Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	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:	31 May 2018
Centre ID:	OSV-0000162
Fieldwork ID:	MON-0024124

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.

Current registration end date:	06/10/2019
Number of residents on the date of inspection:	22

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
31 May 2018	10:00hrs to 18:00hrs	Una Fitzgerald	Lead

Views of people who use the service

There was a high number of residents within the center who had dementia. The inspector met residents, spent time observing staff and resident engagement. Residents were observed to be content in the environment. The communal room at the front of the center was a hub of activity throughout the day. The inspector spoke with a small number of residents about what their daily lives where like in the center. Overall the feedback was positive. The residents said the staff were kind. Call bells were answered in a timely manner. The feedback on the food served was positive. Residents were satisfied with the laundry service. The residents spoken with were aware of who the person in charge was and said they would not hesitate to make a complaint.

Capacity and capability

The system of governance and management in place on the day of inspection was not effective.

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The focus of the inspection was to monitor progress on the compliance plans required from two previous inspections that took place on 23 January and 14 April 2018. The inspector also followed up on information received which raised concerns about the management arrangements in the centre. The information relates to the appointment of a new management consultant. Staff and residents are unsure what the new role is and have had no communication from the provider as to the purpose of the role. This information was substantiated during the inspection. Judgments of non-compliance in relation to governance and management and risk management found in January and April were repeated on this inspection.

A clearly defined management structure as outlined in the statement of purpose was not in place. The inspector found that the roles, responsibilities and the lines of authority and accountability of each member of the management team were not clear. There was no job description for a new manager/consultant employed by the provider and the inspector found that the management team was not clear on their areas of responsibilities or level of accountability. Effective governance and risk management systems were not established and the inspector was concerned at the lack of effective leadership to prevent and reduce risks and to maintain safe levels of care in the centre.

The inspector found that effective governance and risk management systems were

not established and the inspector was concerned at the lack of effective leadership to prevent and reduce risks and to maintain safe levels of care in the centre.

This judgment was evidenced by:

· The management structure and lines of responsibility and accountability were not clear.

· Repeated non-compliance was found with multiple regulations over the previous two inspections since January 2018.

· The absence of effective communication systems at management level.

· There had been no audits to monitor the quality and safety of the service carried out since the last inspection.

· An Garda Síochána vetting disclosure was not obtained for a new employee as required by law.

· There were major gaps in the documentation to guide clinical care in residents' files.

There were sufficient staff available to ensure residents' needs could be met. The inspector observed that the staff knew residents well and had developed trusting and supportive relationships with them. Staff spoken with said that they felt supported by nursing management. Staff were supported and facilitated to attend mandatory training education sessions.

Regulation 15: Staffing

On the day of the inspection, there were a sufficient number of staff on duty to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was maintained. Minor gaps were noted in the information specified in paragraph (3) of schedule 3

Judgment: Substantially compliant

Regulation 21: Records

The inspector reviewed staff files and found gaps in the documentation with Schedule 2 regulation requirements.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that the roles, responsibilities and the lines of authority and accountability of each member of the management team were not clear. The management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff had completed mandatory training on safeguarding, fire safety and manual handling training. There was evidence that staff appraisals had been completed.

Judgment: Compliant

Quality and safety

The inspector judged the quality of care and lived experience of residents within the centre as not compliant.

The findings of the inspection in January 2018 required actions to be taken to improve care planning and assessment processes to make them more specific and ensure they meet residents' needs.

In April 2018 it was found that a full review of all residents' care plans had been conducted and was found to be compliant. This improvement had not been sustained. The inspector examined the files of new residents and found major gaps

in clinical assessments and care plans. The documentation in place to evidence that residents have received appropriate assessments and ongoing person-centred care did not meet with regulatory compliance.

Clinical leadership and supervision required strengthening to ensure that comprehensive nursing assessments were undertaken when residents were admitted, and that care plans were developed and reviewed to ensure the full needs of all residents were met in a holistic manner. The inspector found that some identified risks, associated with the activities of living, were not fully assessed. These included pain assessments and falls risk assessments. As a result of the gaps identified, the inspector could not ascertain if the care needs of residents were being met. The care plans lacked sufficient detail to support a consistent approach to care delivery.

The centre cared for a high number of residents who had dementia, some of whom had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The inspector reviewed the documentation to guide staff. Behavioural support plans in place were person centred and guided care. Throughout the day the inspector observed that staff engaged with residents in a person-centred way and displayed good knowledge of individual residents and their needs.

Evidence of referral and review by a range of medical and allied health professionals was found with documented visits, assessments and recommendations by psychiatry of later life, dietitian and speech and language therapists. Communication regarding residents with specialist dietary needs required review to ensure that residents' nutritional needs were clearly communicated to relevant staff.

The gaps identified by the inspector in relation to fire safety and emergency evacuation procedures during the two previous inspections were addressed. The compliance plan which the provider submitted following the last inspection to address the regulatory non-compliance had not been implemented in accordance with the timeline the provider had committed to.

Regulation 18: Food and nutrition

Residents were provided with a varied, wholesome and nutritious diet that was properly prepared, cooked and served. Each resident had access to fresh drinking water to meet their hydration needs. Residents were offered a choice of hot meals. The inspector observed that residents were offered regular snacks and refreshments. There were sufficient staff to provide residents with assistance during mealtimes.

A review was required to ensure that residents with specialist prescribed dietary requirements have their needs met.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspector noted gaps in the documentation. All relevant information about the resident was not communicated when a resident was temporarily absent from the centre.

Judgment: Substantially compliant

Regulation 26: Risk management

Hazard identification and assessment of risks throughout the designated centre was not completed. The provider had submitted a compliance plan specific to risk as a result of the last inspection. The inspector could not find evidence that supported progress had been made to managing risk within the centre. It was unclear who had responsibility in the centre to ensure that risk management procedures were compliant with regulatory requirements.

Judgment: Not compliant

Regulation 27: Infection control

The procedures in place for managing the prevention and control of infection were in line with National Standards.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector tracked the files of multiple residents within the centre. There was major gaps noted in the files of newly admitted residents. Residents did not have comprehensive assessments carried out and care plans were not in place to guide staff in how to meet the needs of residents.

Judgment: Not compliant

Regulation 6: Health care

Residents had appropriate access to a GP and allied healthcare professionals. There was evidence that advice received was followed up and appropriate action taken.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Many of the residents presented with responsive behaviours. The documentation and care plans in place were found to be person centred. Staff were observed on multiple occasions throughout the day of inspection, and interactions between staff and residents were observed to be kind and patient. Staff had received training in how to respond and manage behaviour that is challenging.

The centre was promoting a restraint-free environment. There was documentary evidence that all residents who have bedrails in place had hourly safety checks carried out.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to ensure that residents were protected from abuse. Training records confirmed that all staff had received appropriate training. Residents told the inspector that they felt safe.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were aware of their rights, including civil, political and religious rights. Residents had been facilitated to vote in the recent referendum. Advocacy services were available to residents when required.

Progress was made since the last inspection and the inspector noted that new call-bells had been purchased. Throughout the day of inspection the inspector observed

that residents had access to their call-bell. Residents within this centre do not have the option to have a bath. The inspector was informed that plans to install a bath were currently on hold.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 16: Training and staff development	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Silvergrove Nursing Home Limited OSV-0000162

Inspection ID: MON-0024124

Date of inspection: 31/05/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: We have updated the directory of residents to include all the information as required by HIQA. An audit of the directory was carried out on 05/06/2018 and updated accordingly. The directory of resident is fully compliant with the HIQA regulatory requirements.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Staff files have been updated. All staff have Garda clearance and contracts of employment.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The management structure of Silvergrove Nursing Home has been reorganized. An Operations manager has been appointed, who has overall responsibility for the running of the centre. The director of nursing will report to the operations manager. NF 31 has been submitted to HIQA on 15/06/2018. All staff have been informed of this. The statement of purpose will be updated to reflect this and residents and families have been informed. Monthly governance and management meeting are held, with PIC, ADON, operations manager and provider nominee in attendence, with minutes kept onsite.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition:	

Training regarding specific dietary requirements for residents has been scheduled. Information packs from the Irish Nutrition& Dietetic Institute has been obtained and will be used as part of training for staff.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

All movements of residents in and out of Silvergrove are recorded, and retained at the nurses station. Staff have been advised of this and are aware of the requirement to document the information.

Regulation 26: Risk management	Not Compliant

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

A comprehensive risk management policy for the centre has been updated. Monthly safety walkabout of the centre, internally and externally, is carried out and a record of this is retained onsite. The health and safety committee has been restructured, with an external health and safety expert involved. Monthly health and safety committee meetings will be held, commencing in July, minutes of which will be retained on site. The Health and Safety committee are concerned with risk assessment and management. This will also be discussed at the monthly meetings.

Regulation 5: Individual assessment and care plan	Not Compliant

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

A detailed care plan audit has been carried out on 05/06/2018 and all residents have a completed, current individualized, person centered, care plan in place. All staff nurses have received training in care planning and documentation. The director of nursing and the assistant director of nursing monitor care plans to ensure that all assessment and plans are current and completed to comply with regulatory requirements.

Regulation 9: Residents' rights	Substantially Compliant

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

The engineer has visited the centre and has submitted a plan for the installation of a bath tub for residents. We are awaiting responses from builders/providers.

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 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	13/07/2018
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	13/07/23/2018
Regulation 21(1)	The registered provider shall ensure that the records set out in	Not Compliant	Orange	27/06/2018

	Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	13/07/2018
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	13/07/2018
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about	Substantially Compliant	Yellow	27/06/2018

	the resident is provided to the receiving designated centre, hospital or place.			
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 centre.	Not Compliant	Orange	13/07/2018
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	13/07/2018
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	13/07/2018
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/10/2018