

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Elm Hall Nursing Home
<b>Centre ID:</b>	OSV-0000034
<b>Centre address:</b>	Elm Hall Nursing Home, Loughlinstown Road, Celbridge, Kildare.
<b>Telephone number:</b>	01 601 2015 / 087 132 1120
<b>Email address:</b>	admin@elmhallnursinghome.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Springwood Nursing Homes Limited
<b>Provider Nominee:</b>	Colin McKenna
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	53
<b>Number of vacancies on the date of inspection:</b>	9

## 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: 04 October 2017 09:45 To: 04 October 2017 16:50

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Major

**Summary of findings from this inspection**

This report sets out the findings of an announced inspection, the purpose of which was to inform a decision for the renewal of the centre's registration.

The centre was going through a transitional phase in relation to the governance and management arrangements and further changes were anticipated. In May 2017 the Health Information and Quality Authority (HIQA) received notifications stating that changes to the provider entity contact information and personnel were to take effect 16 June 2017. However, the registered provider (entity) remained the same. Further changes were also communicated following the submission of the application to renew the centre's registration that expires 12 February 2018. The person in charge and person participating in management (PPIM) who was also the provider representative had tendered their resignations and were last working in the centre 29 September 2017.

The actual roster showed that the person in charge was on annual leave on the week of this inspection and planned to be on annual leave to 15 October 2017. However, the PPIM was not included on the actual or previous rosters but her departure was confirmed. The new provider representative told the inspector they were actively engaged in the management of the centre and would be on a full time basis. He stated that the recruitment of a suitable person in charge had been unsuccessful in external interviews conducted to date. A senior nurse that has worked in the centre since June 2011 was deputising during the absence of the person in charge.

The plan for the inspection was to examine 10 outcomes, follow-up on the actions required following the previous inspection 27 July 2016, notifications and unsolicited information received since the previous inspection and the application to renew the registration. This was outlined to the person deputising in the absence of the person in charge and the provider representative at the commencement of the inspection.

During the course of the inspection, the inspector met and spoke with residents and staff, the nurses in charge and the provider representative. The views of residents and staff were listened to, practices were observed and documentation was reviewed. Questionnaires completed by a resident and two relatives or representatives were also reviewed.

The centre was clean and reasonably well maintained in the areas inspected. Residents' rooms were personalised and those viewed were suitably equipped to meet their individual needs. Residents were accommodated over two floors and bedroom accommodation comprise 58 single and two 'double' rooms that were occupied by individual residents and only for use by couples. Two passenger lifts facilitated resident and visitor movement between floors. Residents had suitable aids to support their needs and were well groomed and dressed. Staff were approachable and responsive. Management and staff were keen to meet the requirements of the regulations.

However, a lack of corporate governance was found. Evidence of major non-compliance was identified within the governance and management of the centre that impacted on the health and safety of residents, risk and fire safety management and staffing arrangements. As a result, the inspection became focused in four main outcomes. A requirement to issue an immediate action plan to the provider representative during the inspection was required in relation to significant risks identified that included inadequate fire safety arrangements, staff training and awareness and a lack of simulated fire evacuation drills. The immediate action plan was recorded against Regulation 28 which the provider representative acknowledged and responded to immediately.

The recent provider representative acknowledged the deficits and limitations found within the service and told the inspector that some training gaps had been identified. The admission of residents had ceased prior to this inspection and an external consultancy group had been contracted by the provider to complete a 'gap analysis' of the service to identify areas in need of improvement and actions to be taken.

Throughout and at the end of the inspection, feedback on the findings was discussed with the provider representative and person deputising for the person in charge. Both engaged, responded and were keen to bring about improvements to meet the requirements of the regulations and standards. The provider representative agreed to provide HIQA with an update 9 October in relation to actions taken along with a declaration that all rostered staff has completed Garda Vetting as evidence that some staff had commenced working this year almost two months in advance of completing Garda Vetting/Clearance.

Matters requiring improvement are discussed throughout the report and set out in an action plan at the end of the report for response.

**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 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:**

This outcome was not inspected on the previous inspection 27 July 2016.

The centre was going through a transitional phase in relation to the governance and management arrangements and further changes were anticipated. In May 2017 the Health Information and Quality Authority (HIQA) received notifications stating that changes to the provider entity contact information and personnel were to take effect 16 June 2017. However, the registered provider (entity) remained the same. Further management changes were also communicated following the submission of the application to renew the centre's registration that expires 12 February 2018. The person in charge and person participating in management (PPIM) who was also the provider representative had recently tendered their resignations and were last working in the centre 29 September 2017.

On the day of the inspection it was confirmed by staff and the roster that the person in charge was on annual leave to the 15 October 2017 and her last working day was 29 September 2017. The previous provider nominee was working in the centre up to the 29 September 2017.

Temporary management arrangements were in place with a senior nurse was deputising in the absence of the person in charge while the recruitment of a suitable person in charge was on-going. The current provider nominee/representative recently took over an active role in the management of the centre. The senior nurse and provider representative told the inspector they had not been involved in an inspection process previously.

The inspector found that the governance and management arrangements since previous inspections had not ensured the effective delivery of care to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Based on the

cumulative findings of this inspection and major non-compliances found in relation to poor risk and fire safety management, insufficient staffing, inadequate governance and management, controls and resource management to ensure the health, safety and welfare of residents on a continuous basis.

A lack of oversight, strategic vision, robust reporting structures, and communication and accountability arrangements between the provider, person in charge and person participating in the management of the centre had led to poor standards and had resulted in a number of major failings and non-compliances. There was evidence of poor leadership, an absence of adequate external scrutiny and risk management. A lack of forward planning, auditing, reporting and management of available resources did not demonstrate that a clearly defined management structure was in place with authority and accountability for specifies roles and responsibilities for all areas of care provision and fire safety.

Approved operational policies were not implemented in practice to ensure resident and staff health and safety, identify and manage risks, safeguard residents, recruit, train, develop and retain staff appropriately.

While a meeting between staff and management had occurred on the previous week, poor communication and consultation arrangements between staff and management, and management and residents were reported and evident. The handover between the previous management and those managing the centre on the day of inspection was inadequate. The nursing managers were not informed of the decision that admissions had ceased, and were not familiar with the requirements or action taken following the previous inspection in July 2016. Management systems, monitoring, self-assessments, and governing practices for the centre were not evident or effective. The arrangements to inform a review of the quality and safety of care for residents were unclear. The current managers were not aware if an annual review for 2016 had been completed that involved residents or relevant parties for strategic time bound improvements in 2017.

Management systems had been ineffective which lead to poor standards and unsafe arrangements. Gaps in staff training from 2014/2015 were found. The management system and decision making processes to date did not demonstrate that the centre was suitable governed to ensure the effective delivery of care and support the needs of residents. Insufficient recruitment and appraisal procedures compromised residents' safety and their quality of life. For example staff had worked in the delivery of direct care to residents prior to the completion of Garda vetting, a lack of meaningful activity and social engagement was apparent and admission of residents continued during periods of high staff absenteeism and turnover. Reliance on agency and relief staff was apparent and rostered mainly for night duty when the least number of staff were available to supervise.

Insufficient governance and management of staff supervision, turnover, training and development compromised resident safety and quality of care. Therefore, safe and effective care was not ensured. Staffing and training deficits were reported on the previous inspection 27 July 2016 that was not sufficiently addressed. Poor governance, remuneration and resource management was attributed to low staff morale and the high turnover of staff. The inspector confirmed that exit interviews with staff were not

recorded or completed to inform improvements. A lack of systematic controls and staffing levels was attributed to the inability to free staff to attend training that could be provided by in-house and rostering of staff without a declaration of Garda clearance.

Deficiencies were found in relation to management and reporting systems. For example, the use of physical and environmental restraint seen in use was not notified to the Health Information and Quality Authority (HIQA) in the previous two quarters, as required in schedule 4. Staff interpretation and understanding of restraint use required review along with the policy available.

The current management group acknowledged the deficits found and limitations within the service to date. The provider representative was positive in his response to the immediate action requirement discussed in outcome 8 and gave assurance that sufficient funds and resources were available to address the failings found. Assurance was given that suitable arrangements would be put in place for the effective delivery of safe care and effective monitoring of the quality of the service.

The inspector was told that an external consultancy group had been contracted by the provider to complete an analysis of the service to identify areas in need of improvement. Two members of the consultancy group were present throughout this inspection and staff said they were engaging with them to bring about improvements. A positive outcome was anticipated. Staff while acknowledging the challenges, had a positive attitude. Core staff told the inspector that resident care was the priority despite the on-going changes. The provider representative said the consultancy group were contracted for twelve months to assist him in the governance and management of the centre and were actively involved in the interviews and recruitment of a suitable person in charge.

Records on display in the reception area included the complaints procedure and s current certification of insurance.

**Judgment:**

Non Compliant - Major

***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 resignation and absence of the registered person in charge was confirmed, as discussed under outcome 2.

The provider representative told the inspector that the recruitment of a suitable person



in charge was on-going and had nominated a senior nurse as the person to deputise in the absence of the person in charge.

Based on these inspection findings, it is critical that a suitable person in charge with not less than 3 years' experience in a management capacity in the health and social care area, and a post registration management qualification in health or a related field is recruited.

**Judgment:**

Non Compliant - Major

***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 not inspected on the previous inspection 27 July 2016.

The centre had policies and procedures relating to health and safety that included a health and safety statement and risk management policy to include items set out in Regulation 26(1). However, the policies had not been implemented or demonstrated in practice.

A safety representative and health and safety committee was not formed or in place as outlined in arrangements in the policy documents. A system to identify, assess, monitor audit or control risks was not in place or known, and a risk register was not available to ensure resident and staff safety. The fire safety precautions and means of escape arrangements were inadequate within this two storey centre accommodating dependent persons. As a result, an immediate action plan in relation to fire safety deficits was issued to the provider representative who responded immediately.

While records dated July 2017 were available for the servicing of the fire alarm, fire extinguishers and emergency lighting, and a number of staff were recorded as attending training in August 2017, routine safety checks, simulated drills and risk assessments were not being carried out to ensure adequate fire precautions were in place.

The following failings in relation to fire safety were found and reported to the provider representative and nurse in charge:

- Staff had not received fire safety induction, training or participated in a simulated fire drill
- Staff were not familiar with emergency procedures, equipment or the means of escape from all parts of the centre. A consistent emergency response was lacking among staff spoken with. The whereabouts or availability of fire safety and response equipment was

unknown to staff

- An up-to-date personal emergency evacuation plan for all residents of varying dependencies had not been completed for some or not updated sufficiently and communicated to all relevant staff for the event of an emergency or fire
- Simulated fire evacuation drills from all parts/floors of the building and compartments had not been carried out with a record to inform learning or improve fire safety arrangements
- Simulated fire evacuation drills had not been completed at varying times of the day or night to test the worst case scenario when the maximum number of six staff were available to residents at night
- The fire evacuation plan/policy and procedure on file outlined the initial steps as communicating with the directors and management, and to take direction from the chief fire officer regarding evacuation. This policy and arrangement required immediate review as it may compromise a timely response by staff in the event of an emergency or unplanned evacuation of the centre
- Staff spoken with and records reviewed showed that arrangements to check the means of escape daily and test of the fire alarm weekly had not been maintained to promote resident, visitor and staff safety
- Tests to ensure compartmentalisation, door releases and safety equipment checks were not completed
- Staff were unfamiliar with the fire safety procedures, appropriate means of escape and how to access escape routes and equipment to aid evacuation
- Staff spoken with told the inspector they would respond in different ways if the fire alarm sounded. Some would go to their nearest exit to ensure their safety and wait for instructions at the assembly point outside, others said they would go to the ground floor panel to get instruction while some said they would use the lift to evacuate residents from the first floor
- Access between the ground and first floor was limited to those/staff with a fob which released the doors to access two passenger lifts. The first floor had four identified fire exit doors which were secure. On enquiry, staff were unaware of how these doors might release or open. Some staff told the inspector there was a key within a key box on the ground floor to unlock the door at the lock which was seen above the door frame but was out of reach to many staff. One of the 12 staff spoken with was aware that the lock on secure fire exit doors deactivated when the fire alarm sounded and of the availability of one ski evacuation pad shown inside a secure stairwell. However, all staff confirmed they had not used the equipment or evacuation pad in a fire drill. The provider representative was informed of the findings and contacted a fire safety consultant who confirmed that the fire alarm system deactivates the fire exit locks when the alarm sounds and this was to be communicated to all staff
- Self closing bedroom doors were seen inappropriately held in an open position by chairs or weights and therefore would not be capable of fulfilling their function of containing a fire and preventing the movement of smoke and fire through the building. Some residents used electric equipment and heaters in their bedrooms
- Fire evacuation plans and procedures were not available on display within compartments to direct you to the nearest emergency exits.

Staff knowledge and records relating to previous fire safety training did not demonstrate the adequacy of the arrangements in place within the centre in the event of a fire. While the records of previous training available for some staff indicated the date of the drill

and names of staff attended, the record did not contain the detail necessary and staff were not sufficiently knowledgeable to assure the inspector that the persons working in the centre were both aware of, and practised in, the procedure to follow in the event of a fire.

Records that included reference to a fire drill did not include details relating to a scenario simulated as part of the drill such as simulated fire location and time of day, staffing levels or the time taken to evacuate the compartment concerned. Therefore, the previous training records were of limited use in ensuring the adequacy of the procedures in place on a continuing basis.

Prior to the end of the inspection the provider representative informed the inspector that he had made immediate arrangements for those working in the centre to have fire safety instructions and to attend training to commence the following day, 5 October 2017, for 3 days to cater for up to 48 staff. As a result of the findings, all staff were to be trained or retrained in fire safety and evacuation procedures as a priority. Staff were to be rostered accordingly to mitigate the risks identified and acknowledged by the provider representative.

**Judgment:**

Non Compliant - Major

***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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Staff were approachable and responsive. However, actions required following the previous inspection 27 July 2016 in relation to staff training and supervision had not been completed appropriately.

The centre is registered for 62 residents. There were 53 residents in the centre on the day of inspection. The inspector was informed of a decision by the provider representative to cease resident admissions from 15 September 2017. Staff and records confirmed that the last resident admitted to the centre was on 14 September 2017. However, senior clinical staff were not aware of this decision made which was

referenced in outcome 2.

Staff turnover in all disciplines was high with up to 39 staff reportedly leaving within the past six months. The roster showed the registered person in charge and three staff on annual leave, one staff on maternity leave and five staff on sick leave. Four of whom were also rostered as sick 4 September 2017. A requirement to contract agency or bank staff was evident to complete the weekly roster.

Staff recruited in response to poor retention levels did not have a record demonstrating an induction or evidence to confirm they had appropriate training to ensure they had adequate knowledge and skills, appropriate to their role, or to respond appropriately to residents needs or emergencies as discussed in Outcome 8.

The numbers, qualifications, supervision and skill mix of staff was not appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. There was evidence of negative outcomes for residents due to staff shortages and lack of training and development.

All reasonable measures to protect residents from all forms of abuse or neglect were not sufficiently maintained or demonstrated due to recurrent turnover of staff and lack of governance and oversight arrangements. Staff described that they shadowed an existing staff member when they commenced working. However, from an examination of staff files, a review of the training matrix and discussions with over 12 staff from various disciplines, it was evident that there was a lack of appropriate induction, appraisal, training and development of staff members. Poor communication was evident.

A complete record of training was not available for all rostered staff. Staff delivering care to residents and working told the inspector they had some training but had little or no recent training or updating in areas such as safeguarding, fire safety, responsive behaviours, restraint, manual handling, first aid and cardio pulmonary resuscitation (CPR). Training requirements were identified for improvement following the previous inspection, however, training dates for some experienced staff in fire safety and safeguarding 'elder abuse' was in 2015 and manual handling training in 2014. There were significant gaps and incomplete records for a high number of staff working in the centre. Staff told the inspector they had identified their training deficits and concerns to those in charge and in management but it had not been addressed. An analysis of staff training needs was needed to ensure they were appropriately trained and suitable their role and responsibilities.

There were operational policies and procedures in relation to staff recruitment, induction, training and development reflecting best practice; however, they were not implemented in practice and staff had commenced working prior to completing Garda Vetting that compromised resident's safety. As a result of staff commencing work prior to Garda Vetting, the provider was requested to review all staff files and provide assurances to HIQA that those working in the centre had completed Garda Vetting.

Due to high turnover and absence of adequate supervision and training for staff, staff practices observed was primarily task orientated rather than person-centred. Some staff told the inspector they were always busy, rushed and did not always have sufficient time

to complete their daily duties. In addition to the call bell system a request for staff to attend or respond to residents was announced over an intercom system. The inspector was told that this practice was as a result of unanswered call bells or timely responses. Staff spoke of the frustration experienced of continuously supporting new staff in their role. This cycle had been ongoing and challenging for core staff.

Opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs were limited and insufficient due to ongoing absences of staff and lack of appropriate contingency measures.

The inspector was informed that the centre had previously operated with two dedicated activity staff members. One of the dedicated activity staff members was on planned leave while the other was on unplanned but long-term leave. The roster showed the allocation of a care attendant to activities, which was seen and confirmed by staff. However those identified for this role varied daily and there was little evidence that they were specifically skilled for this role and responsibility.

The inspector observed a group of up to 23 residents in one day room prior to lunch. A care staff member provided hand massage to an individual resident while others sat watching those visiting, entering or exiting the dayroom. The background noise and music was not appropriate or conducive to any meaningful activity and there was no evidence of any meaningful engagement with the large resident group. The lunchtime experience was also observed in one dining room. The inspector noted that it was primarily task orientated with little quality interaction, conversation or positive engagement. This was likely attributable to the lack of knowledge and understanding new staff had of the resident group as one staff member coordinated the entire period and directed other care staff to assist residents with drinks and meals. Little conversation or encouragement was observed while residents were assisted by staff and the experience was primarily neutral care. The previous inspection highlighted the need for supervision by a nurse at meal times, however, this was not implemented.

Questionnaires were issued to the centre two weeks in advance of this announced inspection for family and resident feedback. However, only three were returned, two from family members and one from a resident. Each had many positive remarks, however, some comments were made in relation to a shortage of staff, lack of relevant activities and outings, boredom, concerns about changes in management without communication mirroring the inspector's findings.

The inspector was informed that there were no volunteers in the centre.

**Judgment:**  
Non Compliant - Major

## 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:***

Sonia McCague  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Elm Hall Nursing Home
<b>Centre ID:</b>	OSV-0000034
<b>Date of inspection:</b>	04/10/2017
<b>Date of response:</b>	23/10/2017

### 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:**

Based on the cumulative findings of this inspection and major non-compliances found in relation to poor risk management and insufficient staffing, adequate governance and management arrangements and suitable resources were not in place to ensure the health, safety and welfare of residents.

Evidence that some staff had commenced working this year almost two months in

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

advance of completing Garda Vetting/Clearance was found.

The governance and management arrangements since the previous inspection 27 July 2016 had not ensured the effective delivery of care and that the service provided was safe, appropriate, consistent and effectively monitored with gaps in staff training from 2014/2015.

Insufficient governance, communication and management of staff supervision, turnover, training and development compromised resident safety and quality of care. Therefore, safe and effective care was not ensured. Staffing and training deficits were reported on the previous inspection 27 July 2016.

Poor governance and resource management was attributed to low staff morale and the high turnover of staff. A lack of systematic controls and staff levels was attributed to the inability to free staff to attend training that could be provided by in-house.

**1. Action Required:**

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**

1. An audit was completed on the 5th of October of all staff files. Staff without Garda vetting were removed from the roster and all Garda vetting documentation was obtained and has been submitted for Vetting.
2. All new staff involved in the recruitment process i.e. the Registered Provider and Acting Director of Care are aware that the Garda Vetting must be completed prior to new staff commencing work within the Nursing Home. This will be incorporated into the recruitment policy and procedure.
3. A full review of the staff training matrix is taking place to ensure all training is kept up to date and staff are enabled to attend training going forward.
4. A schedule of meetings for residents, multi-disciplinary care teams and multidisciplinary service team meetings have been scheduled on a monthly basis for the next three months to ensure residents and staff have a platform to communicate their concerns or issues. Management team meetings will be held weekly for the next two months and will be reviewed to become a monthly meeting after two months.
5. A staff exit interview template will be developed to ensure learning on how the organisation can improve and retain staff in the future.

**Proposed Timescale:** 30/11/2017

**Theme:**

Governance, Leadership and Management

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



**requirement in the following respect:**

Deficiencies were found in relation to management and reporting systems.

A lack of oversight, strategic vision, robust reporting structures, communication and accountability arrangements between the provider, person in charge and person participating in the management of the centre which lead to poor standards and had resulted in a number of major failings and non-compliances.

There was evidence of poor leadership, an absence of adequate external scrutiny and risk management.

A lack of forward planning, auditing, reporting and management of available resources did not demonstrate that a clearly defined management structure was in place with authority and accountability for specifies roles and responsibilities for all areas of care provision and fire safety.

The use of physical and environmental restraint seen in use was not notified to the Health Information and Quality Authority (HIQA) in the previous two quarters, as required in schedule 4.

**2. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**

1. Formal fire training inclusive of timed evacuations is being rolled out to all staff working in Elm Hall Nursing Home and all other mandatory training.

2. An organisational structure for the organisation has been approved at the management team on the 17.10.17. This was then communicated at staff meetings completed on the 18.10.17.

3. A review of Job descriptions and roles and responsibilities will be completed.

4. Persons participating in management have been identified and documentation will be submitted to HIQA and Statement of Purpose will be updated to reflect the PPIM.

5. A Management team meeting was held on the 17.10.17 to discuss the HIQA report and actions arising from the report. A work plan has been developed as well as a quality improvement list. The work plan includes the development of an operational plan, audit schedule and identification of key performance indicators.

6. Elm Hall Nursing Home will endeavour to recruit a PIC. The registered provider has extended the search to additional recruitment agencies.

7. A review of all restraint practices will be conducted by the acting Director of Care and Registered Provider. The restraint register will be updated and reported accurately to the authority.

**Proposed Timescale:** 30/11/2017

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Management systems had been ineffective which lead to poor and unsafe arrangements.

The management system and lack of appropriate decisions to date did not demonstrate that the centre was suitably governed to ensure the effective delivery of care and support needed by residents. Insufficient recruitment and appraisal procedures compromised residents' safety, for example staff had worked in the delivery of direct care to residents prior to the completion of Garda vetting and admission of residents during periods of high staff absenteeism and turnover. Reliance on agency and relief staff was apparent and rostered mainly for night duty when the least number of staff were on to supervise.

**3. 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 monitored.

**Please state the actions you have taken or are planning to take:**

1. As per action 1. Management team meetings are being held on a regular basis to communicate decisions being made within Elm Hall Nursing Home, to ensure that the management team have oversight and effective delivery of care which is supportive of the resident's needs.

2. A review of the recruitment processes will be completed and new practices implemented.

3. A schedule to complete staff appraisals will be developed by the acting Director of care.

4. As per action 1 all staff files were reviewed for Garda vetting. Any staff without Garda Vetting were removed from the roster and their vetting was completed and submitted.

5. A review of the rosters has been completed. Recruitment for Elm Hall is ongoing to replace staff who have left. Further recruitment agencies have been contacted. A staff meeting was held on the 18.10.17 to inform staff of the management's focus on a recruitment drive. Staff will be kept updated. Agency staff where possible will be used for days shifts only

6. Admissions to Elm Hall nursing home have ceased until staffing compliment has increased.

**Proposed Timescale:** 31/12/2017

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

An annual review for 2016 and arrangements that informed an overall review of the quality and safety of care for residents was not available.

**4. 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:**

1. An annual review for 2016 will be completed by the 31st of December.

**Proposed Timescale:** 31/12/2017

**Outcome 04: Suitable Person in Charge**

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The resignation and absence of the registered person in charge was confirmed and the recruitment of a replacement was on-going.

**5. Action Required:**

Under Regulation 14(1) you are required to: Put in place a person in charge of the designated centre.

**Please state the actions you have taken or are planning to take:**

1. All relevant documentation on the resignation of the Person in Charge has been submitted to the authority.

2. As per action 5 and 6 the recruitment of a suitable person in charge is ongoing. An interview is set for 23.10.17.

**Proposed Timescale:** 31/12/2017

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The recruitment of a suitable person in charge was on-going.

Based on this inspection findings, it is critical that a suitable person in charge with not less than 3 years experience in a management capacity in the health and social care area within the past 6 years.

**6. Action Required:**

Under Regulation 14(6)(a) you are required to: Ensure that a person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation has not less than 3 years experience in a management capacity in the health and social care area, where residents are assessed as requiring full time nursing care.

**Please state the actions you have taken or are planning to take:**

1.The acting Director of care will be supported by the Registered Provider and two clinical nurse managers whilst the recruitment of the Director of Care is successfully completed.

2.The recruitment of a Director of Care is ongoing. An interview with a candidate will be conducted on the 23.10.17. The recruitment process will continue until a suitable candidate has been appointed.

**Proposed Timescale:** 31/12/2017

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Based on this inspection findings, it is critical that a suitable person in charge is recruited with a post registration management qualification in health or a related field is recruited.

**7. Action Required:**

Under Regulation 14(6)(b) you are required to: Ensure that a person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation has a post registration management qualification in health or a related field, where residents are assessed as requiring full time nursing care.

**Please state the actions you have taken or are planning to take:**

1.As per action 5. The efforts to recruit a suitable person in charge will be continued until a suitable candidate has been recruited.

**Proposed Timescale:** 31/12/2017

**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:**

A system to identify, assess, monitor audit or control risks was not in place or known, and a risk register was not available to ensure resident and staff safety.

**8. 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:**

1. The risk management framework for the nursing home is under review at present. The Risk Management Policy and Procedure will be reviewed and updated. Once approved will be communicated to staff to ensure they are enabled to identify risks, assess risks and ensure controls are in place to mitigate the risks within Elm Hall Nursing Home.

2. Staff education on Risk Management will be completed to ensure staff are aware of the process to escalate high risk identified to management.

3. Risk registers are under development for the nursing home, to incorporate corporate, service and care and health and safety risks related to the nursing home. The register will be reviewed on a regular basis to ensure that all risks are identified in a timely manner.

**Proposed Timescale:** 30/11/2017

**Theme:**

Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

An up-to-date personal emergency evacuation plan for all residents of varying dependencies had not been completed for some or not updated sufficiently and communicated to all relevant staff for the event of an emergency or fire.

The fire evacuation plan/policy and procedure on file outlined the initial steps as communicating with the directors and management, and to take direction from the chief fire officer regarding evacuation. This policy and arrangement required immediate review as it may compromise a timely response by staff in the event of an emergency

or unplanned evacuation of the centre

**9. Action Required:**

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

**Please state the actions you have taken or are planning to take:**

1. All Personal Emergency Evacuation plans for residents in Elm hall have been reviewed updated and communicated to relevant staff.

2. An Audit on PEEPS will be completed by November 30th 2017

3. The Emergency Evacuation policy and procedure has been process mapped with the registered provider and acting director of care to ensure that the process is correct and implemented into practice. The policy was then updated and communicated to all staff via staff meetings.

**Proposed Timescale:** 30/11/2017

**Theme:**

Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The centre's policies and procedures relating to health and safety and risk management had not been implemented or demonstrated in practice.

**10. Action Required:**

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

**Please state the actions you have taken or are planning to take:**

1. All policies and procedures in relation to risk management are under review at present by the management team. They will be updated and approved at the management team meeting.

2. Once approved and activated staff will be educated on the updated policy and procedure. Staff will acknowledge they understand the policy in relation to health and safety risk management.

**Proposed Timescale:** 30/11/2017

**Theme:**

Safe care and support

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

**requirement in the following respect:**

Staff had not received fire safety induction, training or participated in a simulated fire drill.

Staff were not familiar with emergency procedures, equipment or the means of escape from all parts of the centre. A consistent emergency response was lacking among staff spoken with. The whereabouts or availability of fire safety and response equipment was unknown to staff.

Staff were unfamiliar with the fire safety procedures, appropriate means of escape and how to access escape routes and equipment to aid evacuation

Inconsistent responses were described which were inadequate

Staff were unaware secure fire exits doors might release or open and of the availability of equipment such as a ski evacuation pad

Self closing bedroom doors were seen inappropriately held in an open position by chairs or weights

Staff knowledge and records relating to previous fire safety training did not demonstrate the adequacy of the arrangements in place within the centre in the event of a fire.

**11. Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**

1. Immediate informal fire training given to all staff on duty on day of inspection, night staff for the night of inspection and day staff on the day after the inspection.
2. Fire training booked and commenced by new provider on the 5th, 6th, 12th and 20th of October. The training incorporated evacuation procedures based on building lay out and escape routes, location of alarm call points and equipment.
3. All training records and certificates relating to fire safety training will be inserted into staff files.

**Proposed Timescale:** 30/11/2017

**Theme:**

Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Staff spoken with and records reviewed showed that arrangements to check the means of escape daily and test of the fire alarm weekly had not been maintained to promote resident, visitor and staff safety

Tests to ensure compartmentalisation, door releases and safety equipment checks had not been completed

Simulated fire evacuation drills from all parts/floors of the building and compartments had not been carried out with a record to inform learning or improve fire safety arrangements

Simulated fire evacuation drills had not been completed at varying times of the day or night to test the worst case scenario when the maximum number of six staff were available to residents at night

While the records of previous training available for some staff indicated the date of the drill and names of staff attended, the record did not contain the detail necessary and staff were not sufficiently knowledgeable to assure the inspector that the persons working in the centre were both aware of, and practised in, the procedure to follow in the event of a fire.

Records that included reference to a fire drill did not include details relating to a scenario simulated as part of the drill such as simulated fire location and time of day, staffing levels or the time taken to evacuate the compartment concerned.

The previous training records were of limited use in ensuring the adequacy of the procedures in place on a continuing basis.

## **12. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

### **Please state the actions you have taken or are planning to take:**

1. Staff have received fire training on the following dates 5th, 6th, 12th and 19th of October. The training incorporated the following to ensure the staff have up to date knowledge on fire safety and evacuation of residents within Elm Hall Nursing Home:

- Fire safety and legislations
- Chemistry of fire
- Fire prevention
- Spread and class of fire
- Portable fire extinguishers
- Oxygen and fire safety
- Compartmentation
- Escape routes
- Fire involving clothing
- Emergency procedures
- Evacuation types



- Phases of evacuation
- Action to take in the event of a fire
- Action to take on hearing the fire alarm
- Assisting the fire brigade
- Practical use of fire extinguishers
- On unit fire safety training
- Practical fire evacuation
- Time fire drills

2. A review of training matrix is taking place to ensure training is kept up to date moving forward.

3. All Certs relating to fire training will be stored in staff files.

**Proposed Timescale:** 31/12/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Fire evacuation plans and procedures were not available on display within compartments to direct you to the nearest emergency exits

**13. Action Required:**

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

**Please state the actions you have taken or are planning to take:**

1. A new supplier of Fire training has been identified and a completed fire training with staff.

2. A fire safety audit by an external fire safety company will be completed. Any quality improvements identified from the audit will be actioned and completed by the registered provider.

3. Compartments and locations of fire exits will be reviewed and displayed throughout the Nursing Home.

**Proposed Timescale:** 30/11/2017

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

**requirement in the following respect:**

The numbers, qualifications, supervision and skill mix of staff was not appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. There was evidence of negative outcomes for residents due to staff shortages and lack of training and development.

Staff turnover in all disciplines was high with up to 39 staff reportedly leaving within the past six months.

The roster showed the registered person in charge and three staff on annual leave, one staff on maternity leave and five staff on sick leave. Four of whom were also rostered as off sick on the week of the 4 September 2017.

A requirement to contract agency or bank staff was evident to complete the weekly roster, mainly for night duty.

Some staff told the inspector they were always busy, rushed and did not always have sufficient time to complete their daily duties.

Staff spoke of the frustration experienced of continuously supporting new staff.

Opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs were limited and insufficient due to on-going absences of staff and lack of appropriate contingency measures.

There was little evidence that all staff were specifically skilled for their role and responsibilities.

**14. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**

1. A review of staff rosters and skill mix will be undertaken
2. Clinical Nurse Managers will remain as supernumerary to ensure daily supervision of staff across all roles within the nursing home
3. An induction program will be developed to ensure all new staff are suitably orientated to the residents and procedures within Elm Hall Nursing Home.
4. Recruitment will continue until full complement of staff is achieved.
5. A review of recruitment processes will be undertaken and the new process will be communicated to all staff.
6. An audit on the recruitment process will be completed by 31st of December 2017

7.The activities provided in Elm Hall Nursing home are currently under review to include consideration of activities suitable for residents with dementia and to incorporate meaningful activities.

8.The position of Activities Co-Ordinator has been advertised internally.

9.A resident survey on activities will be completed to incorporate resident input into the review of the activity program going forward.

**Proposed Timescale:** 31/01/2018

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff recruited in response to poor retention levels did not have a record of induction or evidence to confirm they had appropriate training to ensure they had adequate knowledge and skills, appropriate to their role, or to respond appropriately to residents needs or emergencies.

A complete record of training was not available for all rostered staff. Staff delivering care to residents and working told the inspector they had some training but had little or no recent training or updating in areas such as safeguarding, fire safety, responsive behaviours, restraint, manual handling, first aid and cardio pulmonary resuscitation (CPR).

Training requirements were identified for improvement following the previous inspection, however, training dates for some experienced staff was in 2015 for fire safety and safeguarding 'elder abuse' and manual handling training last completed in 2014.

There were training gaps and incomplete records for a significant number of staff working in the centre.

**15. 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. As per action 1 a full review of the training matrix has been completed. Fire Training has been rolled out for all staff working in Elm Hall Nursing Home. Safeguarding training has been booked for 2nd, 6th and 7th of November 2017. Manual Handling ,CPR and First aid training have been provisionally booked for the 8th and 9th and 10th, 27th, 28th, 29th & 30th November 2017.Restraint training has been booked for 27th of October. The Acting Director of Care will continuously monitor the training matrix to ensure gaps presented on the day of inspection do not occur again.

2. An induction programme for all new staff in Elm Hall is under development. The induction programme will incorporate the training requirements relevant to the roles and responsibilities of staff recruited for Elm Hall Nursing Home. When completed it will be reviewed and approved at the management team meeting and implemented for all new staff joining Elm Hall Nursing Home.

3. All training completed in Elm Hall nursing Home will be recorded in the staff files.

**Proposed Timescale:** 31/12/2017

**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

From an examination of staff files, a review of the training matrix and discussions with over 12 staff from various disciplines, it was evident that there was a lack of appropriate induction, appraisal, training and development of staff members. Poor communication was also evident.

There were operational policies and procedures in relation to staff recruitment, induction, training and development reflecting best practice; however, they were not implemented in practice and staff had commenced working prior to completing Garda Vetting that compromised residents' safety.

**16. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**

1. As per action 1 a full review of the training matrix has been completed. Fire Training has been rolled out for all staff working in Elm Hall Nursing Home as per action 13. The Acting Director of Care will continuously monitor the training matrix to ensure gaps presented on the day of inspection do not occur again.

2. An induction programme for is under development. When completed it will be reviewed and approved at the management team meeting and implemented for all new staff joining Elm Hall Nursing Home.

3. Appraisal training will be held for line managers on the 26th of October 2017. Following the training a schedule for appraisal of all staff will be developed and implemented.

4. As per action 1 and 2 All staff recruited in Elm Hall Nursing Home will require Garda Vetting Clearance prior to starting date, in addition to all other relevant requirements in line with legislative requirements.

5.All operational policies are under review at present, once reviewed, updated and reviewed, staff will be communicated the updates.

**Proposed Timescale:** 28/02/2018