Report of an inspection of a Designated Centre for Older People

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Silvergrove Nursing Home Limited</th>
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<tbody>
<tr>
<td>Name of provider:</td>
<td>Silvergrove Nursing Home Limited</td>
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<tr>
<td>Address of centre:</td>
<td>Main Street, Clonee, Meath</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>08 October 2018</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000162</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0025219</td>
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About the designated centre

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

Silvergrove Nursing Home is a family owned business, located close to the village of Clonee, Co. Meath. The centre is a purpose built, single-storey facility with 21 single and seven twin bedrooms. The service offers long-term, respite and convalescence care to male and female residents over 18 years. The centre admits residents of varying degrees of dependency from low to maximum. The staff team includes nurses and healthcare assistants and offers 24-hour nursing care. There is also access to a range of allied healthcare professionals.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Number of residents on the date of inspection:</th>
<th>25</th>
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. **Capacity and capability of the service:**

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

2. **Quality and safety of the service:**

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

   A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
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<tbody>
<tr>
<td>08 October 2018</td>
<td>09:30hrs to 17:00hrs</td>
<td>Sheila McKevitt</td>
<td>Lead</td>
</tr>
<tr>
<td>09 October 2018</td>
<td>09:00hrs to 14:00hrs</td>
<td>Sheila McKevitt</td>
<td>Lead</td>
</tr>
<tr>
<td>08 October 2018</td>
<td>09:00hrs to 17:00hrs</td>
<td>Angela Ring</td>
<td>Support</td>
</tr>
<tr>
<td>09 October 2018</td>
<td>08:30hrs to 14:00hrs</td>
<td>Angela Ring</td>
<td>Support</td>
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**Views of people who use the service**

Most residents and their relatives expressed a high level of dissatisfaction with many aspects of the care they received.

In particular these residents and families expressed dissatisfaction with staffing levels in the centre, describing how insufficient staffing on a day to day basis impacted on their care. Residents and families said a number of long term members of staff had left and the current reliance on agency staff impacted on their continuity of care.

Residents and relatives were also not happy with complaints management in the designated centre. For example residents said when they received a meal in their bedroom it was usually cold, however despite reporting this, it did not improve. In addition relatives identified concerns about the response they received when making a complaint and expressed fear of making further complaints in case of repercussion for their loved one in the centre.

Some residents' expressed dissatisfaction with the manner in which they were treated by some staff. They perceived it as a lack of respect.

Several residents and families also complained about the lack of activities and described how days were long when there was nothing to do to pass the time. Many said they were bored as a result of the lack of choice afforded to them during the day and some said they wanted to leave the centre. Some questioned why they were not allowed go out into the village.

**Capacity and capability**

The findings of this inspection were that the registered provider had completely failed to ensure that a safe and effective service was provided for residents living in Silvergrove Nursing Home.

Poor regulatory compliance has been an issue in this centre previously and since January 2018, with five inspections occurring in 2018. In June 2018 the Office of the Chief Inspector issued a notice of proposed decision to cancel the registration of the centre on foot of repeated failures to address identified regulatory non-compliance's. The registered provider submitted representation to this notice of proposal in July 2018. The purpose of this inspection was to determine if the actions stated in the representation had been implemented and if this had improved the
care and welfare of those living in the designated centre.

Inspectors found that the provider had not taken the actions set out in their own representation and repeated regulatory compliance plans. In addition the information contained in three weekly compliance plan updates submitted to the Chief Inspector on (21 September, 28 September and 05 October 2018) was not verified.

Notably the following items outlined in the providers representation had not been implemented:

- The management structure had not been strengthened
  - An additional director had not been appointed to the board of directors
  - There was no evidence made available on the days of inspection to show that the board of directors met formally on a monthly basis
  - Roles and responsibilities of the management team had not been outlined
  - There was no evidence made available on the days of inspection to show that the provider representative had met with the person in charge twice a week
  - The services of a healthcare management consultancy had not been deployed
  - An education and mentorship programme had not been provided for the person in charge
  - A risk register had not been completed.

The failure to follow through on these actions, or implement any other meaningful actions, meant that the registered provider had not ensured that there was an effective system of governance and management in place to ensure the needs of the residents living there were met.

This lack of an effective system of governance and management adversely impacted on the resident's rights and access to meaningful recreation and activities, staffing, training and development, record keeping, risk management, the management of complaints and the notification of incidents. In addition the registered provider had not adequately addressed previously identified regulatory non-compliance's, nor had it taken a proactive approach to ensure that the designated centre was fit for purpose.

The management team did not have job descriptions and their roles and responsibilities were not clearly outlined. The provider representative and the person in charge told inspectors they were meeting once per week to discuss the operational management of the centre; however evidence of these meetings was not available. A system for reviewing the quality of care and quality of life for residents in the centre had not been established and no assurances could be provided to inspectors that the service was safe, appropriate, consistent or effectively monitored.

The registered provider and person in charge had not ensured that the culture in the centre was appropriate in terms of delivering a social model of care. Care was
characterised by task orientation and institutional practices that did not prioritise meaningful engagement and social interaction for residents. In particular the registered provider and person in charge had failed to ensure that residents in the centre had access to meaningful activities on a daily basis. Inspectors observed residents sitting in day room being told repeatedly to sit down instead of being provided with meaningful activity and engagement.

The centre was not adequately resourced. Staffing levels and skill mix were not adequate to ensure the residents needs were met. Only a small number of the staff who had recently left had been replaced resulting in a reliance on agency staff who were not familiar with residents’ needs.

Inspectors found an ineffective system of complaint management in place in the designated centre; residents, relatives and staff told inspectors they had made complaints but these were not listened to or acted on. Despite this feedback inspectors were advised that there were no records of any recent complaints being made.

An alleged incident of suspected abuse reported by a resident had also not been investigated. To date, the Office of the Chief Inspector has not received a report of an investigation of this allegation or the required statutory notification despite assurances being given to this effect.

The registered provider failed to ensure that records relating to the statement of purpose, staff, residents and admissions were maintained in compliance with the regulations. Policies and procedures for the designated centre had not been updated as required by the regulations.

The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 set out a number of regulations for which the person in charge is responsible. Serious shortcomings were found in compliance with these regulations on this inspection. For example

- there was a lack of knowledge of residents' current health status and awareness of residents ongoing needs; specific examples include lack of awareness that one resident had received treatment in hospital post a fall and lack of knowledge regarding the number of residents who had pressure ulcers
- there was evidence that staff were not appropriately supervised or managed; staff appraisals had not been completed and proposed training had not been provided
- appropriate pre-admission assessments were not completed prior to admission with staff describing how some new residents arrived in the centre without staff being made fully aware of their care needs. Inspectors found one resident who's basic nursing care needs could not be met in the centre due to a lack of required equipment and facilities.
- statutory notifications were not submitted as required

In conclusion the findings of this inspection were that ineffective management systems were in place in the centre. The level of regulatory non compliance had
worsened and this had a negative impact on the provision of a safe and effective service for residents over a ten month period.

### Regulation 15: Staffing

Some of the staff who worked in the centre for several years were seen to know and care for residents in a warm and caring manner. They described their concern about the current lack of effective management and the impact it was having on residents and staff.

The number and skill mix of staff employed to work in the centre was not adequate to meet the needs of residents. This resulted in residents receiving poor quality care, for example; residents assessed as at high risk of falling were left unsupervised in communal areas for long periods of time.

There was an over reliance on agency staff, with one to three agency health care assistants employed to work five out of seven days each week. An additional (second) staff nurse who was to be rostered to work from 8:00 to 16:00 hours each day was not rostered on day two of this inspection. When the staff nurse on duty was administering medications and performing nursing duties, there was no one available to supervise care being delivered to residents.

This is a repeated non compliance since the last inspection of 03 August 2018.

**Judgment:** Not compliant

### Regulation 16: Training and staff development

Staff did not have access to appropriate training prior to commencement of employment. For example,

- two newly employed staff had not received mandatory training in relation to fire and the protection of vulnerable adults prior to commencing in their post.
- one staff member had not completed an induction.

Staff in the designated centre were not appropriately supervised and no appraisals were taking place. Staff described feeling unsupported in their roles and described inconsistent and ineffective management systems which did not support a culture of openness.

This is a repeated non compliance since the last inspection of 03 August 2018.

**Judgment:** Not compliant
### Regulation 19: Directory of residents

The directory of residents was not maintained, for example it did not contain all the details outlined in schedule 3 for a newly admitted resident.

This is a repeated non compliance since the last inspection of 03 August 2018.

**Judgment:** Not compliant

### Regulation 21: Records

Records specified in schedule 2, 3 and 4 were not kept in a manner that was safe or accessible. For example the registered provider failed to provide:

- a record of complaints made by residents.
- a record of residents pre-admission assessments

Not all schedule two documents, required by the regulations, were available for two new employees.

This is a repeated non compliance from the last two inspections which occurred on 31 May and 03 August 2018.

**Judgment:** Not compliant

### Regulation 23: Governance and management

An ineffective system of governance and management remained in place in the designated centre on the day of this inspection;

- sufficient resources were not in place to ensure the effective delivery of care in accordance with the statement of purpose. For example; there was an inadequate number of staff employed to meet the care needs for residents.
- the management structure was not clearly defined with the lines of authority and accountability blurred. Members of the management team did not have their roles and responsibilities outlined on paper and they did not have a job description.
- the registered provider failed to take the necessary action to ensure that the service provided was safe, appropriate, consistent and effectively monitored. There were no audits of practice completed and no key performance indicators gathered since the end of June 2018.
- a quality assurance system had not been established.

This is a repeated non compliance from the last four inspections which occurred on 23 January, 11 April, 31 May and 03 August 2018.

**Judgment: Not compliant**

**Regulation 3: Statement of purpose**

The information contained in the statement of purpose dated 13 July 2018 was not reflective of the service and facilities provided to residents on this inspection. For example:

- residents rights were not respected
- residents care plans were not developed within 48hrs of admission
- the whole time staff equivalent was not reflected on the roster

**Judgment: Not compliant**

**Regulation 31: Notification of incidents**

The person in charge failed to notify the Office of the Chief Inspector about incidents which occurred in the designated centre for example

- the chief inspector was not notified within three working days of a serious accident which resulted in the resident requiring treatment in hospital
- the chief inspector was not notified about an allegation of abuse made by a resident

**Judgment: Not compliant**

**Regulation 4: Written policies and procedures**

The policies outlined in schedule 5 were available for review. however some of these policies were not implemented in practice. For example:

- The complaints policy; complaints made were not recorded.
- The recruitment policy, references were not obtained or checked prior to staff being employed.
• The admission policy, residents were admitted when it was evident their needs could not be met in the designated centre.

Three policies outlined in schedule 5 had not been updated within the past three years.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place but it was not implemented in practice.

Complaints were not:
• listened to
• managed effectively
• investigated
• recorded

Judgment: Not compliant

Quality and safety

The findings of this inspection are that significant improvements are required to enhance the quality of life of residents living in Silvergrove Nursing Home. The daily life of residents was dictated by unconscious institutional practices with very little opportunity for autonomy and personal choice.

The registered provider had taken the voluntary step to reduce the number of residents being admitted to the seven twin rooms from two to one although the second bed and screening had not yet been removed from these rooms. This move had reduced the maximum occupancy of the centre to 28 residents. The registered provider planned to submit an application to vary conditions of registration to regularise same.

Systems to monitor the quality and safety of the service were not in place. This was reflected in the high level of repeated non compliance’s found under quality and safety.

Risk in the centre was not well managed. The risk management system had not been reviewed since the last inspection. Although an external consultant had been engaged with and a proposed action plan advised, this had not been progressed. A
review of the safety policy and of safety procedures had not taken place.

All reasonable measures were not taken to protect residents from abuse. Staff did have garda vetting in place however references had not been sought prior to them commencing work and they had not received mandatory training in the detection, prevention and responses to abuse. An allegation of abuse made by a resident was not notified to the Office of the Chief Inspector as required by the regulations.

Inspectors found that the directly employed staff nurses and health care assistants demonstrated good knowledge and understanding of the needs of residents, though this information was not reflected in resident individual assessments and care plans. The lack of a comprehensive pre-admission assessment, fully completed individualised assessments and care plans together with the lack of supervision and lack of staff has led to a poor standard of care being delivered to residents on a day to day basis.

Medical resources and the services of allied healthcare professionals were in keeping with the assessed needs of residents. Residents were seen by their general practitioner promptly post admission, and they were referred where necessary to members of the allied health care team and seen without delay.

Residents nutritional needs were assessed and their weight monitored. A dietitian had assessed those identified as at high risk of weight lost and put a plan in place which appeared to be followed by staff. Wound management was good, all pressure ulcers were graded by staff.

The service of food to residents was poor. Residents receiving meals in their bedrooms received cold pots of tea and porridge in the morning and cold meals during the day. The residents dining room was too small to accommodate all residents' at the only meal sitting available to residents. A large communal room at the back of the centre was no longer accessible to residents. Staff informed inspectors it was now used as an office and therefore residents could not access it.

During the course of this inspection, institutional practices were seen to impact on many aspects of each resident's day to day living experience. Residents were not afforded choice in terms of what day room they used, where to sit in the day room, where to eat, to go outside or go to visit the local shop. Regular staff were kind and well-meaning but care did not evidence a resident's right to choice. Residents were seen to spend their day sitting in the adjoining day rooms with chairs around the walls, looking under-stimulated and bored.

Following the previous inspection the provider had given an undertaking that meaningful activities would be provided to residents by the 08 October 2018, although a person had commenced in this post on 08 October 2018, residents did not have access to meaningful activities.

Overall the quality and safety of care in Silvergrove Nursing Home required significant review to achieve compliance with the regulations for designated centres for Older People. Poor governance, poor risk management, the lack of supervision and Institutional practices continued to impact adversely on the quality of life for
Residents living there.

**Regulation 18: Food and nutrition**

Residents had access to a varied nutritious diet and a choice of menu was offered at most mealtimes, however, on Tuesday and Sunday evenings residents were offered a variety of sandwiches only, no hot meal was available to them.

Inspectors were satisfied that residents with special dietary requirements were provided with the appropriate diet. Although, the consistency of the meal served was not always reflected in their nutritional care plan.

The service of food was poor. Residents who ate their meal in their bedroom received cold food. They did not receive the food for up to 30 minutes after it had been plated up in the kitchen and no attempts were made to keep food hot.

All residents were served breakfast in their bedroom. Many residents were served their lunch and evening meals in either of the two day rooms or their bedroom. It was unclear if this was through residents' choice or just habit. These residents were not provided with the opportunity to enjoy the same social aspect of dining as those who went to the dining room.

Staff were available to provide timely assistance to residents in the dining room but not to those eating in their bedroom.

This is a repeated non compliance since the last inspection of 03 August 2018.

**Judgment:** Not compliant

**Regulation 26: Risk management**

The risk register had not been updated to reflect the current risks, such as the risk associated with the constant reliance on agency staff and the risk associated with residents identified as at high risk of falling when unsupervised in communal rooms. The recently formed health and safety committee had not yet met.

This is a repeated non compliance from the last four inspections which occurred on 23 January, 11 April, 31 May and 03 August 2018.

**Judgment:** Not compliant
Regulation 5: Individual assessment and care plan

A comprehensive assessment of the health, personal and social care needs of residents before admission as required by the regulations was not carried out. In addition resident assessments and care plans were not developed within 48 hours of admission to the centre.

A sample of the resident assessments and care plans reviewed were incomplete and did not provide clear detail about how residents' needs were to be met. As a result the care plans did not effectively guide the staff in caring for these residents and risked residents' needs not being fully met. For example, a number of residents who were seen to have poor dental hygiene did not have their dental hygiene needs reflected in their care plans. In addition care plans were not consistently revised to reflect the changing needs of the residents.

Overall the systems in place to ensure that care plans were implemented needed to be strengthened. This has been a consistent finding on recent inspections and had not been audited since June 2018 despite assurances to do so.

This is a repeated non compliance from the last two inspections which occurred on 31 May and 03 August 2018.

Judgment: Not compliant

Regulation 6: Health care

There was good access to a range of health care professionals relevant to residents’ needs. Multidisciplinary services in the community were accessible to residents and they also had access to the outreach team from the local hospital which included a geriatrician. There was also access to a general practitioner arranged in the centre, or residents were able to select one of their choice.

However, inspectors saw that evidence-based nursing care as required by the regulations was not consistently provided. For example, inspectors saw that continence was not promoted which significantly compromised residents' dignity.

On a positive note, residents were seen to receive their medications within an hour of the prescribed time which was one area addressed since the last inspection.

Staff nurses had not received medication management training and there was no evidence that this had been arranged. In addition, staff nurses competencies to administer medication safely had not been completed and there was no medication competency assessment tool available for review. An audit of the medication round had not taken place on the 01 October 2018.
Judgment: Not compliant

**Regulation 8: Protection**

There was a safe guarding procedure in place and staff spoken with were clear on the steps to take if they witnessed, suspected or had abuse reported to them. Two new staff had not received mandatory training in the detection, prevention and responses to abuse.

Inspectors were told that no incidents of alleged abuse had been reported since the last inspection. However, one resident told inspectors that they had reported alleged abuse to staff and nothing had happened. The person in charge commenced an investigation into the alleged incident, however a mandatory notification has not been received as is required.

Judgment: Not compliant

**Regulation 9: Residents' rights**

This inspection found many examples where the care in the nursing home was task orientated and where arrangements were not in place to ensure that the rights of residents were respected in relation to privacy, dignity and their ability to exercise personal choice. For example:

- Residents were not offered choice of where to eat their breakfast, lunch or dinner and their preferred choice was not recorded in their care plan.
- Protective clothing was put on residents at lunch time without their consent.
- Shower lists were used with each resident allocated a day to have a shower, care plans reviewed said offer the resident a shower weekly, this reflected institutional care.
- Resident sittings in one of the two day rooms did not have access to a television and were sitting looking bored for long periods.

Residents who required assistance with eating had their meals served to them on a low table in one of the two day rooms. As a result residents had to bend down to the low table to eat their meal. The position did not appear comfortable and also did not promote independence or provide an opportunity to socialise with other residents and enjoy the whole dining experience.

Residents and relatives who spoke with inspectors said there was limited consultation with them and felt their voice was not being heard.

Meaningful activities were not provided to residents. The person employed to provide activities to residents was not functioning in her role as an activities co-
ordinator. She spent most of the day carrying out general care tasks, such as, serving hot drinks and snacks to residents and assisting residents with meals.

One resident told inspectors he was no longer allowed to go to a local shop despite doing so previously. He said he was told that this could no longer be facilitated.

Inspectors were informed by a resident that no internet service was available to facilitate communication with the outside world.

This is a repeated non-compliance from the last four inspections which occurred on 23 January, 11 April, 31 May and 03 August 2018.

Judgment: Not compliant
### Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 19: Directory of residents</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 21: Records</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 34: Complaints procedure</td>
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<td><strong>Quality and safety</strong></td>
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<td>Regulation 26: Risk management</td>
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<tr>
<td>Regulation 5: Individual assessment and care plan</td>
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<td>Regulation 6: Health care</td>
<td>Not compliant</td>
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<td>Regulation 8: Protection</td>
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<tr>
<td>Regulation 9: Residents' rights</td>
<td>Not compliant</td>
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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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time 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:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:
Post inspection the use of agency has decreased. At present we are not using any agency nursing staff.

The following staff have been recruited.
Person In Charge x 1. Commenced 12th October 2018
Clinical Nurse Managers x 2. One has commenced their post and a second due to commence week beginning November 19th, 2018
Activity Co-Ordinator x 1. Commencing 12th November 2018
Health Care assistant x 5. Two have commenced following receipt of Garda Vetting. Three HCAs are awaiting Garda Vetting and are due to commence the positions on receipt of same. Remaining compliance currently being gathered.

All the required documents for Schedule 2 are in place for all staff. Those staff recruited and awaiting Garda Vetting have commenced gathering remaining compliance paperwork.

The roster is currently being completed by the PIC to ensure it is appropriately planned and maintained.

The staffing levels within the home have been reviewed using an appropriate tool.

| Regulation 16: Training and staff development       | Not Compliant  |
Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training matrix has been reviewed by the PIC.

Manual Handling training has taken place for new starters on 9th November with a refresher planned for existing staff
Fire Safety training has taken place for all staff on 19th October, 2018
Safeguarding training has taken place for all staff on 19th October, 2018
Dysphagia training will take place for all staff on November 13th 2018

All Nursing Staff have been requested to complete the HSE Land Training Course
Medication Management Refresher training has been organised for 21st November 2018
We are currently awaiting dates from our external trainer for Challenging Behaviour Training for all staff.
Awareness sessions are taking place with staff on the 2007 Health Act, The Regulations and the HIQA standards.

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<tr>
<th>Regulation 19: Directory of residents</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The resident’s directory has been audited by the PIC. A new audit tool has been devised to ensure compliance and will be completed weekly by the Administrator and reviewed by the PIC. Where information is missing evidence of attempts to secure same will be recorded.

It is the responsibility of the admitting nurse to ensure that all relevant information is recorded in the Residents Directory. This is clearly outlined as part of the admission process.

Each resident in Silvergrove Nursing Home has a personal file which contains all information relating to that individual including but not limited to personal information, medical information and history as well as careplans.

Those residents that request Silvergrove to maintain monies and/or valuable items safely have documents to support any transactions of same. At present we have no residents that have items of value stored within the Nursing Home safe, we do however have one resident who has requested his own safe in his room.
Regulation 21: Records | Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Staff Records: a complete review of staffing files has taken place.
Residents File: care plans are currently under review and are being updated.
Directory of Residents: audit has been completed and will continue to be audited monthly.
Staff Training: updated immediately following all training.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 23: Governance and management | Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Statement of Purpose has been reviewed and updated.
The PIC has commenced staff meetings and appraisals. Same to be completed by December 15th, 2018.
Staff Job Descriptions have been reviewed and all staff will have their roles and responsibilities clearly outlined during these meetings.
The Management structure within the Nursing Home is clear to all staff with clear reporting pathways evident and discussed with all. These will be redefined during staff 1:1 meetings

Regulation 3: Statement of purpose | Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of Purpose has been reviewed and updated. A copy of same is available to all residents and visitors at reception.

<table>
<thead>
<tr>
<th>Regulation 31: Notification of incidents</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</td>
<td></td>
</tr>
<tr>
<td>All incidents post inspection have been informed to HIQA.</td>
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</tr>
<tr>
<td>The PIC is solely responsible for the notification of all events to HIQA.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 4: Written policies and procedures</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</td>
<td></td>
</tr>
<tr>
<td>Silvergrove Nursing Home has in place a comprehensive set of policies and procedures which are to inform and guide staff in the provision of quality care to the residents.</td>
<td></td>
</tr>
<tr>
<td>These policies are under review to ensure they are fully up to date with legislation and reflective of best practice and required national standards.</td>
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</tr>
<tr>
<td>Staff are receiving feedback and on the floor sessions in relation to any changes.</td>
<td></td>
</tr>
<tr>
<td>Staff are supervised on the floor by the newly appointed CNMs and PIC.</td>
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</tr>
<tr>
<td>Staff are receiving 1:1 appraisals at this time.</td>
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</tr>
<tr>
<td>The PIC operates and open-door policy where all issues and concerns from residents staff can be shared and expressed.</td>
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</tr>
<tr>
<td>Staff meetings are taking place to ensure all changes to policy are discussed and an opportunity for clarity can be sought.</td>
<td></td>
</tr>
<tr>
<td>Audits of care provisions have been devised and the PIC and RPR will commence same week beginning November 12th.</td>
<td></td>
</tr>
</tbody>
</table>
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Silvergrove is dedicated to ensuring all complaints, concerns and compliments are logged, noted, investigated and satisfaction with outcome sought. The residents handbook which is given to each resident on or prior to admission also contains important information on how to make a complaint and the process that will occur when a complaint has been made.

The complaints policy has been reviewed.

The complaints procedure is displayed openly in the reception area of the home. All residents and visitors are fully aware of the pathways to be taken to ensure a complaint is managed and dealt with. The PIC has an open door policy and is available daily to address any issues that may arise.

All staff will receive training on the management of a compliant.

A complaint log is in use by the PIC and all complaints are investigated promptly and kept abreast of the process including the outcome and the appeals procedure if required.

Complaints are reviewed monthly or sooner if required by the RPR to ensure oversight and satisfaction.

A Complaint audit is in place to ensure that any actions arising and/or required from the complaint investigation has been implemented.

Complaints are reviewed monthly by the PIC and discussed with the RPR to ensure that any trends and/or patterns are noted and learning can be implemented to ensure issues do not arise again.

Records of the compliant, the investigation and any subsequent audits are maintained at the Centre for review.

A suggestion box is also clearly displayed in the home. Residents and families as well as other visitors are free to post suggestions into the box either anonymously or with a signature.

Residents meetings take place bimonthly. This is an open forum where residents can voice their opinions/issues of concerns that relate to any/all services they are provided within the Nursing Home.
Regulation 18: Food and nutrition  Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Silvergrove Nursing Home is committed to ensuring that Residents have a varied nutritious diet. We are also committed to ensuring our residents are supported to make choices regarding the food they eat and where it is served to them. We want our residents to have an enjoyable dining experience.

Post inspection and following a complete review of the dining experience we have allocated a specific room for dining within the home. Residents that wish to dine here do so and those residents that wish to dine elsewhere in the home are also accommodated.

The catering team work closely with the clinical staff to ensure that all residents receive their food at a temperature that is acceptable to them. Residents that wish to have breakfast in the dining room are afforded the opportunity to do so. At present our residents decline this option. Residents that receive meals in their bedrooms do so by choice and this is now clearly documented in their careplan.

Careplans are currently under review to ensure all resident preferences and wishes regarding mealtimes are recorded.

Communication between the PIC and Catering team occurs daily to ensure the residents needs are met.

A formalized food plan is currently being devised to ensure the dietary requirements for each resident are clearly recorded, noted and communicated to all staff in all departments.

Regulation 26: Risk management  Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Risk Management Policies are currently under review and a comprehensive risk assessment is to be completed on the Nursing Home. The Risk Register is also under review to ensure all hazards and risks are clearly identified and control measures are in place to reduce or minimize the risks attached.

Policies are currently being reviewed and updated for:
- Procedure in the event of a Missing Persons
- Accidental Injury
- Challenging Behaviour
**Self Harm**

All incidents within the Nursing Home are reviewed by the PIC to ensure control measures are adequate and there is no adverse effects on residents. These events are discussed monthly at Health, Safety and Risk Management Meetings to observe any trends or patterns that may be arising and to note learning from these events.

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and care plan</th>
<th>Not Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: All staff nurses will receive care planning training in house. All care plans are under review and where possible and appropriate residents and/or family will be involved to ensure all wishes, preferences and desires are recorded and noted. Care plans will be developed to ensure the appropriate and relevant multi-disciplinary input is noted, reviewed and evaluated. The care plan will reflect the residents changing needs. The review of care plans will also ensure that the supports and resources required by each resident are clearly outlined and the care plan supports communication with the resident in respect of choices all aspects of care. Where a resident is living with a dementia and/or cognitive decline the family will be consulted and the GP where necessary to ensure the best possible health, social and emotional outcomes for that residents.</td>
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</table>

<table>
<thead>
<tr>
<th>Regulation 6: Health care</th>
<th>Not Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 6: Health care: All residents have in place a care plan which is currently being reviewed. All residents are afforded the choice to choose their own GP. Residents that can make their choices, wishes and preferences known have these recorded within their care plan.</td>
<td></td>
</tr>
</tbody>
</table>
The GP in consultation with the resident and/or family ensure referrals are made to relevant MDT members and allied healthcare professionals. All our residents have the right to decline such interventions and this is documented clearly.

The PIC ensures all resident have care plans in place.

<table>
<thead>
<tr>
<th>Regulation 8: Protection</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 8: Protection: Staff have all received training in Safeguarding and refresher training has been scheduled for week beginning 12th November. The current PIC has reviewed all incidents and accident noted. The PIC has spoken to residents and retrospectively submitted 2 x NF06s. Investigations were commenced immediately. Of the two issues both were unfounded. As indicated in the body of the report, staff are very clear on the processes relating to the detection, prevention and responses to abuse. All staff are aware of the respecting the dignity and bodily integrity of all resident during personal care and adhere to the guidelines indicated in the policy. The PIC is fully aware of their roles and responsibilities in investigating any allegation or suspicion of abuse. All residents care plans are under review and all residents that require a care plan for personal care will have one in place.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 9: Residents' rights</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 9: Residents' rights: The rights of all residents are respected within Silvergrove Nursing Home. Residents have access to advocacy and information about their rights. Residents who wish to vote are registered to do so. Resident and families meetings occur within the home. Residents are supported to exercise choice and control in their daily life. Residents are afforded choice and are consulted make decisions regarding The dining areas within the nursing home have been rearranged to utilise a large room</td>
<td></td>
</tr>
</tbody>
</table>
which was not used within the home. All residents now have meals in their preferred area of choice as indicated by them.

The PIC has commenced 1:1 meetings with families to discuss care needs and any issues of concerns with families.

A new Activity Co-Ordinator has been employed and is due to commence on November 12th, 2018. The offering of activities will be reviewed by the PIC and Activity Co-Ordinator and a comprehensive plan will be put in place to reflect the needs, preferences, interests and hobbies of the residents in the Nursing Home.
### 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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>Regulation 16(1)(b)</td>
<td>The person in charge shall ensure that staff are appropriately supervised.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>16/12/2018</td>
</tr>
<tr>
<td>Regulation 18(1)(b)</td>
<td>The person in charge shall ensure that each resident is offered choice at</td>
<td>Substantially</td>
<td>Yellow</td>
<td>29/10/2018</td>
</tr>
<tr>
<td>Regulation</td>
<td>Text</td>
<td>Compliance Status</td>
<td>Color</td>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
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<tr>
<td>18(1)(c)(i)</td>
<td>The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>28/10/2018</td>
</tr>
<tr>
<td>19(3)</td>
<td>The directory shall include the information specified in paragraph (3) of Schedule 3.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>15/11/2018</td>
</tr>
<tr>
<td>21(1)</td>
<td>The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>21(6)</td>
<td>Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>15/11/2018</td>
</tr>
<tr>
<td>23(a)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>23(b)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>15/12/2018</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Status</td>
<td>Date</td>
<td></td>
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<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Not Compliant</td>
<td>Orange 15/11/2018</td>
<td></td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.</td>
<td>Not Compliant</td>
<td>Orange 23/11/2018</td>
<td></td>
</tr>
<tr>
<td>Regulation 26(1)(b)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.</td>
<td>Not Compliant</td>
<td>Orange 23/11/2018</td>
<td></td>
</tr>
<tr>
<td>Regulation 03(1)</td>
<td>The registered</td>
<td>Not Compliant</td>
<td>Orange 09/11/2018</td>
<td></td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance</td>
<td>Color</td>
<td>Date</td>
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<tr>
<td>31(1)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/10/2018</td>
</tr>
<tr>
<td>34(1)(d)</td>
<td>The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>28/11/2018</td>
</tr>
<tr>
<td>04(1)</td>
<td>The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/12/2018</td>
</tr>
<tr>
<td>04(3)</td>
<td>The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/12/2018</td>
</tr>
</tbody>
</table>
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.

<p>| 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 | 28/10/2018 |
| Regulation 5(2) | The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to a designated centre. | Not Compliant | Orange | 28/10/2018 |
| Regulation 5(3) | The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident’s admission to the | Not Compliant | Orange | 28/11/2018 |</p>
<table>
<thead>
<tr>
<th>Regulation</th>
<th>Description</th>
<th>Not Compliant</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6(1)</td>
<td>The registered provider shall, 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 Cnámhseachais from time to time, for a resident.</td>
<td>Orange</td>
<td>17/12/2018</td>
</tr>
<tr>
<td>8(1)</td>
<td>The registered provider shall take all reasonable measures to protect residents from abuse.</td>
<td>Orange</td>
<td>15/11/2018</td>
</tr>
<tr>
<td>8(2)</td>
<td>The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.</td>
<td>Orange</td>
<td>28/11/2018</td>
</tr>
<tr>
<td>9(2)(a)</td>
<td>The registered provider shall provide for residents facilities for occupation and recreation.</td>
<td>Orange</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>9(2)(b)</td>
<td>The registered provider shall provide for residents opportunities to</td>
<td>Orange</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>Regulation 9(3)(a)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
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</tr>
<tr>
<td>Regulation 9(3)(c)(ii)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
</tr>
<tr>
<td>Regulation 9(3)(d)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
</tr>
<tr>
<td>Regulation 9(3)(e)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
</tr>
</tbody>
</table>