Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Elm Green Nursing Home
Name of provider:	MNMS Developments T/A Elm Green Nursing Home
Address of centre:	New Dunsink Lane, Castleknock, Dublin 15
Type of inspection:	Unannounced
Date of inspection:	01 May 2018
Centre ID:	OSV-0000133
Fieldwork ID:	MON-0023859

About the designated centre

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

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

The following information outlines some additional data on this centre.

Current registration end date:	06/03/2021
Number of residents on the date of inspection:	111

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
01 May 2018	09:00hrs to 17:00hrs	Leone Ewings	Lead
01 May 2018	09:00hrs to 17:00hrs	Nuala Rafferty	Support

Views of people who use the service

Residents gave positive feedback to the inspectors about their experiences of the service they were receiving. Residents told inspectors that meals were of a good standard, and they enjoyed the variety on the menu.

The staff team were described by residents as friendly, gentle and caring and were available to meet their needs. Residents confirmed they were happy with the premises, and had been encouraged to bring in items to personalise their bedrooms. They enjoyed the range of activities available, and had access to outdoor spaces and garden walks.

Residents confirmed staff communicated well with them, and they were involved in any decisions about their daily routines, and activity plans.

Residents reported enjoying reading daily newspapers, watching television, music, arts and crafts. Residents expressed satisfaction with their access to activities that suit their preferences. They also confirmed their individual choices to engage (or not engage) in any activity were respected.

The complaints procedure was said to be accessible, and residents confirmed who they could speak to in order to raise any issues. Visitors confirmed they received a warm welcome and could access staff to discuss their concerns and get information.

Capacity and capability

Overall, this was a well-organised and managed service with improved governance arrangements in place. Sufficient resources were in place to ensure the effective delivery of care, and the provider and person in charge had made improvements following the last inspection. Further improvements were required with medicines management, and aspects of documenting care plans to guide staff in managing responsive behaviours for people with dementia.

Clearly defined governance and management arrangements were in place with the provider, person in charge and persons participating in management. The registered provider has recruited an experienced person in charge and made the required improvements. The person in charge gives weekly reports to the provider, and she is supported by an assistant director of nursing, two clinical nurse managers and the area supervisor. There was evidence of audit and service review being used by the person in charge. Training opportunities for staff enhanced the quality and safety of care for residents, and systems of staff appraisal and analysis of training needs were

now fully implemented. An annual report for 2017 had been completed, and areas for improvement identified were informed by resident and relative feedback.

Safe recruitment practices were found to be in place with increased levels of staff administrative support. There was effective planning and oversight of the workforce, and close monitoring of staff turnover levels. Effective care and supports for residents was observed to be in place at the time of this inspection. Relatives and residents confirmed that there was more continuity of care with regular staff.

A clear complaints policy was in place and overseen by the person in charge. All written complaints any issues were recorded and managed by her as the complaints officer. The procedure was on display in the centre and residents who gave feedback to the inspectors confirmed they understood the process, and felt any issues raised would be addressed. Where improvements were required following feedback from residents, this was discussed and addressed at management meetings.

Regulation 14: Persons in charge

The new person in charge had been introduced to residents and relatives and participates fully in management. A review of her fitness to undertake this role took place prior to this inspection. She has completed a management qualification and has suitable experience working with older people to meet the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Staffing provision in the centre was in line with the statement of purpose and staffing rosters reviewed on the day. Staff turnover had reduced and recruitment practices were now overseen by the provider and person in charge in line with the policy on recruitment. Staff received suitable induction and had appropriate qualifications. Nursing staff had evidence of current registration with the regulatory body for nursing.

Judgment: Compliant

Regulation 16: Training and staff development

Staff mandatory training in safeguarding, fire safety and moving and handling was

up to date. Staff appraisals identified areas for staff development, and a training plan was in place for 2018. One area that nursing staff had not yet received a training update on was in relation to restraint and the assessment prior to the use of any restrictive practice. The person in charge confirmed that this training would be sourced and completed to inform practices.

All staff were now supervised and care practices closely reviewed by the person in charge.

Judgment: Substantially compliant

Regulation 21: Records

Records were maintained to a satisfactory standard and had improved since the time of the last inspection. They contained all the information required by legislation. Staff Garda Síochána (police)vetting disclosures for staff were in place prior to their recruitment and start date at the centre.

An electronic record-keeping system was in use and all staff had received training in its use. Records of any complaints received were now recorded and responded to in line with regulatory requirements.

Judgment: Compliant

Regulation 22: Insurance

The provider had adequate insurance cover in place to meet regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The provider had put a new governance and management team in place. The partnership responsible for managing the centre was MNMS Developments. Inspectors were assured that all staff were fully aware of their roles and responsibilities within the new management structure. The person in charge reports directly to a representative of the partnership.

There was clear evidence of improved leadership and governance in place to monitor quality and safety and quality of life in the centre. Nonetheless further work

and oversight by the management team was required to fully embed changes made.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose had been updated to reflect recent changes in governance and management. This document contained all the required information about the centre and the services provided.

Judgment: Compliant

Regulation 31: Notification of incidents

All notifications required by regulation were submitted within the required time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

A complaints procedure was in operation in the centre, and the complaints process was on display in the reception area. The policy and procedure around making complaints identified the complaints manager and the option of an appeal.

Inspectors spoke with residents who confirmed that they would bring complaints to the attention of the staff. Feedback received by inspectors confirmed satisfaction with improvements with staff dealing with complaints had taken place, and complaints were now being addressed satisfactorily.

There had been some written complaints since the last inspection, any issues were reported and recorded by the person in charge or her deputy. Detailed follow up was evidenced and recorded in the records. This included review of staffing and supervision, care practices and communication.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures required by the legislation were in place, and most were evidence based. Nonetheless, some policies required some review and updating to inform and guide staff. The person in charge confirmed that this was an area she was working on to make improvements.

Judgment: Substantially compliant

Quality and safety

Inspectors found there were good healthcare outcomes for residents using the service. Some improvements were required with medicines management and care planning practices.

There was a multidisciplinary care team approach to providing health care to residents. Residents were consulted with regarding the development of their individual care plans which included assessment of needs and treatment plans. They received the care which they needed. Staff liaised with the local community services regarding appropriate admission and discharge arrangements. Residents had timely access and referrals to health care services based on their assessed needs.

Residents with communication difficulties were facilitated to communicate with staff. The approaches used were observed to be gentle, and reflective of good practice.

Arrangements were put in place to assist residents to support them to make decisions consistent with their capacity. Residents had opportunities to participate in meaningful activities in accordance with their interests, abilities and capacities. The group social and recreational programme was relevant and meaningful to the residents, and for those who did not wish to participate staff tried to engage them on a one-to-one basis with activities of their preference. These activities promoted their physical and mental health and well-being.

Residents meetings were held and residents confirmed that they were consulted with about the day-to-day running of the centre. Resident had access to an independent advocate service and this was advertised. Residents were able to develop and maintain personal relationships with family and friends in accordance with their wishes. Visitors were welcomed and encouraged to participate in residents' lives.

Policies and procedures were implemented and they ensured residents were protected from abuse. Inspectors confirmed that all staff were Garda vetted, and a sample of staff files recruited since the last inspection confirmed this information. Staff members who communicated with inspectors were knowledgeable regarding

their duty to report past or current concerns for the safety of the residents living in the centre.

A restraint-free environment was promoted, and any physical restraint was used in line with the national guidelines. Nonetheless further training and improvement with assessments and review was required. This included completing a multi-disciplinary risk assessment prior to the implementation of any restrictive measure. Records regarding physical restraint were maintained in accordance with the regulations regarding restraint. Records reflecting the use of psychotropic medications to manage responsive behaviours also required improvement to inform and guide staff prior using any prescribed prn (as required) medicines. Further training is planned for staff to safely assess and manage restraint practices in use at the centre and promote a restraint-free environment.

Regulation 17: Premises

The registered provider had made improvements since the last inspection, to ventilation and the storage of assistive equipment.

Judgment: Compliant

Regulation 26: Risk management

A full review of the risk register had taken place in December 2017. Risks identified on the last inspection had been addressed by the provider including improvement with the use of the smoking room.

Judgment: Compliant

Regulation 28: Fire precautions

There were adequate arrangements in place against the risk of fire including fire fighting equipment, means of escape, emergency lighting and regular servicing of systems. Staff knowledge of what to do in the event of hearing the alarm was good, and the support needs of each resident were clearly documented. The provider and person in charge confirmed that fire drills took place regularly and records reviewed confirmed this took place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Overall, staff were knowledgeable about the medicines in use, and administration, storage and disposal practices were safe. There were clear arrangements for the receipt, storage and administration of medicines in the centre. Improvements relating to covert and administration of crushed medication had been fully addressed since the last inspection. Nurses had completed medicines management training. The inspectors reviewed a sample of medicines prescription sheets and observed administration practices. They found a small number of medicine errors of omissions on the day of the inspection, which were communicated to the person in charge who undertook to address this in line with the medicines policy.

The use of any psychotropic medicines and antibiotics was closely reviewed and audited each week by the person in charge. Audit had identified some areas for improvement and learning. Improvements were required with the documentation and care plans in place to support residents who are prescribed prn medicines (as required) in order to guide and inform staff prior to the use of any prescribed psychotropic medicines in line with professional guidance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents care records showed that pre-admission assessments were completed, care plans put in place and reviews occurred every four months or more frequently if required. The records of reviews and information about decision-making needed review to fully meet the regulations. Nursing daily records of care also required improvement to clearly record care delivery.

Judgment: Not compliant

Regulation 6: Health care

Appropriate medical and health-care was being provided and was accessible for residents, in line with their identified health and social care needs. The person in charge provided leadership and ensured that a high standard of evidence-based nursing care practice was in place.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The indication for use of prescribed as required psychotropic medications was not clearly outlined in each resident's care plan for managing behaviour that was challenging. Reviews of records of behaviours completed did not fully inform care plans or document individual triggers, or guide staff when an escalation of behaviour occurs.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse. The provider had reviewed procedures for the recruitment of staff, and safe practices were now in place. Training was provided to staff to guide them in recognising and responding to actual, alleged or suspected incidents of abuse. Staff spoken with knew their responsibilities in relation to ensuring residents were safe and protected.

The provider had notified an allegation made to HIQA in line with regulatory requirements. This had been investigated and responded to in line with the policy in a timely way to safeguard all residents.

Residents confirmed to inspectors they felt safe in the centre. Residents pensions were not no longer being managed by the provider at the time of this inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Elm Green Nursing Home OSV-0000133

Inspection ID: MON-0023859

Date of inspection: 01/05/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A member of the management team has been signed up to complete a QQI level 6, Train the Trainer course and a course in restrictive practices. Once completed the team member will roll out restrictive practice training to all members of staff. The time line for this roll out is 30:11:18. In the interim, any restrictive practices will be closely monitored by the management team and audited to ensure compliance.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Policies that were found to be "not evidence based" are currently under review. Policies will be in line with current legislation by 31:08:18.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and	

pharmaceutical services:

The centre is currently undergoing a full review of medication management. In conjunction with our pharmacy provider we are in the process of updating our medication cardexes which will clearly state the rationale for administering all as required (PRN) medication. A new system of administration of prescribed medication is being rolled out in the nursing home and evidence from other centres suggests that this system decreases the incidents of medication errors of omission. Full roll out of new system by 30:09:2018.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Ongoing review and improvement in care planning now overseen by the management team. New auditing tools in place to ensure improvements are made and maintained and will be fully functional by 31:08:2018.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

The new medication management system now clearly indicates the rationale behind the use of “as required” (PRN) psychotropic medications. Ongoing reviews of records of behavior that is challenging, by the management team, and ongoing auditing will ensure full compliance by 31:08:2018.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/11/2018
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/09/2018
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief	Substantially Compliant	Yellow	31/08/2018

	Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Yellow	31/08/2018
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/08/2018