Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Elmgrove House Nursing Home
Name of provider:	Catherine Gallagher
Address of centre:	Syngefield, Birr, Offaly
Type of inspection:	Unannounced
Date of inspection:	18 September 2019
Centre ID:	OSV-0000035
Fieldwork ID:	MON-0027045

About the designated centre

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

Elmgrove House Nursing Home provides accommodation for a maximum of 24 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence care basis. The centre is located on a mature site, at the end of a short avenue and within walking distance from Birr town centre. The premises is a listed period building. Residents' accommodation consists of 22 single bedrooms and one twin bedroom, located over two floor levels. The first floor is divided into three wings: wings D, E and F and are accessible by chair lift and stairs. Residents accommodated on the first floor are assessed as capable of using the stairs and/or chair lift. Shared toilets and washing facilities are available on each floor. A variety of communal rooms are provided for residents' use, including sitting and dining facilities on the ground floor and a sitting room on the first floor. Each resident's dependency needs are regularly assessed to ensure their accommodation is appropriate and their care needs are met. The service provides 24 hour nursing care and the provider employs a staff team consisting of registered nurses, care assistants, activity, housekeeping, administration and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
18 September 2019	09:00hrs to 19:30hrs	Catherine Rose Connolly Gargan	Lead
18 September 2019	09:00hrs to 19:30hrs	Niall Whelton	Support

What residents told us and what inspectors observed

There were 14 female residents living in the centre on the day of inspection. All residents who spoke with inspectors confirmed their satisfaction with the service. Residents spoke positively about the care and support they received there. They said staff were always attentive to their needs and staff cared for them as they wished. Although inspectors observed staff to be very busy throughout the day, residents said that they never had to wait for prolonged periods for staff to come to their assistance and that staff were always 'happy and in good form.'

It was a sunny day and residents were observed engaging in a reminiscence activity in the garden. Residents who spoke with inspectors said they enjoyed the activities and there was 'enough activities to keep them occupied'. One resident communicated her satisfaction with being supported to continue to engage in gardening activities. Another resident was listening to the radio in her bedroom and told inspectors that she 'always loved listening to the radio' and staff always made sure that it was switched on for her. Several residents were looking forward to the exercise class facilitated by a physiotherapist later that day. Residents were glad that they were supported to maintain contacts with the community. Some residents said they pleased that they could continue to attend their local hairdresser.

The local priest celebrated Mass for the residents on one day each week. Residents were happy that they could also listen to the daily Mass in the sitting room, which was broadcasted from the local church.

Residents felt the visiting arrangements were good to support them with keeping in touch with family and friends. A number of residents said they 'loved going out with their families and friends' and talked about the places they visited.

Residents said they felt safe in the centre, and that staff were very kind and approachable. Residents said that they were always encouraged to choose the time they got up or went to bed, the clothes they wore and how they wanted to spend their day.

Residents told inspectors that the quality of the home cooked meals in the centre was 'outstanding' and that they really enjoyed the 'tasty' food provided for them. Residents expressed their appreciation that they had their own room and television set, which meant they could always watch the programmes that they liked. Residents stated that their privacy was respected by staff when they provided care.

Capacity and capability

This was an unannounced risk inspection by two inspectors of social services, one of whom is a specialist inspector in estates and fire safety. The overall governance and management of this centre continues to be weak and requires significant improvement to ensure the service is safe for residents. Systems of governance and management in relation to putting effective fire safety measures in place are slow and fragmented. Systems to monitor the quality and safety of the service were not sufficient or effective regarding continuous improvement in the safety and quality of the service. Proactive systems for identification and documentation of areas of risk in the service were not evident.

Inspectors reviewed progress made by the provider with completion of the compliance plans from the inspections in February and April 2019 which must be completed to bring the centre into compliance with the regulations. Inspectors found that eight of the 26 areas of non compliance found on inspection in February 2019 were addressed to completion. During the inspection in April 2019, non compliance with 14 regulations was identified, 11 of the non compliances were related to regulation 28: Fire Precautions.

On foot of the findings at the last inspection on 24 April 2019, the Chief Inspector requested the provider to arrange for a fire safety risk assessment of the centre to be completed. The fire safety risk assessment included proposals to sub-divide the building into fire compartments to facilitate progressive horizontal evacuation, which would provide a much improved means of escape for residents living in the centre.

At this inspection, fire precautions was assessed to monitor the progress made on required fire safety works identified at previous inspections, fire safety management practices in place, including the physical fire safety features in the building and the outcome of a fire safety risk assessment, which was completed following the last inspection. The building was reviewed in the presence of the centre's administrator. A time frame of the end of August was set by the Provider to have the works complete but was not achieved in a number of areas.

While, it was evident on inspection that the registered provider had made significant progress in relation to the programme of fire safety works, a number of risks remained outstanding;

- The process for identification and management of fire safety risk was not adequate (this was a repeat finding)
- Storage arrangements for Oxygen were not in line with the recommendations in the fire safety risk assessment for the building. (this was a repeat finding)
- risks identified by inspectors in the smoking room were not promptly addressed during the inspection
- Management of the key to the front door. (this was a repeat finding)
- Poor records of equipment servicing (this was a repeat finding)
- The assessment of residents needs was inadequate (this was a repeat finding)

Through discussion and observations, the inspectors identified a significant deficiency in providing fire containment to the laundry room. Laundry rooms present

an increased risk of fire and require robust containment measures to prevent the spread of fire. There was a disused laundry chute, between a bedroom corridor at first floor and the laundry room, separated only by a timber panel. Owing to the risk to residents, an immediate action was required to address this risk on the day of inspection. To this end, the provider arranged for the opening to be appropriately closed up with fire rated construction.

Inspectors found that the interim arrangements to manage fire safety in the centre required improvement. Although a 'Fire Management Plan' was in place, the provider had not yet implemented the plan and told inspectors that they were waiting for the prescribed works to be complete.

Inspectors found that improvements were required in managing the risk of fire while works were being carried out. Fire safety precautions and fire safety management were not appropriately reviewed and there was no system in place to identify, assess and control the risks to residents while on-going construction works were taking place.

Inspectors noted that the registered provider had not carried out a fire evacuation drill since the previous inspection, therefore could not provide assurance that there was adequate staff in the centre at night time to ensure the safety of residents. A recommendation in the fire safety risk assessment required electrical equipment such as the a hair drying unit to be removed from bathrooms. While they were removed, inspectors found that a hair drying unit was now stored along the bedroom escape corridor, creating a potential obstruction to escape.

The centre was not at full occupancy on the day of the inspection and in the main; residents living in the centre were assessed as being mobile. The provider was strictly adhering to the centre's statement of purpose, that restricts accommodation at first floor level to residents who are mobile. However, inspectors were not assured that there was sufficient staffing provided at night to meet the emergency evacuation needs of current residents.

A condition of the centre's registration since the inspection in April 2019 is that an inner room at first floor level is not used as a resident's bedroom, as adequate means of escape in the event of a fire was not available from this bedroom. The provider ceased using this room as a bedroom and confirmed that it would not be used until measures were put in place to ensure an adequate means of escape was provided. No confirmed time bound plan was in place.

When speaking with residents, inspectors were assured that residents were aware of the complaints process and who to speak to if they wanted to raise any issues. Information about who to contact in relation to complaints was displayed clearly. While an appeals process was available, the information in the policy on what to do if a complainant was not satisfied with the outcome presented to them required clarification. Inspectors followed up on unsolicited information received by the Office of the Chief Inspector in June 2019 and found that the issues raised regarding care of residents were proactively addressed by the provider/person in charge.

Regulation 15: Staffing

A minimum of one registered nurse was on duty at all times. There was one staff nurse and two care staff employed during the day and one staff nurse and one care staff during the night. Inspectors observed on the day of inspection that staff were very busy with caring for residents. Residents told inspectors that their needs were met promptly and staff confirmed that they were satisfied with the staffing levels to meet the needs of the current 14 residents in the centre. A review of staffing was required to ensure that there were adequate staff at night to supervise residents in their bedrooms and that bedrails were not used to prevent residents who were at risk of falling from getting out of bed in place of appropriate staff supervision.

In addition inspectors were not assured that the night-time staffing levels of one staff nurse and one care staff was adequate to evacuate all residents to a place of safety in the event of an emergency in the centre. This was also a finding on previous inspections and is detailed further under Regulation 28: Fire precautions.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents detailed all information regarding each resident as required by the regulations.

Judgment: Compliant

Regulation 21: Records

A sample of staff files were examined by inspectors and except for one file which did not have a second reference, all the staff files held the documents as set out in Schedule 2. A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was available in all staff files reviewed. The provider gave assurances that all other staff currently working in the centre had completed Garda Siochana vetting disclosures available in their files.

A record of fire evacuation drills completed on dates in March 2019 and testing of fire equipment (including fire alarm equipment) conducted in the designated centre was maintained. However, identification of defects and action taken to remedy the defects found in the fire equipment was not adequate. For example, defects found on inspection with some fire doors, poor visibility of and non-permanent lighting of some emergency exit signage were not identified as being deficient or actioned in

fire safety checking records. This is also discussed under regulation 28: Fire precautions.

A record pertaining to schedule 3, paragraph 4(c) regarding a daily nursing record of each resident's health, condition and treatment was completed.

The policies as required by Schedule 5 were available.

A record of all visitors to the centre was maintained. Staff controlled access to the centre.

Judgment: Not compliant

Regulation 23: Governance and management

Appropriate management systems were not in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored by the provider. The provider was also the person in charge and was supported by an administrator. As oversight responsibilities were not clearly assigned for managing the significant work project underway to ensure residents' safety in the event of a fire in the centre, necessary works were not completed as scheduled and remained outstanding without confirmed time bound plans for completion. This necessitated inspectors requiring that effective interim fire containment measures were implemented on the day of the inspection to ensure residents' safety in the event of a fire in the centre.

The provider confirmed that management meetings occurred monthly. However, minutes of these meetings were not available for review on the day of this inspection. The systems for monitoring quality and safety of the service were not comprehensive. While some areas of the service were audited, the information collated was not always analysed and action plans were not consistently developed to inform a process of continuous quality improvement. This was also a finding on the inspection in February 2019 and there was no evidence that this process had been strengthened.

Assurances were not available that sufficient staffing resources were provided to ensure the supervision and safety needs of residents at night in line with the centre's statement of purpose.

Although, the provider had progressed some actions in their compliance plans from the previous inspections in February and April 2019, progress in many of the compliance plans was slow or not yet commenced to bring the centre into compliance with the regulations and in particular regulation 28: Fire precautions.

During the inspection, the person in charge outlined that feedback from residents on the service was received from them on a day-to-day basis and during residents' meetings, every three to four months. Some feedback surveys had been

completed by residents previously and confirmed their high levels of satisfaction with the service provided. This concurred with feedback from residents who spoke with inspectors on the day of this inspection.

The provider prepared an annual review of the quality and safety of the service in consultation with residents for 2018 and this was forwarded to the Office of the Chief Inspector.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts for the provision of care had recently been amended and outlined the services to be provided and the fees to be charged. With the exception of one twin bedroom on the ground floor, all other residents' bedrooms in the centre are registered for single occupancy only.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre's statement of purpose was recently revised with some minor revisions and contained the information as required by Schedule 1 of the Regulations. The centre's statement of purpose details arrangements in place where only residents who are independently mobile are accommodated in accommodation above the ground floor.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. No incidents of serious injury to residents occurred since the inspection in February 2019. There was a one month delay in submitting a quarterly report for quarter two 2019. The provider/person in charge confirmed to inspectors that this delay was an oversight and committed to submitting all further quarterly report notifications within the regulatory timescales.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider/person in charge is the designated complaints officer for the centre and confirmed to inspectors that any complaints received were reviewed at the monthly governance and management meetings. Arrangements were in place to record and investigate any complaints received and an independent appeals process was in place. One expression of dissatisfaction regarding the service was logged since the inspection in February 2019. The record maintained demonstrated satisfactory resolution and detailed the actions implemented. The complaints procedure was displayed. Residents and relatives who spoke with inspectors expressed their satisfaction with the service and stated they had no complaints. Residents were aware that they could make a complaint if they were dissatisfied regarding any area of the service they received.

Independent advocacy services were available to assist residents with making a complaint if they wished. Advocacy services had previously supported residents in the service.

Judgment: Compliant

Regulation 4: Written policies and procedures

Inspectors reviewed the centre's operating policies and procedures and noted that the centre had site-specific policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. All policies including the risk management and fire policy were reviewed since the inspections in February and April 2019. However, the risk management policy and fire safety procedures required further review and implementation. For example, not all hazards in the centre were identified and not all controls to reduce the level of risk posed by the hazards identified were implemented.

Judgment: Substantially compliant

Quality and safety

Residents' health and nursing needs were met to a good standard. A review of residents' care plans, practices by staff, and feedback from residents found that residents' healthcare needs were being met in a timely way and care provided reflected their preferences and wishes.

Residents were safeguarded by effective procedures in the centre and they confirmed they felt safe in the centre. Residents with conditions that predisposed them to episodes of responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were well supported. The use of restrictive bedrails for residents in the centre had reduced since the inspection in February 2019. However, use of bedrails was not informed by national restraint policy guidelines, in that less restrictive alternatives were not trialled before full bed rails were used. A staff review was warranted to ensure that bedrails were not used as a falls prevention strategy in the absence of adequate staff to supervise residents appropriately.

Further improvements continued to be necessary to ensure risk was proactively managed in the centre with robust procedures for identifying, risk assessing and managing potential hazards to residents' safety in the centre. Not all risks were identified and responded to through the centre's risk management process. Inspectors were concerned that fire safety risks identified since the last inspection and in the fire safety risk assessment report had not been addressed or incorporated into the risk register for the centre. Although some progress was made to ensure fire safety in the centre, the fire safety arrangements continued to pose a risk to residents' safety.

The findings of this inspection are that further improvements are required to ensure the safety of residents living in the designated centre if a fire was to occur, particularly while the programme of works was being carried out. While there had been significant progress on the programme of works, the risks posed were not addressed in totality.

The registered provider had not taken adequate precautions against the risk of fire. The disused laundry chute between a bedroom corridor and the laundry room presented a risk to residents at first floor. Inspectors noted the door to the smoking room was held open with a chair and two cigarette lighters were left in the smoking room. Inspectors observed an oxygen cylinder located in the bedroom corridor at first floor and within the treatment room at ground floor. The cylinder in the treatment room was on a stand which was too big for the cylinder and it was not secure. It was also located adjacent to electrical sockets. This was at variance to the control measures identified in the fire safety risk assessment for the building. It was also noted that signage to reflect the presence of oxygen cylinders were not in place.

Inspectors noted that since the last inspection, the fire detection and alarm system had been upgraded to a type L1 category system, thereby providing improved early warning of a fire in the centre. There was a zoned drawing of the ground floor available adjacent to the fire alarm panel but the first floor was not displayed. If an activation of the fire alarm panel at first floor occurred, there was no drawing to guide staff to where the room was located. The emergency lighting system had also been upgraded and emergency lighting coverage had been extended along external escape routes.

There had been a deep clean of the kitchen extract system by an external contractor. Work had commenced on the external stairs to address the rust and corrosion. Concrete paths to improve external escape routes were due to be laid in the coming weeks. There were two store rooms which were now fitted with new fire doors. One of these stores had two ventilation openings in the wall which would allow the passage of fire and smoke to the adjacent escape corridor.

Inspectors were told and documentation demonstrated that a fire stopping specialist contractor was due to complete the containment works in the building in the coming weeks. While there was not a date by when this work would be completed, the provider confirmed subsequent to the inspection that this would be complete by 04 October 2019. This outstanding work includes completion of fire rated construction to create a barrier to the passage of fire and smoke where required throughout the building.

While it was evident that fire doors had been upgraded or replaced and that this improved the containment measures in the building, further work was still required in this regard. Some fire doors which had already been upgraded were not capable of preventing the spread of smoke. Gaps were observed and further upgrade works or replacement was required to ensure they could adequately prevent the spread of fire and smoke. Inspectors observed new partitions which were constructed to improve means of escape from areas of the first floor, the fire doors within the partitions were not yet fitted. The provider confirmed subsequent to the inspection that this would be complete by 04 October 2019

Improvements were still required to provide adequate means of escape. In addition to the incomplete fire containment measures in the building, there was confusion amongst staff and management in relation to the management of the key to the main entrance door, which is also a designated exit. Inspectors were told by management personnel that the nurse on duty carried a copy of the key in addition to the key in a break glass unit in the dining room. Inspectors found that the nurse on duty did not carry a copy of the key and relied on the key in the break glass unit or a key hanging unsecured on a nail to open the exit. It was noted that the break glass unit for the key was in the dining room near the main entrance and not adjacent to the door itself.

Inspectors noted that the emergency exit signage at first floor was not adequate and was not visible from most areas of the first floor corridors. Furthermore, inspectors observed that some exit signs were not permanently lit.

The provider had made arrangements for the needs of residents to be assessed, in the form of a Personal Emergency Evacuation Plan (PEEP). These required review as they were not sufficiently detailed to ensure the safe evacuation of residents. They did not give detail on residents cognitive ability, required methods of evacuation for both day and night or supervision requirements post evacuation. This was a repeat finding. The provider confirmed that fire evacuation drills had not taken place in the centre since the previous inspection. Inspectors were not assured that adequate arrangements were in place to ensure that people working in the centre were aware of the procedures to be followed in the event of a fire, particularly while the

programme of work was taking place.

Residents' care needs were met to a good standard and their good health and quality of life was prioritised by staff. Person centred care was provided by staff who knew the residents well. Care records had person-centred information detailed to guide staff care in line with residents' preferences and wishes. Where necessary, health professionals outside of the service were contacted to provide support, for example speech and language therapy, palliative care services or psychiatry of later life.

The design of the premises enabled residents to spend time in private and communal areas of the centre. Residents privacy could not be assured in their bedrooms because their bedroom doors did not have a handle or a lock and could be easily pushed open. This non compliance was identified on a previous inspection in February 2019 and raised at a meeting with the provider but no action was taken to achieve compliance. Storage for commodes in a bathroom used by residents on the ground floor required review to ensure they were stored appropriately when not in use.

Residents had access to a garden and to other outside areas. Residents were being supported to make choices about how they spent their time and they got up and retired at a time of their choosing. Residents had access to a variety of activities that interested them and ensured they could continue to pursue and enjoy these interests in the centre.

The registered provider who was also the person in charge, was present in the centre on a daily basis and residents knew her well. She conversed with residents and relatives and got their feedback informally about the quality of the service, as well as feedback on the service provided during the regular residents' meetings.

Regulation 13: End of life

The centre had arrangements in place to ensure that residents were afforded the opportunity to outline their wishes regarding end of life care. While there was insufficient detail provided in one resident's care plan, this information was known by the person in charge and staff. The person in charge clearly demonstrated the rationale for not documenting this information and the inspector was assured that this resident's end-of-life care priorities would be met.

Other than one twin bedroom, all residents were accommodated in single bedrooms in the centre. Residents' families were facilitated to be with them in the centre overnight when they became very ill. Residents had access to the community palliative care team if necessary. Some nurses working in the centre had completed training in the use of syringe drivers.

Judgment: Compliant

Regulation 17: Premises

The centre premises is a large, period home which had been refurbished to provide a comfortable home for the residents. Accommodation was provided over two floors in 22 single rooms, and one twin bedroom. None of the bedrooms had en suite toilet or shower facilities. There was adequate sanitary and bathroom facilities provided for 24 residents. Toilets and bathrooms or showers were located on each floor, close to bedrooms and communal rooms. Bedroom accommodation on the ground floor, comprised 6 single and one twin bedrooms, a shower room with a toilet and wash basin, a bathroom with a toilet and wash basin and two other toilets. The main sitting room and dining room were located just off the entrance hall.

Accommodation on the first floor was set out in three wings, D wing had five single bedrooms, a shower/toilet and a large sitting room. Wing E had five single bedrooms a toilet and shower room. Wing F had five single bedrooms and shared a bathroom and a toilet. D, E and F wings on the first floor were accessible by stairs and chair lifts. The statement of purpose stipulated that only residents who were assessed as capable of using the stairs or the chair lifts could be accommodated on the first floor. All the residents on the first floor were mobile and could manage the stairs or chair lift independently or with minimal assistance from staff.

Although the centre was generally in a good state of repair internally and externally, works were needed to repair an area of broken plaster on the wall of a corridor, wear and tear damage to the surface of a window board and damaged carpets on a corridor on the first floor and in the smoker's room. Handrails were fitted along most corridors and stairs. As found on the inspection in February 2019, handrails were not provided along one short corridor into a resident's bedroom and a communal bathroom and toilet on the ground floor. Handrails were removed from an area of corridor on the first floor when new fire doors were installed. There were no residents accommodated in this area and the provider/person in charge gave assurances that handrails would be replaced on completion of these works. Since the previous inspection, the provider had commenced installing fixed grab rails in some toilets. Inspectors noted that a grab rail was fitted on one side only and this could present a challenge for some residents with using the facilities independently. Mobile seating frames were in place over many of the other toilets. The provider told inspectors that the safety of seating frames over toilets in the absence of fixed grab rails was risk assessed and work was ongoing to replace mobile seating frames over some toilets with fixed grab rails to optimise residents' safety.

The layout of residents' bedrooms varied and provided residents with sufficient space to meet their individual needs. Working call bells were accessible from each resident's bed and in each room used by residents. Resident’s bedrooms were personalised with soft furnishings, ornaments, plants and family photographs. Residents were provided with televisions in their rooms and adequate

wardrobe space to sore their clothes.

There were communal sitting rooms on both floors and residents also had access to a dining room and a spacious hall area on the ground. There was a separate kitchen where meals were prepared and a spacious laundry room. The sluice room was compact but suitably equipped, with a bed pan washer, sluice sink, a wash hand basin and shelving. The sluice and laundry were accessed by a key code lock to prevent unauthorised access.

The centre was set in mature and well maintained grounds. There was adequate parking at the front of the centre and residents had access to an external garden to the rear. Outdoor seating was provided for residents' comfort and some residents sat out in the sunshine on the day of this inspection.

Storage for equipment used by residents needed improvement. Inspectors found that in the absence of sufficient storage, commodes were inappropriately stored in a communal bathroom on the ground floor on the day of inspection.

Judgment: Substantially compliant

Regulation 26: Risk management

A risk management policy was in place in the centre. This policy included instruction on the risk assessment process, including risk identification, risk assessment, development of controls and learning procedures. However there was limited evidence that it was implemented in practice. There was evidence that some risks identified in the centre were reviewed and updated. However, inspectors found that not all risks were identified, assessed and proactively mitigated. While a fire safety risk assessment report was available, the risks identified were not incorporated into the risk register to ensure that all hazards to residents were comprehensively managed. In addition several hazards identified by inspectors were not addressed through the centre's risk management process. For example,

- height of stair railing and stairwell

- use of mobile seating frames over toilets in absence of secure grab rails. The provider confirmed that risk assessments were completed but were not documented in the risk register.

- handrails not fitted on some parts of circulating corridors.

Controls specified to mitigate the level of risk posed by hazards identified were not consistently implemented. For example;

- controls regarding cigarette lighters given to residents who smoke

- storage of oxygen cylinders in the centre

There was an emergency plan in place and there was evidence of alternative accommodation arrangements in place for residents in the event of an emergency evacuation being required.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions against the risk of fire:

- The disused laundry chute between a bedroom corridor and the laundry room presented a risk to residents on the first floor.
- Inspectors noted the door to the smoking room was held open with a chair and two cigarette lighters were left in the smoking room. This did not accord with the smoking and vaping policy for the centre.
- The storage of oxygen cylinders was not in accordance with the control measures identified in the fire safety risk assessment for the building.
- Signage to reflect the presence of oxygen cylinders were not in place.
- The fire blanket on the wall outside the smoking room included a sign stating that the fire blanket was not of adequate size for an adult clothing fire

Adequate means of escape were not provided from all areas of the designated centre:

- The nurse on duty did not carry a copy of the key to the locked main entrance door.

Adequate arrangements were not in place for maintaining all fire equipment and means of escape:

- While regular checks of escape routes were taking place, fire doors which had gaps or did not close fully were not identified.

Adequate arrangements had not been made for reviewing fire precautions:

- The process for identifying and mitigating fire risks in the centre was not adequate

Fire safety management and fire drills did not ensure that persons working in the centre were aware of the procedure to be followed in the event of a fire:

- fire evacuation drills had not taken place in the centre since the previous inspection. Inspectors were not assured that adequate arrangements were in place to ensure that people working in the centre were aware of the procedures to be followed in the event of a fire, particularly while the programme of work was taking place.

Adequate arrangements were not in place for containing fires:

- the inspector identified a significant deficiency in providing fire containment to the laundry room. There was a disused laundry chute, between a bedroom corridor at first floor and the laundry room, separated only by a timber panel.
- there were outstanding fire stopping and containment works throughout the building.
- further work was still required to upgrade or replace fire doors in the centre.

The person in charge did not ensure that procedures to be followed in the event of a fire were adequately displayed:

- emergency exit signage was not adequate and was not visible from most areas of the first floor escape corridors. Some exit signs were observed to be not permanently lit.
- the procedures to follow in the event of a fire were not adequately displayed

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Residents' medicines were dispensed by a local pharmacist and residents also had access to a pharmacist of their choice. The pharmacist visited the centre to carry out audits and was available to answer any queries residents had regarding their medicines. Clear arrangements were in place for the ordering, receipt, storage, administration and disposal of medicines, including medicines controlled under misuse of drugs legislation. Since the inspection in February 2019, arrangements were put in place to ensure that controlled drugs were checked and signed by two nurses on each change of shift and a separate checking record from the administration register was available. No residents were prescribed for medicines controlled under misuse of drugs legislation and therefore these medicines were not held in the centre on the day of inspection. Medicines requiring refrigerated storage were appropriately stored and the temperature of the refrigerator was checked daily.

Residents' medicines were administered in line with professional guidelines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

On admission, all residents were assessed by a registered nurse to identify their individual needs and choices. The assessment process used validated tools to assess each resident's dependency level, risk of malnutrition, falls risk, oral health and their skin integrity among others. Clinical observations such as residents' blood pressure, pulse and weight were assessed on admission and monthly thereafter. Care plans were developed to inform the care interventions necessary to address each resident's assessed needs. Residents' care plans reviewed by inspectors varied in the level of person-centred information detailed regarding the care that was important to individual residents. For example, some care plans clearly informed residents care preferences such as one resident liked to wear her hair pinned up in a bun. Staff knew residents' care preferences and wishes really well and the person in charge described two residents' preferences regarding their skin care routines.

Care plans were consistently reviewed every three months or more often as residents' needs changed. While inspectors were told by staff that reviews were done in consultation with each resident or their relative on their behalf if appropriate, the records maintained did not consistently reference this consultation process. The incidence of resident falls was very low and there were no residents with pressure related skin injuries in the centre. Since the last inspection, pressure settings on pressure relieving mattresses were monitored to ensure they were set according to individual resident's weights. Residents with diabetes had access to the diabetic clinic in the local hospital. Their care plans directed care in relation to diet, medications, frequency of blood glucose monitoring, guidance regarding the parameters for their recommended blood glucose levels and nursing care interventions if their blood glucose was too high or too low. Daily flow charts were used and narrative notes were entered by nurses on the day and night shifts. The time of the entry was consistently stated.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were met and they were supported to have timely access to medical and allied health-care services. Where possible, residents were supported to retain their own general practitioner (GP) or they were offered alternative general practitioner medical services. A podiatry service was made available for residents since the last inspection. Community dietician and physiotherapy services were not available to residents in the centre. The provider sourced dietician services free of charge and physiotherapy services at a reasonable cost to ensure residents were not negatively impacted by unavailability of these

community resources.available in the area. Inspectors found no evidence of any negative impact on residents in the centre.

Residents had timely access to community, occupational therapy and speech and language therapy. There was evidence in residents' files and from speaking to residents and staff, that timely action was taken in response to recommendations from allied healthcare professionals. Residents were supported to have two yearly eyesight assessments. Some residents attended their own dentist in the community and a dentist was also available to review and treat residents in the centre. All residents were supported to access specialist dental services as necessary.

Inspectors were assured that residents who met eligibility criteria were supported to avail of national health promotion screening programmes. The provider/person in charge confirmed that one resident currently participated in screening programmes available.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was strict admission criteria in the centre to ensure that episodes of responsive behaviours rarely occurred. Staff had been facilitated to attend training to support them to work in a person-centred way with any resident who had responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A very small number of residents were being supported to avoid episodes of responsive behaviours. Residents with health conditions that predisposed them to episodes of responsive behaviours were appropriately assessed. Their care plans described person-centred interventions to de-escalate any incidents and to ensure a consistent team approach to the management of their behaviours. Residents had access to community psychiatry of later life services and a member of their team had met with two residents in the centre a short time before this inspection. During the inspection, staff interacted with residents predisposed to responsive behaviours in a sensitive and appropriate manner and these residents responded positively to the techniques and interventions they used.

Bedrail use had reduced since the last inspection but continued to be used as part of a falls prevention strategy for two residents. One resident who mobilised with assistance had bedrails in case they got out of bed and fell and one resident unable to mobilise independently had bedrails to prevent them rolling out of bed. There was no documentary evidence that less restrictive strategies had been trialled. Half length bedrails were not available. This was found on inspection in February 2019. These findings are not in line with the Department of Health's National policy guidelines. Care plans stated the measures that had been put in place to mitigate

some risks to individual residents, such as bruising or entrapment of residents' legs. Assessments to ensure residents' safety when using bedrails were completed. Records maintained confirmed that the periods of time the bedrails were in place was reduced with regular removal for short periods of time during care procedures.

Judgment: Not compliant

Regulation 8: Protection

Measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Five staff did not have up-to-date safeguarding training. Inspectors were given assurances from the person in charge that these staff would be facilitated to attend this mandatory training in the days following the inspection. The centre's safeguarding policy and procedures was reviewed and was available to inform the procedures to be followed.

The provider did not act as pension agent for any resident. No monies were managed on behalf of residents in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were supported as individuals and they were encouraged to make decisions and choices regarding their day-to-day lives in the centre. Residents' assessments gathered information on their life, experiences and preferences to ensure care provided was person-centred. Residents' activities were facilitated by an activity coordinator employed on a part-time basis supported by staff to ensure that residents were socially engaged. Residents' activities included chair exercises, music, reminiscence, dog therapy and watching old movies among others. Residents' particular interests were fostered where possible. For example, one resident who was a keen gardener before coming to live in the centre was facilitated to tend to the rose bushes surrounding the centre and to plant flowers in planters and pots. Staff ensured residents could listen to their favourite radio shows and watch favourite television programmes in their bedrooms or in the sitting room. Since the last inspection records of residents' participation and level of engagement was maintained to ensure that residents' interests and capacities were met. The records confirmed that all residents were supported to participate in activities that interested them on a daily basis. Residents were supported to maintain contact with and integrate in the local community. Many families and friends accompanied residents into the town located a short distance from the centre. One resident attended day-care services in the community three days each

week and enjoyed the activities in the centre on the other days.

A residents' committee met every three to four months. Inspectors found from a review of the minutes of the meetings and discussion with residents, increased discussion and consultation with residents regarding works underway in the centre would ensure residents were kept informed and involved in changes being made to their environment. For example, no reference was made in the meeting minutes to the fire safety works underway over the past months and residents who spoke with inspectors were not sure why the works were happening. This was also a finding from the inspection in February 2019.

Residents had access to a SAGE advocate whose contact details were posted in the foyer. The registered provider who was also the person in charge worked in the centre each day and interacted with residents and visitors. Inspectors were assured that issues raised by residents were promptly addressed by the person in charge and the management team. Residents' religious and civil rights were supported.

Staff were observed knocking on bedroom and bathroom doors. Staff were using signage on residents' doors to request privacy when residents were receiving personal care in their bedrooms. However as there were no door handles or locks on residents' bedrooms doors, their privacy was not assured. As some residents also used a commode in their bedroom, their privacy may also be compromised by being unable to secure their bedroom doors. This was also a finding from the inspection in February 2019.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Elmgrove House Nursing Home OSV-0000035

Inspection ID: MON-0027045

Date of inspection: 18/09/2019

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since the inspection we have undertaken three Night time scenarios, based on our night time staffing level, and are confident that we have adequate staff to evacuate to safety based on our old evacuation strategy, our new evacuation/compartment strategy will be in place by mid-November, once all fire safety updates have been addressed and new training delivered to all staff. We have installed an L1 'addressable' system. A staffing review confirmed that there are adequate staff on at night to cover and only 2 residents with bedrails. All residents are checked half hourly during the night, more if necessary.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The two references were in the file mentioned but the C.V. was missing. No defects were found relating to the fire equipment and documentation was shown to the Inspector of the Fire equipment service, which was undertaken in Feb 2019, and will continue to be maintained annually as per I.S. 291:2015, unless a defect is found.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The works schedule has taken longer than we anticipated, we should have given a more realistic deadline based on the volume of work carried out, collating quotes and availability of tradesmen. All works will be completed in entirety by mid-November. We are working alongside Fire Engineers who have helped with our Fire Risk Assessment to ensure that all residents are safe, report of which has been set to the inspectors of which Fire Risk findings were low. It is paramount for us to ensure that all residents are safe. The following examples (not in entirety) are monitored on a monthly basis: Barthel TPR & BP Weights Nutritional Status Waterlow Pressure Ulcers Risk assessment 3 monthly Audit/reassessment of all care plans take place including the following: Communication, breathing/circulation, skin condition, meaningful activities, mobility/safety, psychosocial wellbeing, nutrition/hydration, personal care, sleep/rest, continence, key to me. Vital signs, records of referrals sent and any notes on the findings & actions needed. As well as daily flow & daily narrative notes. Management meetings occur monthly, more if necessary. In every hand over any changes are communicated to all care staff & Nurses to act on immediately. Audits take place every 6 months on a sample of care plans where any adverse trends or non-compliances are acted upon and preventative action will be taken. Action plan is in the Audit File. We are currently working on strengthening our Risk Management system to further identify hazards. We also conduct questionnaires and surveys for residents/resident's family to complete and collate and action any dissatisfaction identified; these take place every 3 months.	
Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All reports are up to date.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: We are in the process of reviewing The Risk Management policy, The Fire Risk Assessment is being updated continually until all works are completed.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The plaster work has been completed in the hallway and the other items will be completed by the end of the year. Handrails were temporarily removed on that wing as we were installing 2 new fire doors. No residents were occupied on that wing, the handrails are now back in situ as the door installation has been completed. Grab rails for the toilets have been purchased are being fitted, completion end of November 2019. The commode has been removed from the toilet - immediate	
Regulation 26: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: We are working on strengthening our Risk management process and hope to have this completed by the end of November 2019.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The laundry chute was addressed - immediate
All staff are aware of the smoking policy, a notice has been attached to the door as a prompt to return the lighter after use and the prompt is working, we will continue to monitor.
We were waiting for clarification as to the exact location suitable for the small CD oxygen cylinders, they are now attached to the walls in the appropriate places.
Oxygen signage is in place
Fire blanket has been replaced.
All doors have been upgraded.
The Fire Risk Assessment has been updated.
Since the inspection we have conducted 3 nighttime scenarios with staff to ensure they all are aware of the procedures, PEEPS are now in the front of all resident's care plans as well as the Register.
All emergency lighting has been updated and extra emergency lighting has been added.
Additional Exit lighting has been completed since the inspection.
Procedures to follow have been displayed as requested - immediate

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Consent has been given by the Next of Kin and the GP to authorize use of the bedrails, we are currently researching into alternative measures. When bedrails are in use the residents are checked on every 30 minutes, sooner if necessary.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The kitchen and cleaning staff will have completed Safeguarding of Vulnerable Adults training by end of October 2019.

All Nursing and Care staff have Safeguarding of Vulnerable Adults training.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We conducted a survey (October 2019) with the residents to ensure that they felt their rights and dignity were being respected, this anonymous survey returned 100% positive.
The residents have notices on their doors should personal care be given not to enter. All visitors have to ring the bell for entrance into the Nursing Home and are asked to sign in, we will them ask them to wait in the hallway to check if the resident is available for visitors and then return to accompany them to the residents room. Commodes would only be used during the day in the bedroom for bedbound residents and would need the assistance of the care assistants/nursing staff.
Bedroom door locks are being implemented throughout the Nursing Home, completion End of November 2019.
As we are a small Nursing home all residents are aware of the works being undertaken, we will ensure that this is recorded in the meetings going forward.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Yellow	22/10/2019
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	31/12/2019
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Not Compliant	Orange	22/10/2019

	and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Yellow	15/11/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	22/10/2019
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.	Not Compliant	Orange	15/11/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard	Not Compliant	Orange	30/11/2019

	identification and assessment of risks throughout the designated centre.			
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.	Not Compliant	Orange	30/11/2019
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	22/10/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	22/10/2019
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	22/10/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	22/10/2019

	reviewing fire precautions.			
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant		22/10/2019
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	22/10/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	22/10/2019
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	22/10/2019
Regulation 28(3)	The person in charge shall ensure that the procedures to be	Substantially Compliant	Yellow	22/10/2019

	followed in the event of fire are displayed in a prominent place in the designated centre.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	22/10/2019
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/11/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Yellow	30/11/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	31/10/2019
Regulation 9(3)(b)	A registered	Not Compliant	Orange	30/11/2019

	provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	22/10/2019