Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of designated centre: | Silvergrove Nursing Home Limited |
| Name of provider: | Silvergrove Nursing Home Limited |
| Address of centre: | Main Street, Clonee, Meath |
| Type of inspection: | Unannounced |
| Date of inspection: | 11 April 2018 |
| Centre ID: | OSV-0000162 |
| Fieldwork ID: | MON-0023856 |

## About the designated centre

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

Silvergrove Nursing Home is a family owned business, located close to the village of Clonee, Co. Meath. The centre is a purpose built, single storey facility with 21 single and seven twin bedrooms. The service offers long-term, respite and convalescence care to male and female residents over 18 years. The centre admits residents of varying degrees of dependency from low to maximum. The staff team includes nurses and healthcare assistants and offers 24 hour nursing care. There is also access to a range of allied healthcare professionals.

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

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| Current registration end date: | 06/10/2019 |
| Number of residents on the date of inspection: | 23 |

## 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 |
|---|---|---|---|
| 11 April 2018 | 08:30hrs to 16:30hrs | Una Fitzgerald | Lead |
| 12 April 2018 | 10:00hrs to 18:00hrs | Una Fitzgerald | Lead |

## Views of people who use the service

The inspector spoke with residents about what it was like to live in the centre. The residents spoke highly of the staff looking after them. They felt that their call-bells were answered and staff knew their individual likes and dislikes. During the inspection there was a high number of residents with a diagnosis of dementia. The inspector spoke briefly with multiple residents and spent time observing resident and staff engagement. Overall, residents appeared comfortable in their surroundings. A theme emerged from the conversations had that although residents felt safe and well cared for, there was a underlying worry that confused and mobile residents were not appropriately supervised to ensure that their behaviour did not impact negatively on other residents.

## Capacity and capability

The governance and management arrangements in place in this designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. Following the last inspection, the registered provider representative met with the Health Information and Quality Authority (HIQA) to discuss the findings and to seek reassurance on how improvements would be made. There continues to be an overreliance on the person in charge or senior nurse to undertake the registered provider's regulatory duties and to ensure the quality and safety of the service. Non-compliance continues to be found around governance and management, risk management, supervision of staff and residents' rights.

Consequences of the ineffective and unsafe management system include:

- Poor risk management
- Inadequate oversight and review of the quality of care
- Failure to sustain improvements made and poor practice is allowed to re-emerge.

Risk management procedures were inadequate and required significant improvement. For example, the plan in place for responding to serious disruption to essential services guided staff to evacuate residents to a centre that is no longer in operation. The nursing management team could not confirm what the current emergency evacuation plan is. The risk register in place captures risk specific to

individual residents only and does not refer to operational risk within the centre.

The management had previously committed to holding weekly governance and management meetings where all operational issues would be discussed. The meetings were not consistently held, and as a result the care issues that have a negative impact on resident lives were not addressed. The person in charge and the registered provider representative were documenting their meetings separately. The provider is also the general practitioner (GP) for the centre and visits weekly.
The registered provider representative did not ensure that the designated centre was effectively and safely managed.

There was evidence that some progress had been made since the previous inspection to review the quality and safety of care. An annual review of the service was completed and available for inspection. The person in charge had conducted care audits. A full review of every resident care plan was conducted by the person in charge or her deputy.

Poor practice was not being appropriately addressed. Examples include: residents not having access to a call-bell, and residents being assisted with meals by staff standing over them and not engaging with the residents. The inspector spoke with the person in charge about the number of practices that caused concern during the inspection. The person in charge said that staff have all received training and are aware that these practices are not appropriate. However, the inspector found that the governance, management and supervision of staff is not enforcing improvements. This issue was also identified on the last inspection.

The inspector found sufficient staffing on duty to ensure that residents' needs could be met. Some care staff described being rushed in completing their work and not always having the time to engage with residents in a meaningful way due to the high number of residents with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Complaints made so far for 2018 were minimal and all complaints are logged. The inspector reviewed the records and found that all complaints were appropriately documented. The satisfaction and outcome of the complaint was recorded.

## Regulation 15: Staffing

There were adequate numbers of staff on duty, and appropriate skill-mix, on the two days of inspection. The inspector observed that the nursing management team intervened to support staff with managing residents with responsive behavioural issues. The nursing management team are not on duty seven days a week. The inspector was informed that staffing levels are monitored to ensure that the needs

of residents are met.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to a range of training opportunities. All staff had completed safeguarding, fire safety and manual handling training.

Staff were not being appropriately supervised. While management were aware of poor practice in areas of resident supervision and resident engagement, these were allowed to continue.

Some progress has been made since the last inspection on staff appraisals. Further development is required to ensure that poor practices are addressed under the appraisal system and that improvement is enforced.

Judgment: Not compliant

## Regulation 23: Governance and management

The provider had delegated management responsibilities required of the provider, under the regulations, to the person in charge. The roles and lines of responsibility remained unclear on this inspection. The provider's commitment to support the person in charge and hold weekly meetings to address all areas of service delivery had not occurred.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There was an effective complaints process in place within the centre. Residents and

visitors who spoke with the inspector were aware of the complaints process.

Judgment: Compliant

## Regulation 4: Written policies and procedures

All of the policies and procedures required by the regulations were available within the centre, and had been reviewed within the last three years. These documents were accessible to staff. Further development was required to ensure that procedures were specific to this centre.

Judgment: Substantially compliant

## Regulation 21: Records

The inspector reviewed staff files and found full compliance with Schedule 2 of the regulation requirements.

Judgment: Compliant

## Quality and safety

Significant progress on fire safety management had been made since the last inspection. The centre has appointed a senior nurse to the role of fire safety warden. Records indicated that all staff had completed their annual fire safety training. Following the last inspection, the provider had an external company carry out a review of fire safety within the centre. Staff spoken with on the day of inspection were able to tell the inspector what action they would take in the event of a fire.

The person in charge and a deputy had carried out a full review of the care plans and documentation in place. The care plans reviewed on this inspection were person centred and guided practice. There was evidence that the resident or their relative had been consulted with. Residents' wishes and views were sought to inform end-of-life care wishes.

Residents were not adequately supervised to ensure their safety. A number of residents in the centre had responsive behaviours. The inspector observed multiple examples whereby residents with responsive behaviours were not supported by staff in a person-centred manner. Poor practice highlighted at the last inspection

continued to be an issue. For example: residents in bedrooms with the door closed and no access to a call-bell. Concerns about the culture of care, where the rights of vulnerable residents were not respected, were discussed with management. Further work is required to monitor and supervise all staff to ensure that good communication skills are used when engaging with residents with responsive behaviour.

In conversation with residents the inspector was told that they felt safe in the centre. Some residents informed the inspector that they were mindful of residents with dementia who walk freely around the centre. Residents had concerns about the level of supervision and the possibility of these residents entering their bedrooms. The provider had installed locks on bedroom doors at the request of residents. The resident meetings evidenced that this concern was also discussed.

Residents were updated about developments or changes within the centre. Resident meetings are held regularly, which a small proportion of residents attended. A programme of activities was carried out across the centre by activity staff. The activities schedule was informed by residents' interests and hobbies. Resident choice was listened to.

There was a good emphasis placed on the importance of one-to-one activity for residents who could not partake in group sessions. In addition, residents also attended events in the community, such as shopping trips.

Residents' right to undertake personal activities in private was not consistently respected. The inspector noted that the main bathroom located beside the communal sitting room could not be locked. This meant that residents could not use the facility in private. Management was aware of this, but no action had been taken to protect residents' privacy. The lock was replaced immediately when the issue was raised on this inspection.

## Regulation 26: Risk management

Risk management required improvement to ensure the safety and well being of residents. The risk register only contained individual resident risk. The hazard identification and assessment of risks throughout the designated centre were not identified, and so measures and actions in place to control the risks were not identified.

Judgment: Not compliant

## Regulation 27: Infection control

Overall, the procedures in place for managing the prevention and control of infection

were in line with National Standards. Some surfaces were not conducive to cleaning and required further review.

Residents' bedrooms were cleaned daily and deep cleaning was carried out regularly. There were hand hygiene alcohol dispensers strategically placed along all corridors. Staff were knowledgeable on the colour-coded system in place to minimise the risk of cross infection.

Judgment: Substantially 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 servicing of the systems. Daily checks on fire exits and weekly fire alarm testing are now in place and completed. All staff had completed fire safety training.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

Medication management policies were in place to guide practice. Medication management audits had taken place and areas highlighted as in need of improvement had been communicated to staff. The person in charge had conducted a review of medication kardexes and was taking action on any gaps identified.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Following on from the last inspection the nursing management had carried out a full review of all resident files. There was a comprehensive person centered care plan in place for all resident files reviewed. There was evidence that the resident or family member had been consulted with as per regulatory requirements.

Judgment: Compliant

## Regulation 6: Health care

Residents had appropriate access to a GP and allied healthcare professionals. There was good evidence that advice received was acted upon in a timely manner.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

Staff had received appropriate training in how to respond and manage behaviour that is challenging. The review of the documentation in place found that the care plans guided practice. The inspector was concerned that while staff were aware of appropriate management technique they did not always apply the theory in practice.

A restraint-free environment was promoted in the centre. Alternative measures were tried and consent was obtained when restraint was in use. Records confirmed that staff carried out hourly safety checks when bedrails were in use.

Judgment: Not compliant

## Regulation 8: Protection

There were systems in place to ensure that residents were protected from abuse. Staff had completed up-to-date training in the prevention, detection and response to abuse. Staff who spoke with the inspector knew the processes for reporting any concerns they might have.

The provider acted as a pension agent for a small number of residents. The provider confirmed that the system in place is in line with the guidelines published by the Department of Social Protection.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents were aware of their rights, including, civil, political and religious rights. These rights were respected by staff, and residents were supported to exercise their choice as much as possible. Advocacy services were available to residents where required.

However, residents' rights to undertake personal activities in private were not consistently accommodated and respected.

Judgment: Not compliant

**Appendix 1 - Full list of regulations considered under each dimension**

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| Regulation 21: Records | Compliant |
| **Quality and safety** | |
| Regulation 26: Risk management | Not compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Not compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Silvergrove Nursing Home Limited OSV-0000162

## Inspection ID: MON-0023856

## Date of inspection: 12/04/2018

**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 | Not Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- Ensure a system for assessment of staff on a probationary period is undertaken with employee participation / discussion / consultation and documented
- Ensure adequate supervision of staff to ensure that training received is implemented.

- Establish a system for carrying out an annual training needs analysis in accordance with mandatory and statutory training needs; organisational objectives and based on clinical governance activities and national Legislative / Regulatory / Professional and Policy requirements.
- Utilise the training Matrix that is in place and continue the annual training programme for staff to include Statutory and Mandatory training needs.
- Develop a system of evaluating all training programmes – in-house and external.
- Retain a copy of all training programmes where provided
- Develop key employees to train and act as in-service education facilitators for staff in Silvergrove.
- Utilise the system for staff appraisal with a performance improvement plan.
- Ensure a system for assessment of staff on a probationary period is undertaken with employee participation / discussion / consultation and documented.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:

**Corporate Management (the owners of the NH)**

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| • Establish Corporate and Clinical Governance Strategy, Structure & Systems;<br>• Follow the mission vision and objective of the NH & detail in the Statement of Purpose of the Nursing Home;<br>• Ensure that Board Meeting are held at regular intervals with appropriate representation including resident representation.<br>• Ensure that Risk and Safety are standing Agenda items at all meetings including Board of Management Meetings.<br>• Establish a Nursing Home communication strategy, structure and policy that, is, open transparent and accountable.<br>• Establish an organisation chart with roles and responsibilities clearly defined with line- management reporting functions clearly defined.<br>• The Registered Provider and the Registered Person-in-charge must only delegate management responsibilities to persons appropriate to their role, experience, training and competency.<br>• Ensure a **live on-call rota** including contact details (Phone No) is in place for the nursing home at night and at week-ends in the event of a major disaster necessitating an evacuation of the building or other emergencies including a relief person if only one registered Nurse is on duty.<br>• Develop and implement a policy on whistle-blowing to provide for residents and staff.<br>• Appoint a Clinical Governance Committee who will implement the strategy, the committee must include the owner of the NH, the Registered Provider, the Registered Person-in-charge, the Health and Safety Officer, The Health and Safety Representative. The membership must be documented & all present or deputised at all meetings.<br>• Establish Terms of References, Agenda, Schedule of meetings, template for minutes and a report feedback system for staff and relevant stakeholders.<br>• Clarify the roles and responsibilities of all staff working in the NH (INCLUDING VOLUNTEERS) and those with oversight responsibility to be clearly defined, appropriate to role and responsibilities | |
| • Establish System for collection and analysis of Key Quality Indicators and Key Performance Indicators (KPI's).<br>• Establish a standardised dataset of individualised health date in line with ''HIQA Guidance Document on Patient Data''<br>• Establish a data policy to comply with EU GDPR (May 2018) | |
| • Develop a programme of clinical audit based on priority areas. | |
| • Streamline all policies, procedures, guidelines in use. Ensure that polices are specific to Silvergrove and are an accurate reflection of the work / activities of the Nursing Home as detailed in the **statement of purpose** | |
| • Develop a system of indexing all policies and procedures in use including review dates. | |
| • Identify list of policies, procedures, protocols and guidelines that are still outstanding. | |
| • Establish a system for continuous quality improvement using the clinical governance framework and the **Plan, Do, Check, Act ('PDCA')** approach. | |
| • Ensure greater oversight of the NH service level agreements and contracts, as well as establishing a framework for ethical management to ensure that resident | |

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| care is provided within business, financial, ethical and legal compliance and protects residents, their families and employees. | |

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

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

- A full evacuation plan has been put in place.

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| Regulation 26: Risk management | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management:

- Develop a Risk Management Strategy, Structure, systems and Processes.
- Formulate a Risk Management Plan, Policy, Risk Assessment and a Risk Register
- Develop a risk assessment strategy, reviewed and updated annually and according to upgrading/changes in the nursing home.
- Develop a risk management policy reviewed and updated annually
- Formulate a Risk Management Programme for implementation of the strategy, systems and processes.
- Establish a system for the simplification, clarification, standardisation of risk management and tasks.
- Ensure international definitions for '**Patient Safety and Risk management'** is used (to facilitate evidence based best practice learning.

- Appoint a designated Health and Safety Officer
- The employees to nominate a Health and Safety Representative
- Establish a Health & Safety Committee with schedule of meetings.
- Establish a Risk management Committee (Clinical & non – clinical) with schedule of meetings.

- Establish a standardised list of ''Definitions'' used in the Nursing Home.
- Ensure only Internationally recognised standard **'abbreviations'** are used and that a list is available in the NH
- Provide Risk Assessment and Management training and Health & Safety awareness, refresher / updates for all staff at induction and to be included in annual training programme.

- Establish a system where incidents / accidents / adverse events / near misses / significant events are recorded.
- Ensure that it is collated into one incident reporting system (report form)

- Establish a system for reviewing incidents / accidents / near misses / adverse events / significant events, complaints and suggestions at risk management, health & safety meetings.

- Develop a system for follow-up of incidents / accidents to ensure remedial action based on risk assessment is documented in the risk register with control measures, responsible person and timelines.
- Establish a feedback system to inform staff, residents and appropriate stakeholders of the outcome of reviews, audits, investigations etc.

- Establish a Root Cause Analysis Policy and Procedure to investigate incident /

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| accident / Complaints. | |
| • Develop a '**safety motto**' for Silvergrove that is used throughout the NH e.g. **'Safety is Everyone's Business'** or **'Safety First'** or **'Safety Begins Here', ' Think Safety'**<br>• In High risk areas - **'Safe working needs team-working'** | |
| • Ensure copies of Spring Grove Health & Safety Statement is reviewed annually, updated and displayed in the office on all floors,<br>• Display a mini health & safety statement outlining the NH Health and safety requirement in a public area for members of the public.<br>• Ensure that the Health & Safety Statement is a **working document** | |
| • Conduct a **base-line** safety walkabout and risk assessment to inform improvements required.<br>• Establish a system for carrying out a '**Safety Walkabout' / 'Executive Safety Walkabout'** at regular intervals – to be conducted at least every three months. | |
| • Establish a system of data collection on a **Hazard Log and Risk Assessments** on each floor / every unit & ensure that it is on-going and that all staff are involved. | |
| • Develop a Risk Register based on the most recent Risks identified in addition to the generic risks, H & S reports, safety walkabout, surveys and on-going risk assessments. | |
| • Develop a policy and action plan for responding to emergencies / major incidents / disasters and disruption of essential services in Silvergrove including an emergency evacuation plan. | |
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| • Provide additional barriers and checks that will capture error e.g. in all areas of the NH especially in high risk areas in the form of **checklists (using the Swiss Cheese Model).** | |
| • Develop policies and systems for risk assessments related to occupational health and safety of all employees | |
| • Develop a system where essential information is displayed in a prominent location and is prioritized e.g. Emergency Tel. Numbers, High Alert Clinical Notices, Routine notices etc. (e.g. on office notice boards)<br>• Establish a documentation file System for all relevant information.<br>• Ensure all document files have an index / contents page | |
| • Establish a system for '**safe clinical handover**' for nursing staff and reporting communication with GPs using an international recognised system of Situation, Background, Assessment, and Recommendations Model. (**S.B.A.R.)** | |
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| • Ensure '**reconciliation of all resident medication'** on admission and discharge and throughout the continuum of care. | |
| • 'Improve the safety of all **high alert medications'** *e.g. insulin, anticoagulants, digoxin etc. used by the NH.*<br>• Ensure high risk medications are clearly marked and kept separate from routine medications,<br>• Ensure look a-like, sound-a-like medication are clearly managed and kept separate.<br>• Establish a list of high risk medications for each **clinical area** and that all high risk medications are double checked prior to administration.<br>• Ensure that there is an out-of-hours pharmacy policy with on-call telephone numbers available to night staff to obtain urgent medications in the event of an emergency. | |

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| • Use ''International Patient Safety Goals and Solutions'' as a bench mark for residents' services / clinical care. | |
| • 'The access to care and continuity of care' THE NEED TO STABILISE EMERGENCY PATIENTS PRIOR TO TRANSFER TO ANOTHR ORGANISATION AND THE NEED TO STRENGTHEN THE INTEGRATION OF OUT-PATIENT INFORMATION FOR residents to provide ongoing care from multiple clinics (co-ordinations, communication, management) | |
| • Ensure that '**unique resident identifiers'** (Christian name, surname, Date of Birth) are used in all verbal and written communication about residents.<br>• Ensure that photographic evidence is used for all resident medication administration. | |
| • Ensure that resident **'Allergies**' are recorded on all relevant documentation, medication prescriptions, MARS sheets, Care Plans etc. | |
| • Ensure that all resident documentation is ***signed, timed and dated*** *every time all of the time.* | |
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| • Ensure that all emergency back-up facilities, utilities are checked, are in good working order and available for use in an emergency with records kept. | |
| • Ensure that monitor alarms, warning signals, calls bells are routinely checked, are in good working order with records kept. | |
| • Ensure there is a planned programme of preventative maintenance for all equipment used in the nursing home.<br>• Maintain a log of all equipment purchased and used in the nursing home | |
| • Ensure that calibration of equipment is conducted, records are kept and available to appropriate staff (calibration log to be made available) | |
| • Ensure that **HIQA National Standards for Infection Prevention and Control** is implemented and monitored through the Infection Control Committee.<br>• Ensure that the requirements regarding The use of ' Single-Use DEVICES' (Disposables) is implemented. | |
| • Ensure that the responsible person for overseeing infection control practices monitors and provides feedback on Infection Control Activities at the Clinical Governance Committee. | |
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| • The 'Assessment of Residents' INCLUDE A NEW REQUIREMENT REGARDING TIMELY REPORTING OF CRITICAL RESULTS OF DIAGNOSTIC TESTS (ref. Tallaght Hospital HIQA Investigation) | |
| • The 'Quality improvement and Resident Safety' requirements of a comprehensive risk management framework as a tool for the reduction of adverse events - select at least 5 clinical measures and 2 new standards intended to focus the organisations on the quality of the data that they collect and use in their improvement activities.* | |
| • Ensure effective hand hygiene surveillance and audit<br>• Ensure staff compliance with the **WHO 5 "Moments for Hand Hygiene"** | |

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| • Include training on clinical audit for staff appropriate to their roles. | |

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| Regulation 27: Infection control | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:

- The cleaning policy of Silvergrove has been thoroughly reviewed.
- The cleaning products in use as specified by the manufacturers and are compatible with use Use on the specified surfaces.
- All surfaces are conducive to cleaning.

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| Regulation 7: Managing behaviour that is challenging | Not Compliant |

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

- Ensure that all staff have received training relevant the various types of behaviours that chal
- Ensure the application of training received to practice in the centre.

- Establish a system for reviewing the appropriateness of staffing levels and skill mix.
- Introduce clinical supervision system of clinical staff
- Ensure that an orientation / induction / competency assessment / appraisal system for all sta effectiveness.
- Document arrangements for clinical supervision of new staff.

- Apply the system of staff appraisals, with a performance improvement plan.

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| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- All residents are invited to participate in activities, and should they chose not to participate, their wishes are respected, and alternative activities are offered.
- Residents who choose to undertake activities in private are accommodated and facilitated.
- The documentation reflects residents choices.

## 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)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 21/05/2018 |
| Regulation 23(b) | The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | Not Compliant | Orange | 21/05/2018 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 21/05/2018 |
| Regulation 26(1)(a) | The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated | Not Compliant | Orange | 21/05/2018 |

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| | centre. | | | |
| Regulation 26(1)(b) | The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified. | Not Compliant | Orange | 21/05/2018 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. | Substantially Compliant | Yellow | 21/05/2018 |
| Regulation 04(1) | The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5. | Substantially Compliant | Yellow | 21/05/2018 |
| 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 | Not Compliant | Orange | 21/05/2018 |

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| | a manner that is not restrictive. | | | |
| Regulation 9(3)(b) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private. | Not Compliant | Orange | 21/05/2018 |