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:	Boyne Valley Nursing Home
Name of provider:	Boyne Valley Nursing Home
Address of centre:	Dowth, Drogheda, Meath
Type of inspection:	Unannounced
Date of inspection:	31 March 2021
Centre ID:	OSV-0000119
Fieldwork ID:	MON-0031865

About the designated centre

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

Boyne Valley Nursing Home was originally a family bungalow which was extended and converted into a nursing home. It is situated in the heart of the Co Meath countryside close to the river Boyne and the town of Drogheda.

It is a small, intimate family owned nursing home. The centre provides care to both male and female residents, aged 18 years and over who require long term care, respite, convalescent and end-of-life care. It can care for a maximum of 18 residents as it has 14 single and two twin bedrooms.

All dependency levels can be accommodated for in the centre, ranging from low to maximum dependency. Mobile residents with Alzheimer disease are not accommodated, due to the small and intimate nature of the home. There is a car park at the front of the building and residents have access to a garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Wednesday 31 March 2021	09:00hrs to 12:30hrs	Sheila McKevitt	Lead

What residents told us and what inspectors observed

The centre was a quiet and relaxed place to live where residents received safe care and services and where their rights were upheld.

On the morning of the inspection the inspector observed that the morning routine was flexible. Some residents were having breakfast in bed, others were having a lie-in and some were up and dressed and mobilising around the building. The inspector observed that whilst care was given the staff ensured that resident's privacy and dignity were upheld. Staff were seen to knock on residents' bedroom doors and seek permission before entering. Staff were heard asking residents if they would like assistance to get out of bed while offering them a morning drink. Where a resident was not ready to get up this was respected by staff. Residents spoken with said they were always given a choice about what time to get up and where to take their breakfast.

The staff were observed and heard communicating with residents in a calm and gentle manner throughout the morning. The inspector saw that staff encouraged residents to maintain as much independence as possible. Staff offered discreet encouragement and support to encourage residents to do what they could to wash and dress themselves and to walk to the dining and lounge rooms.

One resident told the inspector she was up and dressed early as she was expecting visitors today for the first time. She was delighted about being able to welcome her visitor in her own bedroom where they could share a private chat and catch up. The inspector observed that some improvements had been made to the premises since the last inspection. The sluice room and main cleaning room refurbishment had been completed, however other refurbishment works had been postponed due to COVID-19 restrictions but were still planned and the provider was clearly working to bring the centre into compliance with the regulations.

The next two sections of this report will set out the findings of the inspection and discuss the levels of compliance found under each regulation.

Capacity and capability

A number of improvements had been made in the governance and management of the designated centre since the last inspection. However significant effort was still required to ensure that the service was brought into regulatory compliance and that the improvements were sustained going forward.

This inspection was carried out to monitor the provider's progress to bring the

centre into compliance following the last inspection in September 2020. The inspector had been informed that a new person in charge had been appointed since the last inspection and had commenced employment in the centre in December 2020.

The Chief Inspector had been notified of one staff being confirmed to have contracted COVID-19 in January 2021. No residents contracted the virus and no further staff contracted the virus.

The inspector reviewed the actions required from the last inspection and found that substantial improvements had taken place. For example, residents health and social care needs were being met, residents had access to a speech and language therapist. However, further improvements with the refurbishment of the premises and reviewing and implementing policies and procedures had been delayed due to the change of person in charge and the current COVID-19 pandemic. Both of these regulatory non-compliances remain outstanding from the last inspection.

There was a clear organisational structure in the centre. The provider representative and the person in charge both worked full-time in the centre. They had reviewed and were aware of their roles and responsibilities, the person in charge reported to the provider representative. The management team were committed to the quality improvement of the centre.

The person in charge had been appointed to this role in December 2020 and was a registered nurse with experience in the area of nursing older people and in managing a centre for older persons. The person in charge demonstrated a high level of clinical knowledge and this was reflected in the improvements made to date and those planned. The person in charge had sourced and was in the process of implementing a process which would facilitate clear and continuous oversight of practices in the centre.

The centre was well resourced. There was an improvement in staffing levels and this had a notable positive impact for the residents. There were sufficient staff on duty to ensure that care and services were provided in line with the residents' needs. In addition the whole time equivalent of house keepers had increased and as a result the cleaning processes were strengthened and the centre was found to be clean and tidy.

Staff had all the required mandatory training in place. They had received additional training in infection control and in nursing documentation since the last inspection and this had resulted in improvements in both these areas of practice.

Phase 1 of a three stage refurbishment plan had been completed. The new sluice room and cleaning room had been completed. Phase 2 and 3 were planned for quarter three 2021.

A small number of policies had been updated, however all other Schedule 5 policies had not been reviewed in the last three years. The person in charge acknowledged this oversight and assured the inspector they would all be reviewed in 2021.

Regulation 15: Staffing

The staffing levels had improved and there were plans for further improvements.

The whole time equivalent of house keeping staff had been increased to 1.4 whole time equivalent. There was now one house keeper scheduled to work from 08:30 - 16:30 seven days per week.

An kitchen assistant had been recruited and was scheduled to assist the chef from Monday to Friday for four hours each day. In addition, an assistant director of nursing was being appointed to cover in the absence of the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

The management structure had changed since the last inspection. A new person in charge (PIC) had been appointed in December 2020 and was deemed fit to hold the post of person in charge. She confirmed she had a period of induction with the out-going PIC.

The provider representative and person in charge were aware of their roles and responsibilities. The inspector saw the management team had identified a process which would ensure they had consistent oversight of all areas of practice. The process would include the auditing of practices over a two year audit cycle. All areas of practice would be audited on either a monthly, quarterly or annual basis. The team were at the early stage of implementing the process.

An annual review was due for completion in May 2021.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and was on display in the centre. It included details about the newly appointed person in charge and met the regulatory requirements.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector found that three policies had been updated these included the infection prevention and control policy and risk management policy together with the cleaning policy.

The inspector found that all Schedule 5 policies had not been updated.

For example:

The admission, transfer and discharge policy had not been updated to reflect the current guidance. (Interim Public Health, Infection Prevention and Control Guidelines on: Admissions,Transfers to and Discharges from Long Term Residential facilities during COVID-19 Pandemic).

There was a medication management policy in place however inspectors found that it was no being implemented in practice. This is discussed under Regulation 29.

Judgment: Not compliant

Quality and safety

Overall, residents received a good standard of care and services from a staff team who knew them well. Residents' health, social care and spiritual needs were well catered for.

Improvements had been made in relation to the following; the management of risk in the centre, infection control practices, care planning processes, access to appropriate specialist health care services and the pension agent arrangements. As a result these regulations were found to be compliant. Some improvements had been made in relation to the premises however further improvements were required. The inspector saw that there was a plan in place and that the plan was due to be completed by quarter three 2021.

Management and staff had strived to ensure residents received a safe and quality service where their abilities and potential were maximised and their needs were met. Residents were complimentary of staff, facilities and of the services available to them.

There were comprehensive processes in place in relation to infection prevention and control. The provider representative had oversight of infection and prevention and control practices. A process of environmental auditing had been established and maintained since the last inspection. This assured the inspector that standards in

this area were consistently monitored.

The risk management policy had been updated and a revised risk register had been developed to ensure all risks were recorded and a plan put in place to control these risks.

The oversight of fire equipment servicing had improved and the recording and learning from regular fire drills conducted with staff had lead to further improvements in practices.

The quality of records in relation to residents assessments and care plans had improved and there was a plan in place to audit this practice to ensure the improvements were sustained.

Regulation 17: Premises

The design and layout of the designated centre did not meet the needs of residents. The three phase refurbishment plan due for completion by 31 December 2020 had been delayed due to COVID-19 restrictions. The inspector observed that phase one of the three phased plan had been completed to date.

This included a refurbished sluice room with stainless steel equipment and a new general cleaning room with a new entrance and with stainless steel equipment installed. This would ensure that all surfaces could be easily cleaned in line with infection prevention and control standards.

The inspector observed the following areas had not improved since the last inspection:
1. There was no cleaning room available to the kitchen cleaning staff and as a result the kitchen cleaning equipment was being stored on a corridor outside the kitchen staff toilet.
2. There were not sufficient bathrooms for the residents. 18 residents had access to two communal bathrooms one which contained a communal bath and another which contained a communal shower.
3. The design and layout of the laundry room did not ensure safe and effective infection prevention and control practices.
4. Staff changing facilities were not adequate and did not promote safe infection prevention and control practices.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place which now met the requirement of the regulations. For example, specific risks as outlined in the regulation such as aggression and violence, and associated measures and actions to control this risk, were included. Arrangements for the identification, recording, investigation and learning from serious incidents or adverse events were evident.

The provider maintained a register of risks which included all risks in the centre. Records reviewed showed that control measures had been put into place and a responsible person had been identified to implement the measures required to mange each risk. Furthermore risk assessments had been completed for all risks identified on this inspection. The risk of COVID-19 was included in the risk register and each resident had an risk assessment completed prior to receiving visitors.

Judgment: Compliant

Regulation 27: Infection control

The centre had clear governance, management and oversight arrangements to ensure the sustainable delivery of safe and effective infection prevention and control practices. It was now clear who had overall responsibility for managing key areas of infection control and there was good oversight of infection prevention and control measures. Furthermore procedures consistent with the standards for the prevention and control of healthcare-associated infection had been consistently implemented since the last inspection

Judgment: Compliant

Regulation 28: Fire precautions

The fire procedures and evacuation plans were prominently displayed throughout the centre. The emergency lighting, smoke detectors fire doors and fire alarm were serviced and tested every quarter. The fire safety equipment was tested on an annual basis.

Fire-fighting equipment was in place throughout the building and emergency exits were clearly displayed and free from obstruction. Daily checks of the external fire escapes were being completed and records of these checks were available for review. Weekly checks were also completed of the fire alarm, fire doors (internal or external) and emergency lighting.

The records confirmed that simulated night-time and daytime fire drills were carried out on a regular basis, and included improved records and to support staff learning.

All bedroom doors were fitted with adjustable self-closing devices.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

There was a computerised system for undertaking nursing assessments and implementing person-centred care plans for residents at the centre. A revised comprehensive assessment tool had been implemented which included an assessment of residents needs prior to their admission. In addition residents all residents had an up to date care plan in place that reflected their current needs and preferences for care and support.

Care plans had been prepared within 48hrs after the resident's admission to the centre and assessments included a range of validated assessment tools. Care plans reviewed showed care plan records offered a true reflection of the care given. The inspector saw that twice daily active monitoring of residents temperature and for any other signs and symptoms of respiratory illness was in place.

Judgment: Compliant

Regulation 6: Health care

The residents had access to General Practitioner (GP's) services including out of hour on-call GP services. There was evidence that residents were being reviewed by their GP including new admissions to the centre. Residents had access to a speech and language therapist and the inspector saw evidence that a number of resident's had been recently assessed by this person.

Judgment: Compliant

Regulation 8: Protection

The provider was no longer a pension agent for any of the 16 residents.

Judgment: 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	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Boyne Valley Nursing Home OSV-0000119

Inspection ID: MON-0031865

Date of inspection: 31/03/2021

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 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: A new policy and procedure review schedule has been implemented. All Schedule 5 policies will be completed by 31/08/2021. All other policies will be completed by 31/12/2021	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A revised renovation schedule has been agreed with the builder. Phase 2 is underway and due for completion by 30/06/2021. Phase 3 is due for completion by 30/09/2021.	

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 17(1)	The registered provider shall 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.	Not Compliant	Orange	30/09/2021
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.	Not Compliant	Orange	30/09/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as	Not Compliant	Orange	31/12/2021

	often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			