Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	23 August 2022
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0037221

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has two buildings that are purpose built. The centre provides accommodation for a maximum of 101 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 23 August 2022	10:00hrs to 18:00hrs	John Greaney	Lead
Wednesday 24 August 2022	08:30hrs to 17:45hrs	John Greaney	Lead
Wednesday 24 August 2022	08:30hrs to 17:45hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Droimnin Nursing Home is located close to the town of Stradbally, Co. Laois and is registered to accommodate 101 residents in 99 single and one twin bedroom. All bedrooms are en suite with shower, toilet and hand wash basin. It is situated on spacious grounds that contain a number of other private dwellings that were originally designed for independent living purposes. The provider has no involvement in these dwellings.

The centre comprises two distinct but adjacent buildings. Building 1, known as Dunamaise, can accommodate 70 residents. It is a two storey building with 29 of the bedrooms on the ground floor and 41 of the bedrooms on the first floor. Building 2, known as Oughaval, can accommodate 31 residents. It is also a two storey building with 11 of the bedrooms on the ground floor and 19 of the bedrooms on the first floor. One of bedrooms on the first floor is a shared room.

While Oughaval is registered to accommodate residents, it has been vacant since the start of the COVID-19 pandemic and has mainly been used for staff facilities. On the days of the inspection, a small number of newly recruited staff were living in Oughaval while they sought permanent accommodation. The inspectors visited and were accompanied on a tour of this building by the person in charge and maintenance manager on day two of the inspection.

This inspection was conducted over two days. There was one inspector on day one of the inspection and two inspectors on day two. On arrival on day one, the inspector was greeted by a member of staff in Dunamaise that assisted the inspector to complete a signing in process and to ensure adherence with infection control procedures. After an opening meeting with the recently appointed person in charge, the inspector went on a tour of the building. The atmosphere in the centre was welcoming, calm and relaxed. Residents were observed enjoying each others' company in the main reception area. The person in charge introduced the inspector to residents and explained the purpose of the inspector's presence in the centre.

The provider had recently submitted an application to renew the registration of the centre. While reviewing the floor plans the inspector found that they did not accurately reflect the current design and layout of the centre. The provider was requested to have a suitably qualified person survey the centre and update the floor plans.

Dunamaise was generally in a good state of repair and was clean throughout. There was adequate communal space for residents. On the ground floor, a number residents spent their day in the reception hall, which was bright and suitably furnished with comfortable couches and armchairs. There was direct access from this area to an enclosed courtyard that was landscaped to a high standard with shrubs and plant beds. Residents could freely access the courtyard in the centre and inspectors saw a small number of residents walking independently around the

courtyard. There was a sitting room located off the reception hall and a number of residents spend the day in this room. On the first floor, most residents spend their day in an area called the coffee dock. Residents also had access to a small courtyard from the first floor.

The inspector interacted with residents informally while on the tour of the building and spoke with some residents in more detail later in the day. One resident told the inspector that "there isn't much to do". Another resident said that "there used to be more activities but not lately". The inspector was also told that residents used to go outside for walks but that does not happen as much anymore. Over the course of the two days of the inspection there were no structured activities taking place, other than one care staff very briefly asking residents to throwing rings at a ring board and swirl a ribbon wand. The inspectors observed residents with a cognitive impairment spend long periods in the sitting room on the ground floor with limited stimulation, other than the television or music playing in the background. This was also the case on the first floor where the inspectors observed care staff updating residents' care records while supervising residents in the sitting area but were not observed to be facilitating activities or interacting with residents.

Visitors were seen coming and going throughout the day of the inspection and were welcomed by staff. The centre's staff ensured that visitors were signed-in and completed safety checks in line with national guidance. Visitors spoken with were complimentary of the care provided by staff. Some visitors did reference the lack of activities available for their relative.

On the morning of the second day of the inspection, the inspectors toured Oughaval building. As already stated, this building is not currently occupied by residents. The centre is in need of decoration as evidence by chipped paintwork and exposed screws and picture hooks. Mattresses had been removed from most of the beds, some bedrooms had their televisions removed and the premises was in need of a deep clean. The inspectors were informed that there are plans in place to admit residents to this building but only after it was redecorated and sufficient staff had been recruited to care for the additional residents.

The following section of this report details the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

Overall, inspectors found that the actions taken by the registered provider to achieve compliance with the regulations were not sufficient to ensure that the care and welfare needs of the residents were fully met. Many of the issues identified on the last inspection had been addressed and some improvements were noted in respect of the premises, however, overall levels of compliance with the regulations

remained poor, and new areas of non-compliance were identified on this inspection.

Droimnin Nursing Home Limited, a company comprising three directors, is the registered provider of Droimnin Nursing Home. While the provider is not involved in the operation of any other nursing homes, the company directors are involved in the operation of a number of other nursing homes throughout the country. None of the directors attended the centre in person on the days of inspection while one did attend the feedback meeting at the end of the inspection via remote technology.

There was a recently recruited person in charge who works full-time in the centre and meets the regulatory requirements. There have been a number of changes to the person in charge in the recent past. The current person in charge was appointed to the role approximately four weeks prior to this inspection and is the fourth person in charge in the past three and a half years.

Similar to the findings of previous inspections, the centre did not have the management structure in place as set out in the statement of purpose and function (SOP). According to the SOP and previous commitments as submitted to the office of the chief inspector by the registered provider, the person in charge is supposed to be supported in her daily role by an assistant director of nursing and two clinical nurse managers. On the days of inspection the two clinical nurse manager posts were vacant and the assistant director of nursing was on leave. This left the centre relying heavily on the person in charge as the only supernumerary management person on duty. In addition, the person in charge had worked on the floor the previous Thursday night to cover unplanned staff nurse absences. Consequently, there was no member of the management team available in the designated centre on the following day. In addition, the SOP states that a general manager (0.5 whole time equivalent) is in place in the centre. This post was not filled at the time of inspection.

Inspectors found that the person in charge did not have sufficient management support. The systems in place are not sufficiently robust enough to ensure sufficient oversight and supervision of staff and to respond to residents needs. This was evidenced by:

- staffing shortages in the clinical nurse manager team and activities staff. This was impacting on their ability to ensure oversight and monitoring of the service delivered.
- care plans were not consistently completed in accordance with Regulation 5 requirements.
- adequate arrangements were not in place for the supervision of staff, including arrangements for enhanced supervision, in instances where concerns had been identified relating to staff performance.

There were 58 residents on the day of the inspection with 16 maximum dependency, seven high, 19 medium and 16 low. Registered nurses, healthcare assistants, activities, catering, household and administrative staff make up the complement of staff responsible for the delivery of care and support to residents. There were insufficient staff to support activities for residents on the days of

inspection. Inspectors were informed that a staff member dedicated to the provision of activities to residents had resigned a number of weeks before the inspection and another was an unplanned absence. As the system in place was dependant on the presence of these staff, their absence had a significant impact on the programme of activities. Over the course of the two day inspection, inspectors observed residents were seen to spend significant amount of time in their chairs in sitting rooms or in their bedrooms with limited stimulation other than music or televisions playing in the background that was of interest to only a small number of residents. This is also set out under Regulation 09 Residents Rights below.

Overall, there was evidence of good systems of communication that included monthly governance and management meetings, staff meetings and group meetings. However, records reviewed by inspectors were not sufficiently detailed to show what was discussed or what actions had been taken to drive improvement.

Regular data on aspects of care such as incidents, wounds and falls was collected by the person in charge. However, improvements were required with regard to the audit tools in use, to ensure all relevant details were captured, which could then inform comprehensive, tailored action plans for improvement.

A policy was available to inform the procedures for receiving and managing complaints from residents or visitors. The person in charge was responsive to the receipt and resolution of complaints in the centre and maintained a complaints log. Inspectors reviewed the complaints log and all reviewed had been closed.

Inspectors noted that staff were being accommodated in the Oughaval Building 2. Consequently it's usage is not as set out in the statement of purpose and function and in accordance with condition 01 of the registration of the centre. The registered provider was requested to regularise this.

The human resource policy was centre-specific and included details for the recruitment, selection and vetting of staff. A review of staff records showed that staff were recruited and inducted in accordance with best practice. A sample of staff files was reviewed and those examined were complaint with the Regulations and contained all the items listed in Schedule 2. Garda Síochána (GV) vetting clearance was in place for all staff.

There was evidence that newly recruited staff had received an induction, with evidence of sign off on key aspects of care and procedures in the centre. Overall, there was evidence of a good system of staff performance appraisal, however, adequate arrangements were not in place for the supervision of staff, including arrangements for enhanced supervision, in instances where concerns had been identified relating to staff performance. A review of the training records evidenced that staff were supported and facilitated to attend training relevant to their role such as fire safety training, cardio-pulmonary resuscitation (CPR), infection prevention and control, manual handling and the safeguarding of vulnerable adults.

The annual review of the quality and safety of the service for 2021 had been completed and shared with residents.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted a complete application for the renewal of the registration within the required time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge had recently been appointed to the role. A review of records identified that the person in charge was a registered nurse and had the required experience and qualifications for the role.

Judgment: Compliant

Regulation 15: Staffing

Worked rosters were not available for inspectors review on the days of inspection. Consequently inspectors could not be assured of staffing levels on duty to meet residents needs at all times.

There were insufficient staff on duty to support the provision of activities for residents. The activity programme in the centre was dependant on the presence of staff that were designated to provide activities. There were none of these staff on duty on the days of the inspection and as a result, there were minimal activities facilitated for residents.

There were two ongoing vacant clinical nurse manager posts and the 0.5 WTE general manager post.

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider had failed to ensure that adequate arrangements were in place for the supervision of staff, including arrangements for enhanced supervision, in instances where concerns had been identified relating to staff performance.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents contained all of the information specified in the regulations.

Judgment: Compliant

Regulation 21: Records

While there were records of planned rosters available to inspectors these records did not evidence unplanned absences or the day to day changes normally evident on working rosters in a nursing home. The person in charge told inspectors that the rosters that were actually worked were not available for review on the days of inspection. Consequently inspectors could not be assured of staffing levels on duty to meet residents needs at all times.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- The governance structure as outlined in the statement of purpose was not in line with the commitments made to the Office of the Chief Inspector from previous inspection compliance plan responses and meetings with the office of the chief inspector.
- Inspectors found that the current person in charge did not have sufficient management support to ensure oversight and supervision of staff and residents care needs. For example, on the day of inspection the person in charge, who had commenced in the post four weeks prior to the inspection, was the only member of the management team available in the centre and did not have access to some key documentation including the worked staff rosters. In addition the person in charge told inspectors that she was unaware of an ongoing staff disciplinary issue and was not clear as to how two clinical nurse managers would be deployed in the centre, or the amount of supernumerary time to be allotted.
- Adequate arrangements were not in place for the supervision of staff,

including arrangements for enhanced supervision, in instances where concerns had been identified relating to staff performance.

- There was evidence that social care needs of all residents were not being met. For example, inspectors were told that a number of residents preferred one to one activities, however there were insufficient staff available on the days of inspection. In particular there were a significant cohort of residents that were under 65 years. There Inspectors were not assured that the social care needs of these residents were being met.
- Worked rosters were not available for inspectors review on the days of inspection. Consequently inspectors could not be assured of staffing levels on duty to meet residents needs at all times.
- While audits that had been reviewed by inspector were of high quality in some cases, there was no overarching audit schedule available. It was not always evident to inspectors that there was any learning or action plans for improvement in place.
- The usage of Oughaval Building 2 is not as set out in the statement of purpose and function and in accordance with condition 01 of the registration of the centre.
- There is a risk register that is kept under review, however, there is a need to ensure that all risks are included in the register such as access to balcony areas on the first floor.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of purpose required review to ensure that it accurately reflected the conditions of registration, the facilities available and the services provided to residents. For example; the statement of purpose was not a clear reflection of usage of the premises or staffing levels in place. This was discussed with the person in charge on the day of inspection

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A number of allegations of staff misconduct had not been notified to the office of the chief inspector as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required in relation to the management of complaints. For example:

- there was no notice on display identifying for residents and visitors the procedure for making a complaint
- there was no record of whether the complainant was satisfied or not
- the complaints policy needs revision as to the personnel in place to handle complaints
- there was no evidence that there was any learning or action plans for improvement in place in response to complaints

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations were available to guide staff. These were updated in accordance with relevant guidance and at a minimum of every three years.

Judgment: Compliant

Quality and safety

Overall, there was mixed feedback from residents in relation to the quality of life in the centre. While residents stated that staff were kind, caring and responsive to their needs, some residents stated that there were limited activities available. Residents had timely access to healthcare services such as a general practitioner and allied health services. Significant improvements were required in the areas assessment and care planning and in residents' rights. These issues and other areas of required improvements are discussed in more detail under the relevant regulations of this report.

Residents had good access to medical care and were reviewed regularly by their GP. Residents were also provided with access to other health care professionals, in line with their assessed needs. From a review of records it was evident that residents who required assessment were referred to allied health professionals, such as a dietetic and speech and language therapy.

The inspectors reviewed a sample of residents' files. Following admission, residents' social and health care needs were assessed using validated tools, to inform care

planning. However, care plans were lacking personalisation, did not provide adequate detail on the care to be delivered on an individual basis to each resident and there were not care plans in place for all issues identified on assessment. This is discussed in more detail under Regulation: 5 of this report.

This is a relatively new purpose-built centre that meets the needs of residents in a homely and comfortable manner. All bedrooms are single with en-suite bathrooms. Bedrooms were personalised with residents' memorabilia and photographs. There was adequate communal space that was suitable furnished and decorated. Dunamaise building was bright, clean and in a good state of repair throughout. Housekeeping staff were knowledgeable and maintained appropriate records of what was cleaned, including deep cleaning. Oughaval building is unoccupied and requires redecoration and deep cleaning before the provider can commence admitting residents to this building.

Inspectors found that comprehensive systems had been developed for the maintenance of the fire detection and alarm system, emergency lighting and fire fighting equipment. Inspectors were informed that, should there be a fire in one building, the fire alarm in the adjacent building also sounded to alert staff in both buildings. The inspector did, however, identify some areas for improvement in relation to fire safety and these are discussed under regulation 28 of this report.

Residents were consulted through regular residents' meetings. There was a need, however, to ensure that issues identified for improvement through the consultation process were addressed. Records reviewed by the inspectors showed that bed rails were individually risk assessed prior to use. Residents were regularly checked when restraint was in use.

Regulation 11: Visits

Visitors were welcomed into the centre and staff guided them through the COVID-19 precautions. There was a high but safe level of visitor activity and inspectors saw and met a number of visitors coming and going to the centre during the inspection. Residents were seen to meet their visitors in their rooms, in communal areas and in the external courtyard.

Judgment: Compliant

Regulation 12: Personal possessions

There were adequate arrangements in place for the management of residents personal possessions. Each resident had sufficient space for storing personal possessions and laundry, including wardrobe space, chest of drawers, and a bedside locker with a lockable drawer. All resident's clothing is laundered in the centre and

there are effective systems in place for the return of clothing to residents following laundering. Bed linen and towels are launder by an external laundry company on an interim basis but plans are in place for all laundry to be done within the centre in the coming months.

Judgment: Compliant

Regulation 13: End of life

Judgment: Compliant

Regulation 17: Premises

While Building 1 was generally in a good state of repair, Building 2 had not accommodated resident since the start of the COVID-19 pandemic. This was clearly evident on the days of the inspection and this building was in need of redecorating as evidenced by chipped paintwork and exposed screws. In addition basic furnishings including mattresses and residents televisions had been removed from the center.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were offered a choice of food at mealtimes. There were two options available for five days each week and an additional fish option was available on the remaining two days. These options were available to all residents, including those prescribed a modified diet. Should a resident wish to have something other than what was listed on the menu, this was facilitated. Food was attractively presented and staff assisted residents that required help with their meals in a respectful manner. There was good access to dietetic and speech and language therapy and any changes to a resident's diet was communicated to kitchen staff.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy that addressed the items specified in the regulations and is kept under review.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure that the provider had procedures in place that were consistent with National Standards for Infection Prevention and Control in Community Services (2018). Issues to be addressed included:

- clinical waste was not managed in line with national guidance. Clinical waste bins were in use throughout the centre in areas where domestic waste bins should be used. For example, the inspector noted that there were three clinical waste bins place at various locations in the main reception area of the centre
- while there was a programme in place to install clinical hand wash sinks for use by staff, this was not yet complete. There were no hand wash sinks in cleaners rooms
- a secure area preventing unauthorised access was not provided for the storage of clinical waste. Large domestic waste containers at the back of the premises were overflowing and the lid was not closed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors were not assured that the opening of the ceiling with wrought iron finish in the main foyer area provided adequate fire containment.

While there were frequent education sessions with staff in relation to fire safety, fire drills were not held in addition to those facilitated as part of annual training by an external trainer.

There were gaps in some cross corridor fire doors that would limit their effectiveness in containing smoke in the event of a fire.

There was no call bell or fire blanket proximal to the upstairs smoking area. Also, cigarette ends were strewn in the gravel in the courtyard indicating that smoking was not confined to the designated smoking area.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were adequate arrangements in place for the management of medications. Nurses transcribed prescriptions and each medicine transcribed was checked by a second nurse to ensure it reflected the original prescription. All prescriptions were signed by a GP. A pharmacist visited the centre and they were supported to fulfil their obligations to residents. There were adequate arrangements in place for the management of medications that required special control measures and for the medicines that were refrigerated.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were generic in nature and did not provide adequate detail of the care to be delivered to residents on an individual basis in accordance with their assessments. For example:

- adequate detail was not provided in care plans to identify the care of residents for issues such as stoma care or indwelling urethral catheters
- the social care needs of residents were not adequately detailed
- not all residents that smoked had care plans to identify their safe level of access to cigarettes and lighters or the degree of supervision required

Judgment: Not compliant

Regulation 6: Health care

There was no system in place to ensure that residents that qualified for national screening programmes through age of condition were supported to participate in these programmes, should they wish to do so. A review of residents' records indicated that a template to be completed by staff, identifying if a resident qualified for national screening programmes such as retinal screening, bowel screening, breast cancer screening and cervical screening was not completed for a number of residents.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

From discussion with staff and observations of inspectors, there was evidence that residents who presented with responsive behaviours were responded to in a person-centred way by the staff using effective de-escalation methods. This was reflected in responsive behaviour care plans. Management and staff promoted the principles of a restraint free environment. There were four residents with bedrails in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure that residents' rights were respected and their social care needs were met. Areas to be addressed included:

- there was minimal scheduled activities observed over the course of the two days of the inspection. Residents were seen to spend significant amount of time in their chairs in sitting rooms or in their bedrooms with limited stimulation other than music or televisions playing in the background that was of interest to only a small number of residents
- records of residents' participation in activities indicated gaps of up to a week when there was no record of residents having participated in activities
- the centre accommodated a number of residents under the age of 65 with complex health and social care needs and in the absence of dedicated activities and occupational therapy staff, their social activities care needs were not consistently met. The prospect of additional social support or advocacy for younger residents had not yet been explored.
- residents meetings were scheduled to take place weekly as identified on a resident' information notice and this was reiterated to residents at one of their meetings. Records of meetings given to inspectors indicated that there were gaps in the meeting schedule extending to five weeks
- while some issues raised at residents' meetings were addressed, records were not available to identify what actions were taken in response to other requests, such as a suggestion for a book club and movie night

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0037221

Date of inspection: 24/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Work rosters were misplaced on the day of the inspection. They have been located and rosters were provided to the inspectors post inspection. Measure have been put in place and are noted below in Regulation 21 to ensure they are available in the future. The centre has in place both a Director of Nursing and Assistant Director of Nursing. Currently the centre is recruiting a Clinical Nurse Manager which will strengthen the management team and assist with the supervision of staff and oversight on the floor. Two activity staff have been recruited post inspection and have commenced employment in the centre. In advance of opening Building 2 and comprehensive work force plan would be devised, agreed and implemented to ensure adequate staffing of the centre and provide safe and appropriate care for any potential residents.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: As advised at the time of Inspection a HR Manager has been appointed and all training needs identified through appraisals, competency testing and day to day observation of practices will be attended to, documented and appraised. The centre has in place both a Director of Nursing and Assistant Director of Nursing.	

Currently the centre is recruiting a Clinical Nurse Manager which will strengthen the management team and assist with the supervision of staff and oversight on the floor.

Two activity staff have been recruited post inspection and have commenced employment in the centre.

Where issues arise that competency of any staff member is called into question additional training needs identified will be provided and the staff member supported to achieve competency. The centre has in place a comprehensive set of policies to support and guide staff. Where competency cannot be achieved, despite support the appropriate actions will be taken to ensure the safety of the residents.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Unfortunately, on the day of the inspection the actual worked rosters could not be located. Post inspection they were located having been misplaced.

Actual worked rosters are filed fortnightly to ensure that they securely stored and retrievable. Moving forward all worked rosters will be stored electronically prior to being filed to ensure a back up copy is always available.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Risks noted during the time of inspection have been reviewed and documented in the Risk Register.

An audit schedule is now in place within the centre and any learning is noted and shared as agenda items in all Heads of Department Meetings.

As advised in Regulation 15 and 21 the worked rosters had been misplaced on the day of Inspection and rosters have since bee sent to the Inspectors for review.

Two activity staff have been appointed post inspection and have commenced employment. As per Regulation 9 noted below a comprehensive review of activity provision in underway.

The centre is currently recruiting a Clinical Nurse Manager to strengthen the management team and ensure supervision of staff on the floor and to assist with the oversight of care delivery and practices within the centre.

The PiC has been fully inducted and briefed on all aspects of the business to ensure full knowledge of the centre. During any leave arrangements of either the PiC or ADoN a member of the clinical team will be put in a supernumery position, off the floor to support the management team.

The Senior Management Team continue to support the Nursing Home Management Team with weekly meetings to review both the clinical and operational management of the nursing home. The Clinical Director meets with the Nursing Home Management Team monthly to review the monthly KPI report. The Clinical Governance meeting is also scheduled monthly with the Clinical Director and other committee members to ensure appropriate oversight over issues arising.

The Oughaval Building, noted as building 2 in the report is currently not in use and the Registered Provider is committed to ensuring that prior to its use a comprehensive plan is in place and discussed with the regulator in relation to its preparation for use, staffing plan and any other requirements necessary to ensure the building is opened in a safe and appropriate manner.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Post inspection the Statement of Purpose has been reviewed and will be resubmitted to reflect the changes required during the Inspection. Maps for the centre have been updated.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Post Inspection the issues noted and identified have been reviewed. A notification will be sent to the regulator retrospectively and an update of the current status of the investigation which remains ongoing will be provided.

Medication errors will be reviewed and reported on monthly to the Senior Management Team to ensure that they are appropriately managed and acted apon. A nurses meeting is scheduled with the Senior Management Team to refresh all Nurse on their roles and responsibilities as Nurses and to ensure all staff are familiar with the Code of Conduct.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Post inspection the complaints procedure has been updated to reflect the complaints procedure and is on display in the main reception are for all residents and visitors. The complaints policy has been reviewed and the appropriate amendments made to ensure the personnel involved in the handling of complaints is clearly identified. Post inspection all complaints were reviewed and where appropriate satisfaction from the complainant sought and recorded. In the future, learning and actions plan will be noted and discussed with all staff during monthly Heads of Department Meetings.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Building two is currently not in use as identified on the day of inspection. Prior to it being utilized in the future, a comprehensive audit would be completed to ensure that any works required could be attended to and any furnishings needed could be replaced. The provider is committed to ensuring all parts of the premises are maintained to a high standard and the works that have been ongoing in the centre will continue to ensure that all aspects of both building's are maintained in keeping with the registration.	

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection	

control:
Clinical waste bins within the centre have been reviewed and excess bins removed.

The provider has committed to installing appropriate handwashing sinks throughout the centre. These sinks have been installed in corridors throughout the centre. We are currently awaiting handwashing sinks to be delivered to accommodate the completion of this programme of works.

Clinical waste storage for the centre has been reviewed and a daily audit of the area implemented to ensure bins are not overflowing and the area is maintained appropriately.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
An independent review of the main foyer was conducted, and a report furnished advising this area provided adequate fire containment. This report will be filed on site and has been submitted to the regulator. Additional to the review of the foyer area all fire doors noted as having gaps have been reviewed also and any works required post review will be attended to.

Education sessions on site simulate a fire event but do not engage in a complete evacuation of a designated area within the centre. The centre is committed to ensuring appropriate drills are completed with staff and will conduct, record and take learning from the completion of appropriate fire drills to include simulated evacuation events on site.

The upstairs smoking area has been audited post inspection and cleaned. Residents smoking in this area have been reminded of the need to ensure safety. Fire blankets and apron now in situ.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A computerised system has been approved and arrangements are in place for its set up. It is anticipated this system will provide a platform for the appropriate care planning of all areas of needs for each individual residents.

In the interim, all residents that smoke have had their care plans reviewed an updated to reflect the needs of each individual and the supports required to ensure safe level of access to smoking paraphernalia is documented.

Those residents requiring specific care in relation to stoma care and catheter care have had their care plans reviewed to ensure the care plan adequately reflects the level of care required.

Following the appointment of 2 x Activity Staff all residents will have their social care care plans reviewed and updated to reflect the needs, choices and abilities of all residents.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Post inspection all residents have been reviewed and those that wish to participate in the National Screening programs have had the appropriate referrals made.
Moving forward this information will be captured on our preadmission assessment and followed up on admission.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Following on from the Inspection 2 x Activity Staff were appointed and have commenced their roles within the centre.
Activity provision within the centre is undergoing change. Meetings have been held with residents to determine a suitable schedule of activities to meet the needs of the residents on site.
Activity staff have taken on the role of ensuring weekly meetings are taking lace and minutes maintained. These meetings are discussed with the PiC and ADoN to ensure any actions arising are addressed and action plans put in place. Activity satisfaction from residents will be audited monthly and recorded. Where appropriate and required changes will be implemented as per the outcome of the audit findings.
Residents within the centre under the age of 65 has been explored in depth following on from the inspection. Several offerings have been made to these residents and have been declined for various reasons which have been recorded and discussed with each individual. We will continue to support these residents to avail of additional supports and services where they consent to same. Advocacy arrangements are ongoing also for the

residents within the centre under the age of 65.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	28/10/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	28/10/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	07/10/2022
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	25/08/2022

	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.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	28/10/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	28/10/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	15/10/2022
Regulation 28(2)(i)	The registered	Substantially	Yellow	07/10/2022

	provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Compliant		
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	07/10/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	07/10/2022
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	27/09/2022
Regulation 34(1)(c)	The registered provider shall	Substantially Compliant	Yellow	07/10/2022

	provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	07/10/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	21/10/2022
Regulation 6(1)	The registered provider shall,	Substantially Compliant	Yellow	21/10/2022

	having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	14/10/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	14/10/2022