Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Elm Green Nursing Home
Centre ID:	OSV-0000133
Centre address:	New Dunsink Lane, Castleknock, Dublin 15.
Telephone number:	01 811 3900
Email address:	reception@elmgreen.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	MNMS Developments T/A Elm Green Nursing Home
Provider Nominee:	Martin O' Dowd
Lead inspector:	Leone Ewings
Support inspector(s):	Helen Lindsey
Type of inspection	Announced
Number of residents on the date of inspection:	115
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 October 2017 09:30	10 October 2017 19:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of a one day announced inspection, the purpose of which was to inform a decision for the renewal of the centre's registration. As part of this inspection notifications and unsolicited information received were also reviewed. Information received included concerns about the governance and management of the centre, which included recruitment practices and staffing turnover.

During the course of the inspection, the inspectors met with residents, relatives, staff and the management team in the centre. Two residents were in hospital at the time of the inspection. The inspectors spoke with the provider and person in charge at the start of the inspection. The views of all were listened to, staff practices were observed and documentation maintained was reviewed. Feedback questionnaires completed by 16 residents and five relatives were also reviewed and informed this

inspection.

Overall, the inspectors found that the care was delivered to a satisfactory standard by staff that knew the residents well, and were familiar with the assessed needs of each resident. A person-centered approach to care was noted. Residents were well cared for, had good access to health and social care services and expressed satisfaction with the assistance and support they received in the centre. Relatives spoken to were complimentary of the care. However, some feedback related to how variations in care were dependent on which staff were on duty from the staff team. Staff turnover was found to have increased over the past three months but was now settling down.

The provider and person in charge were responsible for the governance, operational management and administration of services. Management had arrangements in place to ensure that the service provided met identified health and social care needs. Improvements were required relating to record-keeping, health and safety and risk management, complaints records, and staff recruitment procedures. Staff recruitment practices seen did not safeguard residents and improvements were required. Schedule 2 information was not in place to inform a decision to recruit in all instances. The provider confirmed that at the time of the inspection all staff had completed Garda vetting disclosures on file.

Three actions required following the last inspection had been satisfactorily addressed. The findings of this inspection are discussed throughout the report, and areas for improvement are outlined in the action plans found at the end of the report.

Compliance with Section 41(1)(c) of the Health Act 2007 and 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.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a written statement of purpose (version 13) dated October 2017 that described the service and facilities that are provided in the centre. The written statement of purpose consists of detailed aims and objectives of the designated centre. The management have kept the statement of purpose under review. A revised version to reflect recent management changes was submitted shortly after the inspection.

The statement of purpose contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People).

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Structured governance and management systems were found to be in place. The partnership responsible for operating the centre was MNMS Developments. A new

management structure as outlined in the statement of purpose was being implemented in the centre. The structure and size of the management team had changed. Inspectors were assured that all staff were fully aware of their roles and responsibilities within this new management structure.

The newly-appointed person in charge, also known as the director of nursing had been working at the centre for a number of years as a clinical nurse manager. Her fitness to undertake this role was reviewed as part of an interview which took place on 14/9/17 and during this inspection. The management team now consisted of the provider representative of the partnership, and the person in charge. Both were supported by the wider management team including the newly-appointed assistant director of nursing, area manager, education and advocacy officer, quality and compliance manager, healthcare supervisor, administration team and two clinical nurse managers. The reporting structure was clear and all staff were clear on who they would report to for clinical care issues, safeguarding, complaints and management guidance. The inspectors found that the daily operational running of the centre was adequately resourced and staffed. Improvements were required in terms of the findings as detailed in the outcomes of this report in terms of safeguarding, staff recruitment practices, record-keeping, and oversight of complaints.

Five notifications were received by HIQA relating to safeguarding reports. The management team were made aware of these incidents, and had responded in a timely way and all were reported within the required timeframes to HIAQ. The provider had taken timely and appropriate actions on receipt of allegations, and acted in line with the internal safeguarding policy to safeguard all residents. Nonetheless, the findings of this inspection were that the provider did not demonstrate adequate systems in place to ensure Garda Vetting disclosures were on file prior to commencement of newly recruited staff. This was not in line with the centres' own policy and procedures.

Inspectors reviewed the provider's 2017 annual report on the quality and safety of the service delivered to residents. Feedback had been sought from residents and relatives during May 2017 to inform the review completed. However, the template report used and completed by the management team was in line with disability regulations. A revised version was submitted following the inspection. The outcome and findings of this report had identified amongst other areas the need to implement clinical governance meetings at the centre as a recommendation.

Judgment:
Non Compliant - Moderate

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:
The person in charge had changed since the last inspection, and HIQA were notified recently of the change by the provider. The person in charge is a registered nurse, with management experience as required by legislation.

The person in charge had been working at the centre for a number of years as a clinical nurse manager. Her fitness to undertake this role was reviewed during the inspection and at a separate interview which had taken place prior to this inspection. She was found to be a suitably qualified and experienced nurse, who worked full-time in this role.

She was observed interacting with resident's during the inspection and she demonstrated an adequate knowledge of the regulations and standards relevant to her role and responsibilities.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The records as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness and accuracy. Overall, the standards of record-keeping required improvement. Records requested were accessible and mainly kept electronically on a system staff were familiar with.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a residents' property.

A directory of residents was maintained which contained all of the matters as set out under regulation 19.

A sample of staff files were reviewed, as outlined in this report in Outcomes 2 and 18

the files did not contain all the requirements of schedule 2 of the regulations. This included gaps including no photo identification or evidence of qualifications obtained. The records reviewed also evidenced some staff had previously commenced employment prior to the date of receipt of satisfactory references and Garda Vetting Disclosures. Inspectors formed the opinion that record-keeping in terms of recruitment procedures was unsatisfactory and unsafe.

The designated centre had all of the written operational policies which had been recently reviewed as required by schedule 5 of the regulations. Policies were evidence-based and guided staff practices. However, some of the policies reviewed were not found to be fully referenced and did not sufficiently guide staff, for example, the restraint policy. The scope of the residents property policy did not include resident's personal finances or the role of the provider in the management of pensions. Improvements were also required in terms of staff responsibilities outlined in the recruitment policy and the smoking policy.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Details of the newly-appointed assistant director of nursing had been notified by the provider. She was a suitably qualified nurse who deputises for the person in charge in her absence. She found to be experienced and fit to undertake this role, and full and complete information was made available to HIQA by the provider. She was responsible for audit and clinical supervision duties at the centre.

She is a registered nurse and had completed a management qualification, and was engaged in continuous professional development. At present she is completing post-graduate study in gerontological nursing.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place

and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Systems were in place to protect residents from being harmed or suffering abuse. There was a written policy to guide staff, and they had received appropriate training in this area. Care and communication was observed to be person-centred and in an environment which promoted residents' rights.

The person in charge was aware of the requirement to notify any allegation of abuse to the Authority. There had been five reports made to HIQA since the time of the last inspection. The provider and person in charge were found to have acted in a timely manner to implement the policy, and put protective measures in place to safeguard all residents. Nonetheless some of the records of the investigation reports reviewed, required improvement in terms of reflecting the decision-making and review of any evidence found during the investigations completed. For example the record of the decision-making by the person in charge following an investigation, in terms of referring a concern to statutory authorities had not been fully documented in the investigation report.

The provider was involved with supporting two residents with their finances at the centre, and a staff member acted as the pension agent. A review of records and accounts at the centre confirmed that the policy and procedures were not fully in line with best practice. A good standard of record-keeping was evident and monies accounted for in terms of balances. However, the provider did not have in place a robust policy to inform and guide staff responsible for administering monies in line with best practice guidance. The provider confirmed that residents' funds were held in a separate named resident bank account and that he would review the process in place to safeguard resident's finances.

Staff spoken to were knowledgeable of the different types of abuse and the reporting arrangements in place. The inspectors spoke to a number of residents who said that they felt safe and secure in the centre. Staff were guided by a written detailed policy on the protection of vulnerable adults in place. Staff had received safeguarding training and refresher training was in place or dates planned for over the coming weeks. The findings of this inspection were that the policy had been updated.

A policy on the management of any responsive behaviors was in place that guided practice. Detailed supportive behavioural care plans were developed, and in place to inform staff and guide practice where required. The findings were that evidenced-based

tools were utilised to monitor behaviours. Staff were familiar with the residents and understood their behaviours, what triggered them and implemented measures including the least restrictive interventions as outlined in the written care plan. Improvements had taken place since the last inspection and staff carefully considered and documented the rationale for use of any psychotropic medication. This was used a second-line option and detailed care plans were in place for any residents with prn (as required) medicines. This area was subject to review and evaluated carefully on an individual basis.

The use of bedrails and as a form of physical restraint was not found to be in line with National policy and evidence-based practice. The risk assessment and use of any restrictive practices was subject to ongoing audit and oversight by the person in charge. The inspectors acknowledge that the provider and person in charge have clearly made improvements in the record-keeping and awareness of risks associated with any decision to implement the use of bedrails or lap belts at the centre. Nonetheless further improvements were required. The restraint policy was not fully implemented by staff. For example, a high level of the use of bedrails (60) was noted for in the centre's completed risk register for 115 residents. Three lap belts used in one unit did not appear on the most recent audit completed, nor were recognised a possible form of restrictive practice by staff in the centre. Inspectors saw another example of a specialised custom chair used at a tilt, and this could also be seen as a possible restriction of a residents movement. The care plan for this resident did not identify this risk, and the assessment in the decision-making records had not documented or considered this aspect.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
This outcome was reviewed by inspectors and overall the health and safety of residents, visitors and staff was seen to be promoted in the centre.

There were risk management policies and procedures in place. The policy contained the procedures required by regulation 26 and schedule 5 to guide staff. Staff were familiar with the contents of the emergency plan.

The risk register in place dated December 2016 was detailed and this was overseen by the provider. Each risk assessment set out the identified risk, the level of risk identified, the steps taken to mitigate the risk and the person responsible for taking the action. The documents reviewed were detailed and covered a wide range of areas. There was also

an up-to-date health and safety statement available. Environmental audit took place and was documented, nonetheless some risks observed by inspectors associated with the storage of oxygen in clinical rooms, had not been fully mitigated or monitored by staff. The storage of moving and handling equipment also required additional monitoring to ensure this did not present any hazards to staff or residents.

The records of fire safety maintenance and checks confirmed that there were routine checks to ensure fire exits were unobstructed, automatic door closer were operational and fire fighting equipment was in place. Annual checks were carried out on the fire safety equipment, and the fire alarm was serviced on a quarterly basis. Clear signage was in place throughout the centre guiding residents, visitors and staff to the nearest exit. The layout of the centre was zoned and this was outlined in a sign with narrative. There was a visual map displayed to clearly outline this to residents, staff and visitors to the centre.

The procedure to follow in the event of a fire was posted in different parts of the centre, and staff were able to describe their role in evacuation when the inspectors spoke with them. Records confirmed that all staff had completed refresher training in fire safety procedures. A record of fire drills showed that seven individual drills had been carried out in the last year.

The centre was separated for fire safety purposes into multiple smaller compartments or zones. Residents dependencies varied and a number of residents were identified who would need the assistance of one or two staff in the event of an emergency or fire. This was clearly recorded on each individual evacuation plans kept up-to-date by staff in each area. Staff were clear about their roles in the event of a fire or evacuation for any other reason. Simulated fire evacuation drills from all parts of the building had taken place and were documented.

Overall, any identified clinical risks were well documented and addressed in a timely manner, with the involvement of the person in charge and senior staff. For example, the follow-up on any falls and incidents included referral and review by the physiotherapist. Moving and handling assessments were up-to-date. The use of any assistive equipment was monitored closely to ensure adherence to best practice including servicing of hoists and slings. The use of the smoking room and residents' independent use of this facility needed review on the day of the inspection. a free-standing heater was observed by inspectors placed proximal to a resident sitting in a chair, and the ventilation system was partially covered with plastic sheet. The provider confirmed that this would be reviewed on the day, to ensure that adequate heating, ventilation and access to call bell system would be fully-maintained.

Overall there were safe procedures in place for the prevention and control of infection. The centre was clean, hygienic and well presented. Personal protective equipment was available in the centre, and there were hand gel sanitizers available throughout the centre, and available to visitors to the centre in reception. Staff were observed practicing hand hygiene procedures. Nonetheless inspectors saw that the inappropriate storage of a shower chair in a sluice room made the hand washing basin inaccessible to staff. A sluice room on the ground floor was found to have a rusty drying-rack, the provider removed this on the day of the inspection. He also outlined plans to address

the sink splash back with a suitable surface which would be easily cleanable.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspectors were satisfied that residents were protected by the designated centres' policies and procedures for medicines management. Improvements were found to be fully implemented and the recording of administration of any variable dose medicines was now in line with best practice. Staff nurses had attended medicines management updates since the time of the last inspection. Medicines audit takes place, the last recorded audit was on 4 October 2017, with recommendations for practice documented and any actions generated from audit finding were communicated to staff to improve practice. Medicine errors and omissions were fully documented and the outcomes were used for learning purposes.

The inspectors reviewed a sample of completed prescription and administration records and saw that they were in line with best practice guidelines. Medicines that required crushing were prescribed as requiring same. Residents medication records also contained records of any communication with the pharmacist. For example, staff requesting specific guidelines and information on the preparation of medication had been provided with clear directions on how to prepare, dissolve and administer the medication. However, on the day of the inspection some nursing staff were observed using foods and drinks to administer some prescribed medicines covertly to residents. For example, spreading medicine on bread, or mixing liquid medicine with drinks. The decision-making rationale around the use of this technique was not found to have been fully assessed and documented in residents' care plans viewed by inspectors.

Medicines used in the management of diabetes had clear guidelines to support staff in the safe administration of the medicines. The inspector reviewed practices around PRN (as required) psychotropic drugs and found that residents requiring these drugs now had a care plan to support an evidence-based and individual approach to administration. Nursing staff were knowledgeable about the frequency and use of these drugs in line with medicines management policy. All psychotropic medicines in use had been reviewed in September 2016, and staff demonstrated good knowledge about alternative approaches to reduce anxiety and responsive behaviours prior to administering a prn (as required) prescribed medicine. There was sufficient evidence that the staff team

sufficiently monitored medicines use at a multidisciplinary level.

The inspectors reviewed practices around medications that required strict control measures (MDAs). These medications were kept in a secure cabinet in keeping with professional guidelines and nurses maintained a register of these medications. There was a written policy in place for receipt and administration of medicines. The policy for disposal of medicines required review as this did not fully outline the local procedures in place for return of MDA medicines to pharmacy provider. Inspectors reviewed records which confirmed that the stock balance was checked and signed by two nurses at the change of each shift. The inspectors also observed nurses administering medication to residents. Medications were kept in a locked treatment room, and only nurses can administer medication to residents. Inspectors found that staff adhered to appropriate medicines management practices. Overall processes in place for handling medication were found to be safe. However, the practice of storage of unused medicines on trolley in yellow sharps boxes tied to drugs trolley for disposal was not safe. The person in charge at feedback confirmed she would action this aspect to ensure safe disposal of medicines.

At the time of this inspection, no resident was self administering medication, However, systems were in place to support residents that may choose to self administer and assessments were in place to enable staff to support residents who wished to self administer.

Judgment:
Substantially Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Arrangements were in place to provide nursing, medical care and allied healthcare for residents.

A sample of resident records and plans were reviewed. A full pre-admission assessment was completed prior to resident admission and formed part of the centre's admission policy and routine practice.

There was a documented assessment of all activities of daily living, including

communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. Social and recreational assessment tool known as PAL (Pool Activity Level instrument) was also completed in a sample reviewed. This informed a personalised activity care plan, which in turn informed the activities programme and staff.

There was evidence of a range of evidence-based assessment tools being used to monitor areas such as the risk of falls and malnutrition, mobility status, cognition, skin integrity and to identify any risk of developing pressure ulcers.

The development and review of care plans was done by a key worker in consultation with a resident or their representative. Each resident's care plan was subject to a formal review at least every four months or as changes occurred. Feedback received from residents and relatives also confirmed this took place.

Inspectors were informed that an assessment of resident's views and individual wishes at end of life were fully documented in care plans, and subject to regular reviews. A care plan to include details and information made known to staff regarding religious, spiritual and cultural practices or named persons to assist residents in decisions and arrangements made was noted in the records reviewed. A collaborative decision regarding active treatments such as cardio-pulmonary resuscitation formed part of the assessment and care planning process.

Inspectors were informed that one resident had a pressure ulcer. Inspectors reviewed the management of clinical issues including wound care and falls management and found they were subject to regular assessment and reviews of planned care. Inspectors found that some of the assessments reviewed were not updated if the residents condition changed or on return to the centre from acute care. For example, no review of the Braden Scale (to review risk of developing pressure ulcers); failure to reassess the Cannard falls risk tool following a fall and not recording if residents skin was intact following return to care from a hospital admission. The nursing narrative in some cases did not adequately describe the care or reference the detailed care plans. Audit of the care plans was in place

Physiotherapy and occupational therapy (OT) services were available to residents on a referral basis. Residents had suitable mobility aids and custom chairs following seating assessments by an occupational therapist. Hand rails on corridors and grab rails were seen in parts of the facilities used by residents.

Residents were satisfied with the healthcare service provided and good access to general practitioner (GP) services was reported. General Practitioner (GP) services were well established and out-of-hours medical cover was available. A range of other services was available on a referral basis including chiropody, speech and language therapy (SALT), and dietician and tissue viability services. The inspectors reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes and care plans.

Communication systems were in place to ensure that residents' nutritional and care needs were known by staff supporting residents to eat and drink and to those preparing and serving food. Procedures were in place to guide practice and clinical assessment in

relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents' clinical observations that included regular monitoring of weight, desire for recommended food and fluid consistency and intake.

Residents were seen enjoying various activities at times during the inspection. Each resident's likes and preferences were assessed, known by staff and daily activities undertaken were recorded and seen in logs made by the activity staff and dementia care specialist who worked at the centre. Music and activity such as board games and one-to-one friendship moments were seen to be enjoyed by a residents in the day of the inspection.

Emphasis was placed on family engagement, and residents were encouraged and facilitated to access external events and family occasions. Religious ceremonies were celebrated, and a weekly mass service in the centre was available to residents. Overall, most residents had opportunities to participate in meaningful activities that were purposeful to them and which suited their needs, interests and capacities.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre was originally purpose-built in 2008. Since the last registration renewal process, HIQA had received an application to vary and increase numbers to 120 from 96 people.

The provider was found to have fully addressed improvements to premises and the finished building and the premises was found to be suitable for its' stated purpose. The inspectors reviewed the building against plans received from the provider on the day of the inspection.

The provider was now found to be substantially in compliance, with some improvements required in ventilation in bathrooms, cleaning room and the safe storage of assistive equipment.

The centre was well maintained clean and hygienic. Bedrooms were all single with en-suite facilities and personalized to each residents' taste. Adequate storage space for personal belongings and space for personal assistive equipment was in place.

Residents' accommodation is laid out over two floors and separated into two areas known as Oak and Laurel. Three passenger lifts serve the first floor areas. Access to outdoor space is available on both floors with an outdoor balcony accessible on the first floor. Seating and level access for wheelchair users is accommodated on both floors. Corridors were wide and suitable hand-rails were in place for use.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A written complaints policy and procedure was in place that guided staff on the management of complaints in the centre. The complaints procedure was displayed in the reception area and it included an appeals process.

Residents and relatives told the inspectors they could talk to the person in charge if they had any complaints, and complaints were dealt with promptly. However, the implementation of the complaints policy could not be fully evidenced by the provider as records were not fully maintained by the person in charge as complaints officer, and the provider as the person responsible for oversight of the process.

Inspectors formed the opinion from feedback received from residents and relatives, that there was a clear willingness to address any concerns or complaints raised. Issues raised included concerns about supervision at mealtimes, availability of staff and staff turnover. A number of complaints were recorded and all complaints had been resolved according to the person in charge. Records of any investigation undertaken were evident. However, the records reviewed by inspectors did not consistently record the outcome or the level of satisfaction of the complainant. In addition the final outcome was not clearly recorded. The complainant's right of appeal was not communicated with any final outcome responses. This is a requirement of the regulations. A small number of complaints were open and under investigation at the time of the inspection. The person in charge undertook to ensure that the complaints process was fully documented and respond in line with legislative requirements.

Management oversight and governance of the complaints process requires review as

outlined in Outcome 2 of this report in terms of record-keeping and ensuring learning from complaints informs service improvements.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents were consulted with and participated in the running of the centre. Overall, residents' rights were respected and their independence promoted. There were residents' meetings held on a monthly basis in the centre. The meetings acted as a forum for the management to communicate any changes in the centre to the residents, and to facilitate residents to raise any issues or suggestions they had to the management. Topics discussed included meals and additions to the menu, activities available. For example, records confirmed that these activities included a tea dance and resident choir activity. Art classes had been stopped and this matter was raised in the resident's meeting, a follow-up meeting was being held on the day of the inspection with this item also on the agenda for discussion.

Residents informed the inspectors that they could choose to do what they wanted during the day. Residents stated that at meals they could order whatever they wanted if they didn't like the menu options available and this was facilitated.

The inspectors observed that residents' independence was promoted. Residents were observed mobilizing around the centre and to leave the centre independently and enjoyed sitting in the sun near the front entrance area.

The inspectors reviewed a number of communication care plans for residents with communication difficulties. The care plans reviewed provided clear instruction on how to attend to the resident's communication needs. There were individualized systems in place to assist residents to communicate. A person-centred approach was in place to assessing and providing activity, pastimes including providing individualised supports. A sensory based communication programme for people with cognitive difficulty, called SONAS took place on the day of the inspection as part of the activities programme.

Residents' religious and spiritual needs were well met in the centre, Mass was held in the centre weekly on a Sunday, and pastoral care needs were met. Residents of other faiths were facilitated to attend services also, and contacts were available. An oratory room was available for quiet reflection or prayer and was accessible to relatives and residents.

Voting in elections or referendums was facilitated in the centre. Residents could be registered to vote in the centre and a polling station would be set up there.

Visiting was encouraged, all visitors signed in at reception, and arrangements could be made at night to access the centre if visiting out of hours for any reason.

There was access to an independent advocacy service in the centre, contact details were displayed in the front reception of the centre. The complaints procedure was displayed in reception area.

All residents had access to a telephone. There was also access to television, radio, newspapers and books. Inspectors were informed that nursing staff could facilitate any resident who wished to access e-mail accounts.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors were not satisfied that staffing and governance of recruitment practice was robust and in line with best practice. The inspectors confirmed that staffing was in place in line with the statement of purpose and the range of needs of residents at the centre. A recruitment policy was in place but not found to be fully implemented by the provider and person in charge. For example, staff had been delegated to undertake recruitment, selection of staff outside the scope of the policy and best practice.

Inspectors requested details of joiners and leavers since January 2017. A review of this information provided by the provider found that overall staff turnover had been minimal in the months prior to August 2017. However, during the month of August 22 staff had left their roles in the centre. Measures to address this turnover had been implemented by the provider. The provider had been recruiting since this time to fill vacant posts. Staffing requirements as a result of unnanticipated leave were addressed using relief and bank staff who worked at the centre. Agency staff were not utilized according to the provider.

Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill-mix was found to be sufficient to meet the assessed needs of residents. Ongoing review of resident dependency and staffing levels were monitored by the person in charge to inform staffing levels and planning rosters. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities.

Clinical nurse managers and nursing staff explained the systems in place to supervise staff. Inspectors were satisfied on the day of the inspection that adequate staff supervision was in place. Staff were observed by inspectors to have a gentle approach and knew residents well. However, resident and relative feedback received by inspectors related to their concerns about the competency of some new staff, and the availability at mealtimes to assist those residents identified as needing supervision or support. Some additional feedback received related to staff turnover and some staff moving around the centre to work in different areas. The provider and person in charge undertook to closely monitor this aspect of care particularly as a number of new staff had recently come into post. The provider had a process of staff induction and appraisals in place. However, the records were not found to be fully maintained by staff responsible for supervising new staff members, and ensuring completed induction procedures took place.

Records of current professional registration for all registered nurses working in the centre were seen by inspectors. Training records showed that mandatory training had been undertaken, and staff spoken with confirmed this. This included training on safeguarding, moving and handling, fire safety and infection control. All staff nurses had additional training such as medication management and cardio pulmonary resuscitation. The training matrix was completed for all staff training and dates identified for the coming weeks to refresh staff with moving and handling and safeguarding.

There were no volunteers working at the centre.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Elm Green Nursing Home
Centre ID:	OSV-0000133
Date of inspection:	10/10/2017
Date of response:	20/12/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Management systems in place do not effectively manage and oversee key areas such as staff recruitment, safeguarding and complaints in the centre.

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

monitored.

Please state the actions you have taken or are planning to take:
1) Management systems have been reviewed and are effective in safe provision of service and monitoring of the same. Recruitment involves a senior staff member for all stages of recruitment process. ADON & Senior nurses have weekly informal meetings to discuss requirements for the week and progress from previous weeks, any issues or concerns raised are discussed and addressed, and review of any incidents for the week.

2) Senior management are commencing 6 weekly meetings to review changes being made, staffing levels, issues/concerns raised & review of incidents and any prospective admissions for the home, these will commence in the New Year and minutes will be recorded.

Proposed Timescale: 1) 02/11/17 2) 04/01/2018

Proposed Timescale: 04/01/2018

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The annual review of quality and safety for 2017 was not adequate to demonstrate learning from this review or to identify areas for improvement.

2. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
Annual review was completed again following inspection – report submitted to Inspector 02/11/17 which indicated learning from the review and areas for improvement (completed from HIQA template)

Proposed Timescale: 02/11/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was resident's property policy did not fully reflect arrangements in place for the

management of residents' personal finances and pension agency.
Improvements were required in terms of staff responsibilities in the recruitment policy and updating the smoking policy.
The policy on restraint in use required review to fully inform and guide staff in assessing for alternatives and working in line with National policy.

3. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
Resident's finance management policy reflects existing arrangements for safe management of resident's finance and pensions – this was sent to inspector 17/10/17
Restrictive practice policy is in line with National policy and guides staff regarding use of alternatives – individual assessment & approval forms for residents includes specific details relating to the individual resident relating to alternatives, criteria for use and any reduction plans appropriate.

Proposed Timescale: 17/10/2017

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Staff files were incomplete and did not contain all the requirements of schedule 2 of the regulations. This included gaps including no photo identification and evidence of qualifications obtained. The records reviewed also evidenced staff commencing employment prior to receipt of satisfactory references and Garda Vetting Disclosures.

4. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
Staff files have been reviewed & all records not located on the day of inspection have since been obtained & filed – same sent to inspector 17/10/17

Proposed Timescale: 17/10/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:
Restraint assessment and the use of restraint did not fully meet the requirements of the National Policy.

5. Action Required:
Under Regulation 07(3) you are required to: 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.

Please state the actions you have taken or are planning to take:
Restrictive practice assessments were in place on the day of inspection for inspectors to view, these contain detailed information relating to specific individual supports required for each resident. These assessments are in line with National Policy.

Proposed Timescale: 11/10/2017

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Two residents' pension funds were not managed in line with best practice by the provider.

6. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Resident pension funds are managed in line with best practice, as outlined in relevant policy and national guidelines. All funds used for resident benefit. Relevant existing policy sent to inspector 17/10/17

Proposed Timescale: 17/10/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Risks relating to: the smoking room, the storage of oxygen and storage of hoists and assistive equipment in inappropriate areas of the centre have not been sufficiently mitigated.
The risk register was last reviewed in 2016 and requires more frequent review in terms of the overall governance and management systems at the centre.

7. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Any risks identified during the inspection have been addressed to ensure safety within the centre.
The risk register is reviewed as and when a new risk is identified or current controls are not appropriate or adequate to provide safe services, all risks are reviewed following incidents and if there was a requirement to review the risk register at this time, this would be completed. To date there have been no incidents that have had an impact on the risk register to instigate a review – risk register review will be completed December 2017. Any risks identified during the inspection will be included in the review.

Proposed Timescale: 11/12/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Nursing staff were observed using foods and drinks to administer some prescribed medicines covertly to residents which was not in line with best practice.

8. Action Required:
Under Regulation 29(5) you are required to: 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.

Please state the actions you have taken or are planning to take:
Any covert administration of medication has been identified and the appropriate documentation & records have been put in place, following a multi-disciplinary review to ensure is in line with best interest of the resident only – medication that has been approved for covert administration is identified also on the resident's medication Kardex.

Proposed Timescale: 17/10/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
The practice of storage of unused medicines on trolley in yellow sharps boxes tied to drugs trolley for disposal was not safe.
Arrangements in place for the safe disposal of any unused MDA medicines awaiting return to pharmacy were not robust or guided by policy.

9. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
Medication policy & practices relating to this area have been reviewed and amended to include specific requirements & arrangements for safe disposal of unused MDA's and any disposal of medication required during a medication round.

Proposed Timescale: 17/10/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Nursing risk assessments reviewed were not consistently reviewed and updated if the residents condition changed or on return to the centre from acute care.

10. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
As and when a resident returns from hospital all assessments and care plans are reviewed and updated, irrespective if there has been a change in condition or not – this is now current practice and monitored at regular intervals.

Proposed Timescale: 17/10/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in provision of ventilation in bathrooms, cleaning room and in the safe storage of assistive equipment.

11. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Improvements required from the inspection have been addressed; bathrooms & cleaning rooms have adequate ventilation as the 3 broken fans have been replaced. All assistive equipment is stored safely within the centre.

Proposed Timescale: 28/10/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The nominated person did not sufficiently maintain a record of the outcome of the complaint and whether or not the complainant was satisfied.

12. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
All complaint records and documentation contain information as to the complainant satisfaction relating to the outcomes and the actual outcome of the complaint in line with policy.

Proposed Timescale: 11/10/2017

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider did not evidence sufficient oversight of complaints. The final outcome of any investigation or complaint was not clearly recorded. The complainants' right of appeal was not communicated or evidenced in the records.

13. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
All complaints are sufficiently managed in line with policy, and records were available on the day of inspection to evidence this in the centre's complaints records. Final outcomes of all complaints is always recorded on the centre's complaint form. The right to appeal relating to complaints has not arisen as all complaints to date have been addressed and person satisfied with the outcome. Investigations are recorded and all reports available on site, these contain information of outcomes of investigations and would not contain information relating to appeals as this would not be an appropriate place to record this – this information would be provided to the relevant person in an individual letter.

Proposed Timescale: 11/10/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had been delegated to undertake recruitment duties, including selection of staff outside the scope of the policy and best practice.
Robust induction training procedures for new staff were not fully evidenced.
Nursing staff required additional training on implementing a restraint-free environment.

14. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
1) The recruitment policy has been reviewed following the inspection and includes details relating to recruitment process and selection of staff. This policy was sent to the inspector on 02/11/17.
2) Induction processes were in place during the inspection and contain a detailed assessment and supervision for all new staff members – these may not have been viewed by inspectors during the visit, all included in the recruitment policy.
3) Training for nursing staff has been scheduled to enhance their current knowledge and experience relating to promoting restraint free environment.

Proposed Timescale: 1) 02/11/2017 2) 11/10/17 3) 15/12/17

Proposed Timescale: 15/12/2017