

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Silvergrove Nursing Home Limited
Centre ID:	OSV-0000162
Centre address:	Main Street, Clonee, Meath.
Telephone number:	01 825 3115
Email address:	silvergrovenursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Silvergrove Nursing Home Limited
Lead inspector:	Una Fitzgerald
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	11

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 January 2018 09:30	23 January 2018 17:30
24 January 2018 09:30	24 January 2018 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a two day unannounced inspection, which was triggered following receipt of unsolicited information of concern received by the Health Information and Quality Authority (HIQA). The concerns alleged poor quality of care and inappropriate management of residents who have responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Evidence found during this inspection substantiate the concerns. On arrival to the centre, the inspector met with the person in charge who was informed of the purpose of the inspection.

Silvergrove Nursing Home is a family owned business, registered to provide care for a maximum of 35 residents. On the day of inspection there was a total of 24 residents. The inspector met with residents, relatives and staff members. Staff observed were courteous and responsive to residents and visitors during the inspection. The case files of a number of residents within the service were tracked.

Documentation such as care plans, medicine records, medical and clinical records, policies and procedures, and staff training records were examined. In general the living environment was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness.

The inspector found that the governance and management structure was not sufficiently robust and the lines of authority and accountability were not defined. The person in charge is also the named representative on behalf of the provider, Silvergrove Nursing Home Limited. However the person in charge/provider representative has limited authority to make decisions that have a budgetary implication. There is no system in place for the person in charge to meet with the Board of Management on a formal regular basis to discuss operational matters. Effective management systems are not in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. A review and improvement plan in relation to the governance arrangements is required to ensure that the service delivered is safe, appropriate, consistent and effectively monitored.

There were nine outcomes monitored as part of this inspection, and one outcome Medication Management (Outcome 9) was found to be compliant. The inspector found multiple judgments of non compliance in eight of the nine outcomes that all have a negative impact on residents' outcomes. Four outcomes are judged moderate non compliance and four outcomes are judged as Major non compliance. The findings are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose does not clearly outline a statement of the aims, objectives and ethos of the designated centre. All of the information required by Schedule 1 of the regulations is not included in the statement of purpose. For example, a description of all rooms in the centre, including their size and primary function. A full review of the detail of the statement of purpose is required to ensure that it accurately describes the service that is provided in the centre.

The management team informed the inspector that the statement of purpose has been kept under review and revised at intervals of less than one year. The statement of purpose does not have a review date documented. HIQA had not been notified of changes made to the statement of purpose. For example, changes made to the organisational structure.

Judgment:

Non Compliant - Moderate

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:

The governance and management structure in place does not clearly outline and identify the lines of authority and accountability. The person in charge is also the provider nominee on behalf of Silvergrove Nursing Home Limited. However, the inspector could not find any evidence of how this dual responsibility role is supported by the provider. Decision making ability on day to day operational matters is the responsibility of the person in charge/provider nominee. However, from discussions had with the person in charge and the representatives of two company directors, the person in charge/provider nominee had limited authority to make decisions that have a budgetary implication.

Management systems are not in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. For example, the inspector found evidence of peer to peer abuse that had occurred within the centre. The management of the incident was recorded. However, HIQA had not received any notification as per regulatory requirements. The person in charge had carried out audits on care plans, falls audit, wound management and nutritional audit. However, findings from audits were not linked to continuous improvements. There was no evidence that audit findings are communicated to the Board of Management or to the staff delivering the care.

On discussion with the providers the inspector was informed that a company director attends the centre on a weekly basis. However, the weekly attendance is in the capacity as medical practitioner. The person in charge does not meet with the provider on a formal regular basis to discuss operational matters. Issues that are not of clinical nature but do have a negative impact on residents are not followed up on. For example, the non compliance found and discussed in Outcome 8 in relation to fire safety management and record keeping.

The 2017 annual review for the service was carried out during the inspection. The review was carried out by the person in charge on the day of inspection. The quality improvement plan presented to the inspector was a summary of the findings highlighted by the inspector throughout the two day inspection. The review was not prepared with in consultation with residents and their families as required by the regulations.

Judgment:

Non Compliant - Major

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Not all aspects of this outcome were inspected. The inspector was satisfied that the action required from the last inspection with regard sufficient details within nursing notes had been completed.

However, the inspector found clear evidence as described in Outcome 18: Suitable Staffing, that the recruitment procedures do not ensure that the requirements of Schedule 2 of the regulations are met. The inspector found evidence that a member of staff who was working within the centre did not have Garda Vetting disclosure prior to commencement of employment.

Judgment:

Non Compliant - Major

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a system in place for the safeguarding of residents' finances and property. The provider was acting as a pension agent for one resident. The centre has a resident only account set up. The management team within the centre confirmed that procedures are in line with the guidelines as set out by the Department of Social Protection.

The inspector found that there were systems in place to safeguard residents from being harmed or suffering abuse. There was a policy dated May 2016 that outlined the procedure to follow for the prevention, detection and response to abuse. Records indicated that staff had received up-to-date training. The centre had a trained member of staff who can deliver the training on safeguarding and safety. The staff who spoke with the inspector were knowledgeable of their training and could describe what they

would do in the event of an allegation, suspicion or disclosure of abuse. Residents told the inspector that they felt safe in the centre.

The systems in place to promote a restraint free environment in line with the national policy was described. A restraint policy, last updated in May 2016 was available. Alternative measures are also available for use. The inspector reviewed files. A consent form was in place. Initial assessment of the need for bedrails had been carried out. However, the frequency of the assessment for the continued need to have bedrails in use required review. The inspector found evidence of a gap of up to 12 months in the reviews carried out to ensure that bedrail restraint is currently required. Records of the duration of restraint and safety checks or releases were recorded hourly.

As previously stated, HIQA had received unsolicited information relating to the poor management of responsive behaviours. There was a policy and procedure in place for managing responsive behaviours dated May 2016. Findings on this inspection relating to the management of responsive behaviours, indicate that a full review is required. The centre currently has multiple residents that have responsive behaviours. The inspector saw that assessments had been completed. The centre had good access to external consultants and a number of specialist community healthcare practitioners visited multiple residents over the two days of inspection. However, the inspector found that the care plans for residents had not been kept under review and there were significant gaps identified within files reviewed. Relevant staff members could not allocate key information that would guide clinical decision making. For example, the record of behavioral charts that are maintained when an incident of responsive behaviour occurs.

Staff who spoke with the inspector were aware of possible triggers of responsive behaviours for residents and could describe the interventions that they would use. However, during the two day inspection the inspector observed that the management of residents shouting and calling out, was in some instances, to isolate the resident. The inspector discussed the instances with the person in charge who spoke with staff. Reassurance was given to the inspector by the management team that isolation of residents will discontinue.

Judgment:

Non Compliant - Moderate

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

Theme:

Safe care and support

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

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

Findings:

The centre has policies and procedures relating to health and safety. The Statement of Safety, Health and Welfare Policy was made available, dated May 2016. The risk management policy required review as it did not include all items set out in regulation 26(1). For example, there was no policy on the management of self-harm. The inspector reviewed the file of one resident with a history of self-harm and the care plan was detailed and comprehensive. There was a risk register available in the centre which was kept under review by the person in charge. Risk was identified and additional controls to minimise any negative impact on residents was also included.

There were fire policies and procedures that were centre-specific. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Each staff member spoken to was familiar with evacuation requirements of residents and confirmed that they had attended fire evacuation drills. The records of the fire drills were reviewed and there was sufficient detail recorded. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Quarterly servicing was carried out and fire safety equipment is serviced on an annual basis. There were records of daily checks on the means of escape to ensure fire doors were not blocked. However, there were multiple examples of fire doors wedged open. The inspector found that the weekly fire alarm activation check had not been carried out since October 2017. On discovering this gap the inspector requested that the fire alarm be tested. The alarm was activated and found to be in working order. However, the test did reveal that the magnetic function in four of the fire doors were not in working order and require maintenance. The inspector was informed that this issue had been escalated to the management team on two separate occasions and to date no action was taken. This was discussed with the person in charge and the management team at the feedback meeting who provided reassurance that a review of the management of fire safety and procedures within the centre will occur as a matter of priority.

Overall the premises, including the communal areas and bedrooms were found to be clean and there was adequate standard of general hygiene at the center. All hand-washing facilities had liquid soap. There were policies in place on infection prevention and control. There was personal protective equipment such as latex gloves and plastic aprons available. Staff interviewed demonstrated adequate knowledge of the correct procedures to be followed. The inspector spoke with household staff who were knowledgeable on the cleaning schedule and the cloth color coded system in place. The daily cleaning schedule is not recorded. The person in charge drafted daily signing sheets and implemented the use of daily recordings during the inspection. The deep cleaning which occurs on a monthly basis is recorded. Residents spoken too confirmed that their rooms are cleaned daily.

Judgment:
Non Compliant - Major

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There were written operational policies dated May 2016 relating to the ordering, prescribing, storing and administration of medicines to residents. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses. The inspector observed that residents' medicines were stored appropriately, including medicines controlled under Misuse of Drugs legislation and medicines requiring refrigeration. Checks were consistently completed of balances of controlled medicines twice every 24 hours and refrigerator temperatures were recorded on a daily basis.

The inspector observed medicine administration to residents on this inspection. Residents' medicines were administered on an individual resident basis. The inspector observed that medicines were administered to residents in line with professional guidelines. Medication reviews occur with the clinical team involving the person in charge, general practitioner and pharmacist every three months or more frequently if required.

There was a system in place for reporting and investigating medication errors or near misses. The inspector reviewed these reports and found that any errors reported were investigated and actions were put in place to mitigate the risk of such errors reoccurring. The person in charge had carried out multiple medicines management audits. All actions were followed up and learning is communicated to the nursing team.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Residents' health care needs are met through timely access to medical treatment. Residents have good access to allied health care services which reflect their different care needs. Evidence was seen that when a resident is admitted, transferred or discharged to and from the centre, the relevant information about their care is shared between providers and services.

A comprehensive and personalised assessment of each resident's health and social care needs is undertaken on admission. The clinical assessments in place are based on evidence-based practice. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Each resident had a care plan in place. From a sample of resident files reviewed, there was evidence of a comprehensive assessment of needs carried out within 48 hours of admission. However, gaps were identified within files that each care plan was not reviewed and evaluated at intervals not exceeding four months as per the regulations. Residents and relatives spoken too during the inspection informed the inspector that they were familiar with care plans and felt they were kept informed of any changes.

The inspector reviewed a number of files specific to the management of wound care. The person in charge had carried out an audit in July and October 2017. Improvements that were recorded as actioned were not sustained. For example, the inspector found that wound care plans are not updated. The required detail on the frequency and type of dressings required to maximise on healing was either not recorded or guidance was not followed.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence of consultation with resident's and their representatives in a range of areas on a daily basis and a formal resident meeting was held frequently. There was evidence that issues raised by the residents were followed up and closed out to their satisfaction.

Residents have access to independent advocacy services. The centre is part of the local community and residents have access to radio, television, newspapers and information. The activity programme within the centre is varied and is changed as per residents' requests. There was evidence of outings and events held within the centre that had been organised and enjoyed by residents.

There was good evidence that residents have the opportunity to participate in activities that are meaningful and purposeful that suits their individual needs and interests. Each resident has a daily activities document and care plan. Each file reviewed had daily entries documenting their participation in an activity. The right to refuse was also respected.

There is a visitors room for residents to receive visitors outside of their bedroom. Overall, the inspector found that there are adequate facilities for occupation and recreation including the opportunity to undertake personal activities in private.

Whilst staff did their utmost to support the rights and dignity of residents, aspects of the premises impacted on the rights and dignity of residents:

- *double room screens in one room did not meet and so privacy during personal care was not assured

- *the storage in some double rooms was inadequate. Residents could not access their personal bedside lockers because they were positioned behind the beds and out of reach.

- *on the first day of inspection the centre did not have adequate bath towels available to attend to the residents' needs.

- *the double room floor space did not allow for residents who have specialised seating requirements to sit at their bedside, if they wished to do so.

- *showers were available but the residents did not have the option to have a bath

- *the inspector observed examples of call bells not within easy reach of residents who were in bed.

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):

No actions were required from the previous inspection.

Findings:

The actual and planned rosters for staff was reviewed. The inspector found that staffing levels and skill mix were sufficient to meet the needs of residents. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. Due to occupancy levels the management team had recently reduced the number of staff on duty. The inspector did not find evidence that the reduction has had a direct negative impact on the care delivered to residents. Residents and relatives spoken to confirmed that they felt their care needs were met by staff. Residents confirmed that their call bell was always answered and felt safe in the centre.

Evidence of current professional registration for registered nurses was seen by the inspector. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Training included in house mandatory training on safeguarding and safety, patient moving and handling and fire safety. The training records evidenced that all mandatory training was up to date.

The centre had a process of staff appraisals in place. However, of the current staffing compliment only fifteen of the forty two staff have had an appraisal completed. The person in charge explained the systems in place to supervise staff. The inspector observed that the supervision of staff required review. This finding is evidenced by the observations made by the inspector on the management of resident behaviour when shouting out as described in Outcome 7 Safeguarding and Safety.

Recruitment procedures do not ensure that the requirements of Schedule 2 of the regulations are met. Of the four files reviewed, the inspector found significant gaps. The management team closed out on some of the gaps identified during the inspection. For example, references from previous employer. However, the inspector found evidence in one file that Garda Vetting disclosure was not received prior to the staff member working within the centre. This is actioned under Outcome 5 Documentation to be kept at a designated centre.

The centre currently has volunteers working within the centre. All volunteers had evidence of Garda Vetting in place. The centre has an agreement on the level of involvement and the role of volunteers within the centre.

Judgment:

Non Compliant - Moderate

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:

Una Fitzgerald
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 report¹

Centre name:	Silvergrove Nursing Home Limited
Centre ID:	OSV-0000162
Date of inspection:	23/01/2018
Date of response:	28/02/2018

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 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

A full review of the detail of the statement of purpose is required to ensure that it accurately describes the service that is provided in the centre.

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

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

A full review of the Statement of Purpose has been undertaken and updates and revisions were completed, with details regarding the care needs of residents and the rooms that can be offered. Specifically, double rooms will only be offered to residents who can transfer independently or with minimal assistance. Currently, some double rooms are in use as single rooms. The review of the Statement of purpose was carried out by the directors of Silvergrove Nursing Home, the Person in Charge (PIC) and the Assistant Director of Nursing (ADON). The updated Statement of Purpose has been submitted to HIQA. Copies of the Statement of Purpose are available for residents and their families.

Proposed Timescale: 28/02/2018

Theme:

Governance, Leadership and Management

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

The management team informed the inspector that the statement of purpose has been kept under review and revised at intervals of less than one year. The statement of purpose does not have a review date documented. HIQA had not been notified of changes made to the statement of purpose.

2. Action Required:

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

The Statement of Purpose has an annual review date. The next review date is 26th February, 2019. The review will be carried out by the directors, the PIC and ADON in consultation with residents and their families, and revisions will be made accordingly. There is ongoing monitoring of services provided and infrastructural requirements throughout the year and these will be referred to in the updated Statement of Purpose annually. The updated review will be submitted to HIQA on completion.

Proposed Timescale: 28/02/2018

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:

The governance and management structure in place does not clearly outline and

identify the lines of authority and accountability.

3. 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:

Silvergrove Nursing Home Limited is the provider

The company directors of Silvergrove Nursing Home Limited are Dr. Mary Boyd, Dr. Louise Boyd and Emily Boyd. The Provider Nominee is Dr. Louise Boyd.

The Person in Charge, Najamol Natarajan, is responsible for managing the centre, and is assisted in this role by the Assistant Director of Nursing, Yvonne McCarney. As the Person in Charge, she ensures the health, safety and well being of the residents and staff, and manages the running of the centre. She ensures that the systems and policies in place and are being adhered to in accordance with the regulations. The PIC performs regular audits of the service provided and makes changes as needed. Audit outcomes, action plans and implantation schedules are discussed with the team and the provider nominee at regular meetings. The Person in Charge reports to the provider nominee, Dr Louise Boyd, and to Dr Mary Boyd Director, on a weekly basis. Documented minutes of these meetings are now being maintained.

Proposed Timescale: 28/02/2018

Theme:

Governance, Leadership and Management

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

Management systems are not in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

4. 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:

Policies regarding health and safety, and fire safety have been reviewed and are in line with current requirements. There is a nominated fire safety officer and all fire safety equipment has been checked to ensure that it is functioning properly. There is a nominated health and safety officer. Meetings with the fire officer and the health and safety officer have taken place to ensure that they are aware of their roles and responsibilities. Risk assessments are carried out on an ongoing basis and any actions that are required are carried out. There are risk management policies in place regarding self harm, aggression & violence, accidental injuries to staff or residents, assault, resident absent without leave. There are systems in place to investigate any incident and prevention and control measures are in place. The provider nominee

reviews the risk assessments on a monthly basis.

The nominated Fire & Safety Officer officer undertakes weekly checks of the fire alarm activation system and is responsible for ensuring that all procedures, documentation and training in compliance with the fire safety regulations. All staff have received fire safety training and a training register is being maintained. A record of weekly fire alarm activation checks is being maintained by the nominated fire and safety officer.

Proposed Timescale: 28/02/2018

Theme:

Governance, Leadership and Management

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

The 2017 annual review for the service was carried out during the inspection. The review was carried out by the person in charge on the day of inspection. The quality improvement plan presented to the inspector was a summary of the findings highlighted by the inspector throughout the two day inspection. The review was not prepared with in consultation with residents and their families as required by the regulations.

5. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

For the annual review, quality of care and the experience of residents in the nursing home are monitored and improved in an ongoing basis, in consultation with residents and their families and improvements made where needed. The annual review is currently being finalised.

We carried out a residents' satisfaction survey in January 2018 as part of the annual review. Questionnaires were issued to residents and their families to get feedback on their experience and any improvements or changes that they would like to see. This has been included in the annual review.

Proposed Timescale: 03/03/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The inspector found clear evidence that the recruitment procedures do not ensure that the requirements of Schedule 2 of the regulations are met.

6. Action Required:

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

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

The recruitment policies and practices of the centre have been reviewed and protocols are now in place to ensure that all staff members have all the appropriate documentation in place, including Garda vetting and references, in place before commencing employment in the centre. All staff currently employed in the centre have the correct documentation in place.

The recruitment procedures have been reviewed and prospective employees do not commence until references and Garda clearance is in place. Staffing issues and recruitment is discussed with the provider nominee and director prior to new staff commencing.

Proposed Timescale: 28/02/2018

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

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

Findings on this inspection relating to the management of responsive behaviours evidence that a full review is required.

7. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

There are systems in place in the centre to promote a restraint free environment. An assessment for use of bed rails is carried out on initial assessment. Re-evaluation of the requirement or request for bed rails will be reviewed four monthly, or more frequently if required. This will be recorded in the residents' care plan. Medication reviews are carried out on a 3 monthly basis and more regularly as required. There is multidisciplinary team input, from the geriatric community liaison team, psychiatry of old age and community palliative care, as well as pharmacy input and GP input regarding pharmacological requirements.

Individual, person centred care plans are in place for each resident, reflecting their personal, healthcare and social care needs. The residents' care needs are monitored and reviewed in an ongoing basis, and care plans are reviewed four monthly or, more frequently. All care plans for dementia and responsive behaviour are in place and will be

reviewed and updated four monthly, as per the regulations, or more frequently, as required.

Isolation of residents is not used as a management measure for responsive behaviour. Staff have received training in responsive behaviour management and care plans are in place for residents individual care needs.

Staff have received training in managing responsive behaviour and in maintenance of care plans and record keeping. Staff are knowledgeable regarding interventions responsive behaviours and behaviour charts are being maintained.

ONGOING

Proposed Timescale:

Theme:

Safe care and support

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

The frequency of the assessment for the continued need to have bedrails in use required review.

8. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

A comprehensive review of the risk management policies and procedures has been carried out and updated to include a policy on the management of self harm to ensure that our policies are in full compliance with the regulations.

The fire safety policy and procedures, and equipment have been reviewed. The nominated fire and safety officer is carrying out and recording weekly fire alarm activation checks. Any faults highlighted are brought to the attention of the person in charge and issues rectified. All staff have undertaken fire safety training and are aware of the proper procedures regarding evacuation procedures fire safety equipment. Household staff are maintaining a record of the daily cleaning schedule. There is a nominated member of the housekeeping team who has been taken on this responsibility.

Proposed Timescale: 28/02/2018

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:

The risk management policy required review as it did not include all items set out in regulation 26(1).

9. Action Required:

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

A thorough review of the policies and procedures of the centre has been undertaken and a comprehensive policy on the management of self harm has been included so that our policies are fully compliant with the regulations. Risk assessments are carried out on an ongoing basis by the PIC or ADON in conjunction with the health and safety officer. There are risk management policies in place regarding aggression and violence, accidental injuries, assault, residents absent without leave and self harm. The maintenance officer has been tasked with performing a specific walk through risk assessment monthly, in addition to his ongoing monitoring of the physical infrastructure. Any risks identified will have a risk assessment preformed and a policy to reduce, prevent or control the risk put in place

Proposed Timescale: 28/02/2018

Theme:

Safe care and support

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

The daily cleaning schedule is not recorded. The person in charge drafted daily signing sheets and implemented the use of daily recordings during the inspection.

10. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

A daily cleaning schedule and register, by means of a daily signing sheet has been commenced on 24/01/2018. All housekeeping staff have been updated regarding this and are aware of their responsibility to comply with this measure. A nominated member of the housekeeping team has taken responsibility for this and the person in charge will review the signing sheets to check compliance.

Proposed Timescale: 28/02/2018

Theme:

Safe care and support

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

An immediate review of the management of fire safety and procedures within the centre is required.

11. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

A full review of the Fire & Safety policies and procedures has been carried out. There is a nominated Fire & Safety Officer who is who is responsible for all procedures, documentation and training to comply with the Fire & Safety Regulations.

A full review of the fire safety equipment has identified some faults which are currently being repaired. A weekly fire alarm and exit door check is being preformed, and recorded, and the monthly check of extinguishers and emergency lighting system is being carried out. Fire evacuation drills are carried out at six monthly intervals and this is being recorded.

Proposed Timescale: 10/03/2018

Outcome 11: Health and Social Care Needs**Theme:**

Effective care and support

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

Gaps were identified within files that care plans are not reviewed and evaluated at intervals not exceeding four months as per the regulations.

12. Action Required:

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

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

An audit of the care plans has been carried out by the person in charge.

The nursing staff have received training on record keeping and person centred care planning. The nursing staff get additional time to complete their care plans. The nursing staff are currently reviewing and updating the residents' care plans to reflect each residents' individual care need. They are supported by the person in charge, and the assistant director of nursing in completing their care plans. Nursing staff are

receiving additional, protected time to complete care plans.
The Assistant Director of Nursing will monitor the on-going review of the assessments and care plans.

Proposed Timescale: 10/03/2018

Theme:

Effective care and support

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

The inspector found that wound care plans are not updated. The required detail on the frequency and type of dressings required to maximize on healing was either not recorded or guidance was not followed.

13. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The person in charge has reviewed nursing care plans and all wound care plans have been updated to reflect each individual resident's wound care needs, with specific reference to the type dressings required and used, and the frequency of dressing changes. Care plans will be reviewed on an ongoing basis and updated according to changing wound care needs. As part of an audit of care plans, shortcomings identified have been rectified and there is ongoing completion of care plans by nursing staff with the support of the ADON and the person in charge. Care plans are being reviewed and assessed by the person in charge and the ADON on an ongoing basis.

Proposed Timescale: 10/03/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Whilst staff did their utmost to support the rights and dignity of residents, aspects of the premises impacted on the rights and dignity of residents:

*double room screens in one room did not meet and so privacy during personal care was not ensured

*the storage in some double rooms was inadequate. Residents could not access their personal bedside lockers because they were positioned behind the beds out of reach.

*on the first day of inspection the centre did not have adequate towels available to

attend to the residents needs

*the double room floor space did not allow for residents who have specialised seating requirements to sit at their bedside

*the residents did not have the option to have a bath

*the inspector observed examples of call bells not within easy reach of residents who were in bed.

14. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

The welfare, health and wellbeing and dignity of our residents is our foremost priority and we are reviewing all systems to ensure that we are operating to the highest standards.

There are adequate supplies of all sizes of towels for all residents and stocks levels will be monitored by a housekeeping staff, and stocks will be replenished as needed.

We have scheduled a meeting with contractors regarding the installation of a bath in order to facilitate residents who request baths. Options for our double rooms are being reviewed, in particular to seating arrangements and storage facilities. All screening curtains in our double rooms have been checked and replaced where necessary with appropriately sized curtains. Regarding double rooms, residents are assessed prior to admission as to the suitability of the nursing home for their care needs, and for residents who may be candidates for double rooms, we ensure that they are independent in moving and transferring, or require minimal assistance so as use of transfer equipment will not be required. Ongoing monitoring of residents care needs takes place and if there are changes in needs rooms may be reassigned.

The positioning of call bells in residents' rooms has been reviewed to ensure that they are accessible to residents. This will be checked on a daily basis by the staff nurses on duty. All staff members are aware that every resident must have access to their call bell in their rooms, and in communal areas.

Proposed Timescale: 28/02/2018

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The centre had a process of staff appraisals in place. However, of the current staffing complement only fifteen of the forty two staff have had an appraisal completed. The person in charge explained the systems in place to supervise staff. The inspector observed that the supervision of staff required review.

15. 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:

There are systems and policies in place to ensure there is adequate supervision of staff. Performance reviews and staff appraisals are being carried out by the person in charge and will be completed by the end of February 2018. Staff appraisals are discussed with the provider nominee completion, and at times, the provider nominee has partaken in staff appraisals. Staff are rostered to reflect the level of care needs of residents to ensure the optimum ratio staff to residents. Staffing requirements are reviewed based on the care levels of residents as well as bed occupancy and are altered as needed.

Proposed Timescale: 10/03/2018