Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Office of the Chief Inspector

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

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| Name of designated centre: | Elm Green Nursing Home |
| Name of provider: | MNMS Developments T/A Elm Green Nursing Home |
| Address of centre: | New Dunsink Lane, Castleknock, Dublin 15 |
| Type of inspection: | Unannounced |
| Date of inspection: | 03 February 2019 |
| Centre ID: | OSV-0000133 |
| Fieldwork ID: | MON-0026094 |

## About the designated centre

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

Elm Green Nursing Home is located in Dublin 15 and is located in its own grounds. The centre is a two-storey purpose-built building and has 120 single bedrooms all with full en-suite shower rooms. Floors can be accessed by stairs and passenger lifts. Admission takes place following a detailed pre-admission assessment. Full-time long-term general nursing care is provided for adults over 18 years, including dementia care, physical disability and palliative care.

**The following information outlines some additional data on this centre.**

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| Current registration end date: | 06/03/2021 |
| Number of residents on the date of inspection: | 117 |

## 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 |
|---|---|---|---|
| 03 February 2019 | 18:00hrs to 20:00hrs | Ann Wallace | Lead |
| 04 February 2019 | 08:00hrs to 17:00hrs | Ann Wallace | Lead |
| 04 February 2019 | 09:15hrs to 17:00hrs | Helen Lindsey | Support |
| 04 February 2019 | 08:00hrs to 17:00hrs | Michael Dunne | Support |
| 03 February 2019 | 18:00hrs to 20:00hrs | Helen Lindsey | Support |

## Views of people who use the service

Overall residents and families who spoke with the inspectors reported high levels of satisfaction with the care and services provided for them in the designated centre.

Both residents and their families said that staff were kind and patient and that they were respectful. Residents told the inspectors that they felt safe in the designated centre. Families said that nursing staff were very attentive to clinical problems such as wounds and nutrition and commented on how much their relative had improved since their admission.

Residents said that staff changes were still happening but that this was happening less frequently. Records showed that the turnover of staff had reduced since the last inspection. However a small number of residents told the inspector that they were still finding it difficult when new staff were involved with their care as they were not familiar with their needs and that at times communications were difficult with some staff for whom English was not their first language.

Families said that they were made welcome at the centre and were encouraged to visit regularly. On the first evening of the inspection a number of families with children and young people were visiting in the centre and inspectors noted that there was a real sense of community and activity which residents were enjoying to the full.

Residents said that they enjoyed their meals and that there was enough choice on the menus. Residents enjoyed having the option to have breakfast in bed and at a time that suited them.

A number of residents remained in their rooms during the inspection and told the inspectors that this was their choice. Other residents were seen mobilising around the units either independently or with the support of staff. Residents enjoyed meeting in the communal rooms either to watch television or to participate in the activities. Residents told the inspectors that they enjoyed the activities that were on offer and that activities staff worked hard to vary the programme and organise entertainments. However families on Oaks unit said that there were not enough activities on offer that were suitable for residents with dementia. Inspectors noted that at the time of the inspection one activities staff was off and another was new in post.

## Capacity and capability

Inspectors found that overall care and services were well managed for the benefit of the residents and staff who lived and worked in the designated centre and that a number of improvements had been achieved since the last inspection. However there were some areas that had not been adequately addressed in relation to ;

- the management of staff resources
- activities for residents with high levels of cognitive impairment
- specialist training for staff
- seating arrangements at meal times
- care plans

In addition this inspection found that improvements were required in policies and procedures, risk management in relation to fire safety at night and in the recording of complaints.

The person in charge worked full time in the centre and was supported by the assistant director of nursing who acted into the role of person in charge in her absence. Residents and their families were familiar with senior staff and said that they were approachable if they had any issues or concerns. The provider representative was regularly in the designated centre and was known to staff and residents. The provider representative had daily contact with the person in charge and was involved in the oversight of care and services through the quality and safety committee.

Staff working on the units had access to support and supervision from two clinical nurse managers who worked full time in the centre. Inspectors noted that the clinical nurse managers were familiar with the residents and staff in their units and were up to date with any concerns or issues in relation to individual residents health and well-being.

Staff had access to appropriate induction and mandatory training and as a result were were clear about their roles and responsibilities and the standards that were expected of them in their work. Staff had access to specialist training from an in house dementia specialist who was based in the centre. However a number of staff had not attended this training at the time of the inspection and inspectors found that specialist training required further improvement to ensure that all staff had the required knowledge and skills to provide care and services in line with the statement of purpose.

Oversight and supervision systems had improved since the last inspection and records showed that under performance was being actively managed. However quality assurance processes needed to further improve to ensure that where improvements had been identified through audits and other review processes that these were implemented by the relevant staff and followed up by managers.

## Regulation 15: Staffing

Rosters showed that there was a nurse on duty on each unit at all times.

The number and skill mix of the staff had improved since the last inspection however due to current vacancies and staff absence the following areas still needed to be addressed to ensure that there were enough staff with appropriate skills and knowledge to meet the needs of the residents.

- one occupational therapist vacancy
- three full time health care assistant vacancies
- absence of one activities staff.

The inspectors noted that these shortages had been covered on the rosters but that in some cases this took a member of staff away from their own duties. For example on the first evening of the inspection a clinical nurse manager worked as the nurse in charge on one unit to cover a nurse absence. On Oaks unit activities staff were observed helping with personal care and at meal times which reduced the time available to plan and provide appropriate activities for the residents.

In addition the centre had not completed a fire drill with the reduced number of staff available on night duty and as a result had not tested whether these staffing levels were adequate to maintain the safety of the residents in the event of a night time fire emergency.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

Inspectors found that mandatory training had significantly improved since the last inspection. However access to specialist training appropriate to some roles needed to improve.

Staff training was being actively managed and records showed that there were good levels of compliance with mandatory training requirements in key areas such as fire safety, moving and handling and safeguarding. However further improvements were required in areas of specialist skills and knowledge such as pharmacology for nursing staff and to ensure that new activities staff had access to training in meaningful engagement and appropriate activities for residents with cognitive impairment.

Supervision of staff had also improved since the last inspection. Records showed

that staff were being actively supervised and supported in their work by senior staff and managers. Staff under-performance was being managed in line with the centre's policies and procedures. Where staff did not meet the required standards this was addressed by managers. As a result staff were clear about what was expected of them in their roles and took responsibility for their work.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The governance and oversight processes in the centre had improved since the last inspection. However further improvements were required to ensure that; the staff resource was effectively managed to provide care and services in line with the statement of purpose and; that the quality assurance processes were used more effectively to bring about improvements when these had been identified in the monitoring processes.

There was a clear management structure in place. Changes to the structure since the last inspection helped to ensure that there was clarity around roles and responsibilities for all areas of care and service provision. As a result staff were clear about their areas of responsibility and about the reporting structures that were in place.

Although resources had improved since the last inspection further improvements were still required to ensure that resources were being effectively managed to deliver care and services in accordance with the designated centre's statement of purpose. For example there was no clear strategy to cover a long term sickness in the activities team and as reported under Regulation 16, there was no clear training plan in place to ensure that newly appointed activities staff had the skills and knowledge they required for their work. For example newly appointed activities staff with no specialist training were allocated to provide activities on Oaks unit where the residents were living with dementia.

Managers completed twice daily walkabouts on each unit to check that care and services were being delivered to the required standards. These checks were recorded and where improvements were required this was communicated to the relevant staff. In addition there was a comprehensive range of audits in key areas such as falls, care plans, medication practices, wounds, complaints and incidents. Quality and safety meetings were scheduled quarterly and minutes showed that they were attended by the provider representative. During the inspection the provider representative was aware of recent complaints and incidents that had occurred in the centre.

The systems that were in place to monitor the safety and quality of care and services had improved since the last inspection. However improvements were still required to ensure that when improvements were identified that the relevant

managers oversaw the implementation of the changes. For example the inspectors found that a number of agreed actions had not been adequately addressed in relation to care plan audits and medication audits.

The annual review for 2018 was being completed at the time of the inspection. The review process had sought the views of residents and their families.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

The inspectors found that the processes in relation to the management of complaints had been addressed in line with the requirements of the last inspection. However this inspection found that improvements were required in the recording of complaints.

There was a clear complaints procedure in place which explained how to make a complaint and who was responsible for managing complaints in the centre. The procedure was displayed in a prominent position in the reception area and residents were given the information on admission to the designated centre. Residents and their families told the inspector that they were satisfied with how staff and managers had dealt with any issues or complaints that they had raised.

The complaints procedure had been reviewed and disseminated to staff since the last inspection. As a result staff had read and were familiar with the correct process to follow if a resident or a family member raised a complaint.This was an improvement from the previous inspection.The complaints log was reviewed during the inspection. Records showed that complaints were addressed within the required time scales and that they were appropriately investigated. However not all complaint records documented

- whether the complainant had been notified of the outcome of the complaint
- the complainant's level of satisfaction with how their complaint had been managed.

Residents had access to an independent advocate and contact details were available in the centre for residents and their families.

Judgment: Substantially compliant

## Regulation 4: Written policies and procedures

There was a comprehensive range of policies and procedures in place to guide staff working in the centre which included those policies required under Schedule 5 of the regulations.

Policies and procedures were made available to staff through induction training, ongoing mandatory training and in staff meetings.

Policies and procedures were reviewed every two years. Overall policies were found to reflect best practice guidance and current legislation. However improvements were required to the current Safeguarding Policy to ensure that the policy reflected the guidance from the Health Services Executive in relation to the protection of vulnerable adults and children.

Judgment: Substantially compliant

## Quality and safety

Overall resident's needs were being met but improvements were required to ensure the policies and procedures in the centre were being fully implemented in practice. While improvements had been identified since the previous inspection, further improvements were required in relation to, care plans, risk management and medications. These were outstanding actions from the previous inspection.

The inspectors reviewed a sample of care plans. records showed that prior to admission residents had a comprehensive assessment of their needs which helped to ensure their needs could be met in the centre. When the resident was admitted a more detailed assessment was completed which included information about the resident's life experiences and current health care needs. This information was used to develop a care plan with the resident and their family. Inspectors found that care plans were comprehensive and included the resident's preferences for care and daily routines. However a number of records did not provide enough up to date detail to ensure that staff knew how to meet the resident's current needs.This was seen in relation to communication needs,nutrition and managing responsive behaviours.

Where residents had identified health care needs there were procedures in place to monitor those needs, and take appropriate action if they changed. A number of nursing tools were used to assess and monitor resident's needs and potential problems, for example the risk of developing pressure areas, changes in mobility, changes in cognitive ability, and the risks related to poor intake of foods and fluids. These were kept under review, and referrals were made to the specialist health care professionals when required. Records showed that where a resident's needs changed this was reported promptly to nursing and medical staff and appropriate actions were taken.

While procedures around risk management and medication management were seen

to be in place, it was identified that they were not always fully implemented. For example in relation to medications practices an improvement action relating to staff knowledge around common medications had not been adequately addressed by managers. In addition records showed that the management of fire risks at night time had not been adequately assessed and managed in line with the centres fire safety policy.

Residents were positive about the food and drinks provided in the centre, and confirmed there was always a choice and that they were of a good standard. There were sufficient staff to support those residents who needed it, and residents could choose where to take their meals. An issue that remained outstanding from the previous inspection related to the furniture available to residents in one sitting area, and the impact it had on those residents being able to eat and drink in comfort and safety.

There was a good focus in the centre on ensuring residents rights were being met and care was found to be person centred. Inspectors observed that residents' privacy and dignity were maintained by staff. Staff were seen to be engaging with residents respectfully. Residents told the inspectors that staff were kind and caring.

Records showed that relative and residents meetings were held regularly and were well attended. This helped to ensure that the management team were able to receive feedback from those people using the service. The person in charge and clinical managers were regularly available on the units which further helped to ensure that they were accessible to residents and their families and were able to receive feedback on an ongoing basis.

While a program of activities was being provided, and improvements had been made since the previous inspection, further improvements were required in the provision of activities for those residents who had higher levels of cognitive impairment.

## Regulation 18: Food and nutrition

Residents provided positive feedback about the quality of meals and refreshments available. Inspectors observed that residents had access to drinking water in the communal areas and those in their rooms had a jug of water within reach.

Residents were seen to choose where they had their meals. Where residents required support it was done sensitively by staff who sat next to the residents and provided individual support to ensure they were able to eat and drink. Staff were knowledgeable about each resident's nutritional needs and the help they required at meal times. Where possible staff were seen to encourage residents to eat and drink independently.

The menu was available in the dining areas and offered two options. Residents said other options were available if they asked or didn't like what was being served.

The meals were seen to be well presented and offered a range of vegetables and fruits to suit resident's tastes.

The inspectors found that the seating arrangements for some residents who took their meals in the lounge areas required review. This is addressed under Regulation 17.

Judgment: Compliant

## Regulation 26: Risk management

Inspectors found that although the identification of hazards and the assessment of risks in the centre had improved since the last inspection further improvements were required in relation to the assessment and management of fire safety risks.

There was a range of risk management policies in place in line with the requirements of Regulation 26. and this included an emergency plan to keep residents and staff safe in the event of a major incident.

Inspectors found that the identification of hazards had improved since the last inspection. Oversight processes included a daily walkabout to check for hazards such as wet floors, storage of COSHH products and that risks associated with maintenance work were being managed appropriately.

There was a risk register in place which identified environmental, occupational and clinical risks. However the inspectors found that the arrangements in place for managing a fire emergency during the night had not been adequately risk assessed and managed. The centre had not completed a night time scenario fire drill to test whether the current fire safety procedure would be effective with the reduced number of staff on duty at night.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

Inspectors found that although improvements had been achieved in relation to the safe storage of medications further improvements were required to ensure that nursing staff had appropriate knowledge to administer medications safely. This was

an outstanding action from the previous inspection.

Residents had access to appropriate pharmacy services. The designated centre had changed pharmacy services since the last inspection. Records showed that there were clear systems in place for ordering and renewing medication supplies. This helped to ensure that residents had access to their medications and that medications were stored securely and appropriately.

The inspectors observed part of a medications round on the second day of the inspection and found that medications were administered safely and in accordance with best practice guidance.

Records showed that nurses had access to training and support in relation to medications management. Regular competency assessments were completed by clinical nurse managers to ensure that nursing staff had the required skills and knowledge to administer medications safely. However inspectors noted that improvements were still required in relation to nursing staff's knowledge about the medications that they were administering. In addition improvements were needed to ensure that where medication audits identified the need for changes or improvements, for example further medication training for nurses, that these were fully implemented by the relevant staff and signed off by managers.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Records showed that each resident had an assessment of their needs prior to their admission to the centre. Following admission a comprehensive assessment was completed with the resident and or their family. Improvements were required to ensure that care plans set out what residents current needs were, and also provided sufficient information to guide staff to be able to fully meet those needs. This was an outstanding action from the previous inspection.

Care plans included information about each resident's needs and preferences for care and support and were person centred. While some care plans were up to date and reflected the resident's current needs, others had not been updated to reflect the findings and recommendations from allied professionals. For example one nutritional care plan had not been updated following a recent review by the dietician. Other care plans did not clearly record the residents current equipment needs, for example if residents used a wheelchair to mobilise or required a hoist when moving from one place to another.

Where residents had responsive behaviours or behaviours and psychological

symptoms of dementia (BPSD) care plans did not set out sufficient detail to identify what the specific behaviour may be, the triggers that may cause them to become anxious, and the way for staff to respond. While staff knew residents well, and responded well to any incidents this was not accurately recorded in the care records. At the time of the inspection there were a number of newly recruited staff on duty. These staff were not familiar with all of the residents and referred to handover reports and care plans for guidance about each residents needs. As a result there was a risk that they would not get accurate information from the care plans in order to care for residents appropriately.

Overall care plans did reflect a person centred approach setting out residents likes and dislikes and preferred routines.

Judgment: Not compliant

## Regulation 6: Health care

Care records showed that residents had good access to medical and specialist services such as physiotherapy, occupational therapy, social workers, dietician and speech and language therapists. A number of care plans were seen to set out how residents needs has been identified as changing, and so referrals were made to relevant services. For example in the case of residents with pressure area care needs, a referral was made to the tissue viability nurse if any change or deterioration was noted.

Inspectors observed handover between the teams when shifts changed, and observed it to be very detailed setting out how the health and social care needs of residents had been met. Healthcare assistants were reporting anything they felt was a change for residents, and the nursing staff were then following it up.

Records showed that there was a low incidence of key clinical indicators such as pressure sore wounds, falls and infections which indicated that residents healthcare needs were being well met by the staff team.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

There were policies and procedures in place setting out how to identify residents needs where they had responsive behaviours or behavioural and psychological

symptoms of dementia (BPSD). Staff had completed training in supporting residents with dementia which included identifying and de-escalating responsive behaviour. Staff were seen to be interacting positively with residents, and providing appropriate support, this included ensuring residents dignity by moving away from other residents or speaking quietly with residents so others could not overhear. Nursing hand over reports included information about each resident's current needs including how they were emotionally as well as physically.

There was a clear policy on the management of restraints which was reviewed by the inspectors and found to reflect national best practice guidance. Where restrictive practices were being used there were assessments in place, for example in relation to bed rails and as required medications (PRN). records showed that appropriate alternatives were trialled before equipment such as bed rails were introduced. Residents and their families were involved in the decision process around the use of restraints. Risk assessments were completed to ensure that restrictions were used in the safest way possible and for the least time necessary. Audits were carried out to ensure records and practice in the centre were implemented in line with the centre's restraint policy.

One area for improvement was identified during the inspection in relation to care plans for responsive behaviours. This is addressed under Regulation 5.

Judgment: Compliant

## Regulation 8: Protection

There were arrangements in place to safeguard residents from abuse. All staff had received training that included the main signs of abuse, and how to respond if they observed abuse or had it reported to them. Staff who spoke with the inspectors were clear of the steps to take and felt confident that residents would be safeguarded in the designated centre.

Residents told the inspectors that they felt safe in the centre.

There was an Elder Abuse policy in place which was available to staff and set out the roles and responsibilities and the steps to take in the event of a concern being raised. However the current policy needed further review to ensure it provided more comprehensive guidance about the safeguarding process including; time lines and the steps to follow when it is not a staff member that is identified as the person the allegation is made about. This policy improvement is addressed under Regulation 4.

Judgment: Compliant

## Regulation 9: Residents' rights

The centre was being run with a focus on ensuring residents rights. On admission residents provided information about their interests, religious practice and preferred routines. Throughout the inspection inspectors observed residents were being supported to spend their time in their preferred way, and were supported to maintain routines that were important to them, for example when to get up, and when to go to bed.

Religious services were provided in the centre for residents who chose to attend them. This included a daily reading of the rosary which a number of residents said they enjoyed each day.

Residents meetings were held at least every three months. Minutes showed that issues raised in those meetings had been addressed by the provider, for example improvements to the dining experience and the service provided by the hairdresser and barber. A representative from an external advocacy centre attended the meeting and was available to support residents directly if requested. The provider also employed a staff member to act as an advocate and provide support to residents and their families to ensure any issues could be resolved. This was a particularly useful service for new residents when they first came to live in the designated centre.

Relatives meetings were also held. These meetings provided information and support for relatives, for example there had been a recent presentation about dementia. It also enabled relatives to raise issues for discussion in the group. Recent topics included missing items, feedback on the impact of the staff rotation in the centre, and also requests for more notice for the outings being planned.

The premises provided single en-suite rooms throughout, and inspectors observed that staff were mindful of residents privacy at all times. Staff were seen knocking on doors before entering bedrooms and ensuring doors were closed when personal care was being provided. Residents were seen to be receiving visitors throughout the inspection. Some chose to spend time in their room chatting or watching favourite TV shows together. Others chose to meeting in the communal areas or head out with their visitors for a walk in the grounds. Visitors said they were welcomed in the centre in the day and evening and that they were encouraged to maintain regular contact with their relative.

There was a scheduled programme of activities which were provided by dedicated activities staff in the centre. At the time of the inspection there was one experienced member of the activities team working across Laurel unit and a newly recruited member of the team working on Oaks unit where the residents were living with dementia. Another experienced member of the team was on long term leave. Inspectors observed that the quality of the activities programme varied between the units. On Laurel units the programme was provided in line with the planned schedule and inspectors observed that activities were delivered by experienced staff throughout the day. However on Oaks unit the inspectors noted that the activities staff were helping care staff with care support and assisting with mealtime duties.The inspector observed that a musical entertainer and 1:1 activities were

provided throughout the afternoon but only a small number of residents were seen to benefit form this service. This was also a finding from the previous inspection.

Overall residents reported that they enjoyed the activities that were on offer and said that activities staff knew them well and knew what activities they liked to join in with. Residents reported that they enjoyed being in the choir and that they enjoyed the musical entertainers. Residents and their families told the inspectors that they enjoyed the external providers such as visits from the pet farm and pet dog therapist. Residents had particularly enjoyed the special events and entertainments that had been provided over the Xmas period.

Judgment: Substantially compliant

## Regulation 10: Communication difficulties

Staff were seen to be engaging well with residents, using communication approaches relevant to the resident they were with. When speaking to inspectors they knew residents needs well, and were able to identify if there were any changes to residents presentation.

Care plans set out residents needs in a range of areas including sight, hearing, speaking skills and also their ability to understand, linked to their assessment of cognitive abilities. Whilst inspectors found that there were a number of good examples of communication care plans, some care plans did not include important information. For example one resident was partially deaf but this was not stated in the communication care plan.

Judgment: Substantially compliant

## Regulation 17: Premises

While dining areas were spacious and comfortably set out for residents not all residents took their meals in the dining rooms. Inspectors observed that in one lounge area residents were taking their lunch time meal sat at low tables or with lap trays in place. These seating arrangements did not support a safe and dignified dining experience for the residents. These arrangements required review to ensure that those residents who took their meals in the lounge could sit on a chair and at a table that met their dining needs. This issue remained outstanding from the previous inspection.

Judgment: Substantially 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 |
|---|---|
| **Views of people who use the service** | |
| **Capacity and capability** | |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| **Quality and safety** | |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 26: Risk management | Substantially compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |
| Regulation 10: Communication difficulties | Substantially compliant |
| Regulation 17: Premises | Substantially compliant |

# Compliance Plan for Elm Green Nursing Home OSV-0000133

## Inspection ID: MON-0026094

## Date of inspection: 04/02/2019

**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 | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>Occupational therapist (full time mandatory) requirement is removed from statement of purpose and the SOP is updated. We will continue to have an in house OT but shared across centers now. The fact that the in house OT is an enhanced service and not a mandatory requirement has been overlooked by the inspection team.<br>The vacancy for health care assistants and activity staff is managed among all 6 units using staff members who wish to work extra shifts. Normally there is full compliment of staff as per roster, except on unanticipated sick leave. Activity staff and nursing staff always help with residents' activities of daily living as part of our holistic care delivery system. The management also think proactively when doing the roster to cover any anticipated shortage. All these were evident during the inspection time that there were 3 extra staff members rostered for the weekend to ensure adequate staffing.<br>There is a comprehensive recruitment programme ongoing and the vacancy for HCA s' has not affected the standard of care provided to the residents as evidenced by reduction in falls, incidents, accidents, pressure sores and complaints from residents and relatives.<br><br>The nursing home had done a night time fire evacuation scenario on 11/02/1 and the details of the evacuation process was submitted to the inspector on 11/02/19/ Further evacuation scenarios are planned on monthly basis. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development: | |

All ongoing nurse medication competency assessments are completed. Where a nurse is identified with a need to improve knowledge on medications the management team provides additional support and gives a timeframe for reassessment. In the case of safe practice this is normally 3 months. All staff nurses have access to MIMS and BNF in their individual medication trolley for reference. All staff nurses have completed HSEL and Medication management training and most staff completed INMO medication management training. Furthermore, the pharmacist provides additional training on pharmacology.

The newest activity coordinator is on an induction phase to establish her ability and suitability in this role. If successful, this person will be supported for activity related training by the Centre.

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| Regulation 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Centre now has a full complement of activity staff (4 staff members). A new member is due to start on 25/03/2019. He is an existing HCA with extensive knowledge of residents needs and abilities.Also in addition to our inn house team we have several external providers who daily provide exercise classes and three times weekly provides aromatherapy and similar activities.

The management team meets every Monday, to discuss the progress/ concerns and to ensure follow up of any actions required.

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| Regulation 34: Complaints procedure | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
As per our complaints policy all complaints will now be closed off to include the signature of complainant to indicate satisfaction and that the complainant has been notified by the DON/ADON in a timely manner.

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| Regulation 4: Written policies and procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Safe guarding policy has now been updated to reflect the guidance from the HSE in relation to protection of vulnerable adults and children.

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| Regulation 26: Risk management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management:
The nursing home had done a nigh time fire evacuation scenario on 11/02/19 and the details of the evacuation process was submitted to the inspector on 11/02/19/ Further evacuation scenarios are planned on monthly basis.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medicines and pharmaceutical services:

In this case, the staff nurse was assessed for medication competency on 12/01/19 by CNM and had identified that the nurse needs to improve the pharmacological knowledge. The CNM had discussed action plans with the nurse- including repeating the HSELand medication management training and using available resources such as MIMS and BNF. The CNM also had agreed with the nurse to reassess the competency in 3 months' time as the CNM identified that the nurse's practice was safe, which the inspectors also commented on the day of inspection. This nurse also was provided with additional medication management training by INMO in October 2018. All the staff nurses repeat their HSELand medication management training yearly. In addition, the pharmacy agreed to provide pharmacology training in March 2019.

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| 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:
All care plans have been comprehensively reviewed along with assessments and team notes from MDT. All recommendations have now been included in care plans to guide all staff in managing the residents' health needs.

Where there was a new staff member, the staff was always mentored/ paired up with an experienced staff. The management have implemented comprehensive handover sheets in each unit in order to ensure that all staff are aware of residents' care needs in detail and can refer to it during the shift if in doubt. This is in line with safe best practice This handover sheet is regularly reviewed by the staff nurse in the unit as the residents' condition changes.

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| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The management have now resolved the short staffing in activity team and is restructuring the activity program to ensure effective and suitable activity in each unit.

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| Regulation 10: Communication difficulties | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
All care plans are reviewed comprehensively now and it will be reviewed regularly by the management.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to facilitate supporting seating arrangements for residents during lunch time, the management has sourced an ‘able table’, which will enable less able residents to maintain appropriate posture and promote independence. This will be in the centre by 30th March.

## 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 |
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| Regulation 10(2) | The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5. | Substantially Compliant | Yellow | 07/03/2019 |
| 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. | Substantially Compliant | Yellow | 25/03/2019 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to | Substantially Compliant | Yellow | 30/03/2019 |

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| | appropriate training. | | | |
| 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 | 30/03/2019 |
| 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. | Substantially Compliant | Yellow | 25/03/2019 |
| 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. | Substantially Compliant | Yellow | 30/03/2019 |
| Regulation 26(1)(a) | 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. | Substantially Compliant | Yellow | 13/02/2019 |

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| Regulation 26(1)(b) | 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. | Substantially Compliant | Yellow | 28/02/2019 |
| Regulation 29(5) | The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product. | Substantially Compliant | Yellow | 25/02/2019 |
| 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 | Substantially Compliant | Yellow | 10/02/2019 |

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| | resident was satisfied. | | | |
| Regulation 34(1)(g) | The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process. | Substantially Compliant | Yellow | 10/02/2019 |
| Regulation 34(2) | The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan. | Substantially Compliant | Yellow | 25/02/2019 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where | Substantially Compliant | Yellow | 10/02/2019 |

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| | necessary, review and update them in accordance with best practice. | | | |
| 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 designated centre concerned. | Not Compliant | Orange | |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Not Compliant | Orange | 07/03/2019 |
| Regulation 9(2)(a) | The registered provider shall provide for residents facilities for occupation and recreation. | Substantially Compliant | Yellow | 30/03/2019 |
| Regulation 9(2)(b) | The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and | Substantially Compliant | Yellow | 30/03/2019 |

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| | capacities. | | | |