with PEG tubes and are satisfied that all relevant care required by special services took place, documented and were followed up.

All residents on a calorie controlled diet have been reviewed and we are satisfied that the recommended diets are being followed within our control.

Proposed Timescale: 17/10/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An existing six-bedded room and the layout of some twin rooms did not meet their stated purpose and were not in compliance with the requirements of the Regulations and minimum standards as set out in the National Standards document is required by July 2015.

Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated

centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
a) In view of the new regulations we are no longer referring to the 6 bedded unit in the nursing home as a "High dependency unit". Therefore this 6 bedded does not require a specific criteria for admission, nor does it require additional support staff.
b) Plans have been prepared by our architect for a 12 bedded extension for review by the Chief Inspector as the timescale for completion of this project will extend beyond July 2015.
c) In consultation with our architect, plans have been drawn up to redesign the existing 6 bedded unit. This will be converted into two 2 bedded rooms with en suite. This will take place on completion of our proposed 12 bedded extension which will be phase 1 of our existing planning permission.
d) All beds in the twin occupancy rooms have been repositioned to ensure adequate space for each resident.

Proposed Timescale: 31/12/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Glass window panels are fitted in an adjoining wall between the multi occupancy room and a circulating corridor on each side of the entrance door to the multi-occupancy room.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Plans are in place to address the 6 bedded.

On review of the issue in relation to glass panels in the 6 bedded, arrangements are in place to maintain the resident's privacy and ensure that it is not compromised.

The two glass panels are fitted with Venetian blinds which are drawn closed along with the individual resident's bed curtains to ensure maximum privacy for any resident being attended to in the 6 bedded.

The glass panels will be removed when the 6 bedded is redesigned.

Proposed Timescale: 31/12/2015

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A person was not nominated as required, 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).

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:
Plan: The Home Managers name has been added to the Complaints Policy as the nominated person to ensure that all complaints are appropriately responded to and in a timely manner.

Proposed Timescale: 17/10/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The nominated complaints officer for the centre was not stated in the policy document.

Action Required:
Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

Please state the actions you have taken or are planning to take:
Nominated Complaints Officer has been added to the complaints Policy document.

Proposed Timescale: 17/10/2014

Outcome 18: Suitable Staffing

Theme:
Workforce

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

the following respect:
Staffing levels found did not reflect an adequate staffing level/skill mix to provide for the required '24 hour high support nursing care' in the area referenced as a high dependency unit, as described by the National Standards.

The staffing levels at times of the day/night where evidence was found of residents at increased risk of falls required review.

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:
We have reviewed our staff and skill mix and we are satisfied that staffing levels are adequate.

In view of the above we continue to closely monitor all our residents in relation to their falls risks. Falls Risk assessments are carried out post each fall to inform us of changes required. Resident's mobility is assessed and monitored by in house Physiotherapist and care plans altered to reflect changes accordingly. The incident report forms have been reviewed to include neurological observations of residents.

We purchase specialised equipment for residents in an effort to prevent falls occurring. Falls are analysed on a monthly basis and an individual summary of falls for each resident is maintained and an annual audit is carried out. Audits have been reviewed to include outcomes and learning measures.

Plan: To continue to implement all of the above interventions and preventative measures and monitor effectiveness of same. Completed and ongoing.

Proposed Timescale: 17/10/2014

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The training records evidenced that 16 staff had not completed elder abuse training and seven staff had not completed fire safety/drill training.

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:
- At the time of inspection the Elder Abuse training record was not updated to reflect the number of new staff having received Elder Abuse Training. At this time we were

awaiting certificates from new employees who had already received Elder Abuse training as part of their course. On review of this record it showed that there was 6 new staff awaiting training on Elder Abuse. - At the time of inspection the Manual Handling training record was not updated to reflect staff having completed manual handling training. On review of the updated record all staff in the home have completed their Manual Handling training.
Proposed Timescale: 17/10/2014