Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Elmhurst Nursing Home
Name of provider:	Sparantus Limited
Address of centre:	Hampstead Avenue, Ballymun Road, Glasnevin, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	30 January 2024
Centre ID:	OSV-0000134
Fieldwork ID:	MON-0042082

About the designated centre

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

Elmhurst Nursing Home is located in Glasnevin, Dublin 9. The centre can accommodate 44 residents, both male and female over the age of 18. The centre provides long-term care to older persons, some of whom have a cognitive impairment. Elmhurst Nursing Home is a single-storey building comprising of two units. There are a range of communal areas available to residents, including an activities room, two dining rooms and an oratory. Elmhurst Nursing Home provides long-term care to older persons, and is committed to providing the highest standard of care and support to all residents. Elmhurst Nursing Home cares for residents in an environment appropriate to their needs, where the priority is to preserve their dignity and promote their independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as 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
Tuesday 30 January 2024	08:50hrs to 17:35hrs	Niamh Moore	Lead
Tuesday 30 January 2024	08:50hrs to 17:35hrs	Frank Barrett	Support

What residents told us and what inspectors observed

This inspection took place in Elmhurst Nursing Home in Glasnevin, Dublin 9. During this inspection, inspectors spent time observing and speaking to residents, visitors and staff. The overall feedback inspectors received from residents was that they were happy living in the centre, with particular positive feedback attributed to the staff. Comments included "I would be lost without being in here", "they do their best" and "they have the place spotless". Visitors spoken with were also complimentary of the quality of care that their family members received and the communication from the nursing team. Overall feedback relating to the food and meals provided was positive during the morning of the inspection, with comments such as "the food is nice", "on a whole its good" and "they never bring you what you did not ask for", however inspectors did receive negative feedback relating to the food provided on the day of the inspection which is further discussed within this report.

Shortly after arrival at the designated centre and following an introductory meeting the inspectors completed a tour of the designated centre with the person in charge.

The centre is laid out across a ground floor which contains two units referred to as Elmhurst and Desmond. Residents were accommodated in 44 single bedrooms, all with en-suite facilities. Inspectors observed that residents had personalised their bedrooms with family photos, flowers, plants and other personal items such as blankets and ornaments. Residents told inspectors that they were very happy with their bedrooms, including the view out some of their windows and the cleanliness.

The designated centre had one activity coordinator working in the centre Monday to Friday. Activity schedules were on display where activities were available seven days a week facilitated by carers at the weekends. This schedule was seen to be varied and residents reported to be happy with the activities on offer. Inspectors were told of a recent outing to the Botanical gardens which was facilitated with the assistance of volunteers. In addition, a birthday was celebrated the day prior to the inspection with singing and a cake provided. There was seasonal decoration throughout the nursing home for the upcoming Valentine's Day. Inspectors observed signage displayed which referenced the day was going to be celebrated with a party and live music.

Residents had access to numerous communal spaces such as an oratory, an activity room, day rooms, a dining room, a visitor's room and a hairdressing room. Residents also had access to an enclosed courtyard garden and ample landscaped gardens surrounding the centre. Residents were seen to be supported by the activity coordinator to enjoy a walk on the grounds on the day of the inspection.

Residents could attend the individual dining rooms in Elmhurst and in Desmond, or to have their meals in their bedroom if they preferred. A menu was displayed in the dining room which showed there was three options available for the main meal and

two options for desserts at lunch-time. There was also options available for the tea time meal. Inspectors observed the lunch-time meal served in Elmhurst and was told by three residents that they did not enjoy the chicken option reporting it was "hard" and "dry". Inspectors observed that a number of dinner plates with the chicken option returned to the kitchen almost full. There was fish and chicken curry also on offer on the day of the inspection, however residents reporting to be unhappy, or with plates returning full, were not seen to be offered these options. Instead residents were offered dessert. Inspectors saw that assistance was provided by staff for residents who required additional support and these interactions were observed to be kind and respectful. Feedback related to the food was raised with management on the day of the inspection who committed to responding to it.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). Overall this inspection identified there were some good management systems in place, however the registered provider's oversight was not always identifying and responding to areas for improvement. Inspectors found that further action was required to ensure compliance, particularly in fire precautions which is further discussed within this report.

Sparantus Limited is the registered provider for Elmhurst Nursing Home. There were clear roles and responsibilities outlined with oversight provided by a director from the company, a Chief Executive Officer and a Chief Operations Officer. The person in charge reported directly into the Chief Operations Officer. The person in charge was supported in their role by support from the registered provider group which included access to personnel such as quality, human resources and maintenance teams.

The registered provider had reviewed and revised the statement of purpose within the last year. However, inspectors found that the statement of purpose did not contain all information set out in Schedule 1.

The registered provider had prepared a number of written policies and procedures as required under Schedule 5 of the regulations, however one policy was not available. This is further detailed under Regulation 4: Written Policies and Procedures.

The person in charge has been in post since 2017 and fulfilled the requirements of the regulations. They facilitated the inspection and engaged positively with the

inspectors during this inspection. In addition, they were seen to be well known to the staff team and residents.

Staff spoken with were knowledgeable in infection control measures, safeguarding and fire precautions. Records showed that staff were supported to attend safeguarding training, however a significant number of staff required refresher training in infection control and fire safety.

There was evidence of management systems in place such as a number of management meetings including nursing home forums, quality, safety and service improvement committee, and senior management meetings. Meetings were seen to discuss key areas of service delivery to include occupancy, staffing, restrictive practices, safeguarding, catering and infection control. Areas for improvement were identified such as the requirement for auditing of sluice rooms to occur on a weekly basis. Some meeting minutes were seen to document actions with a person responsible and timeframe identified, however not all were. For example, in the Nursing Home forum of January 2024, areas for improvement have been identified in care planning, reviewing restrictive practices and on fire doors, however there was no time bound plan in place. In addition there was regular auditing seen to occur such as on incidents, complaints, falls, respiratory infections and the environment. However, some items raised in audits were still seen to occur on the day of the inspection and thus inspectors found that auditing was not always leading to quality improvements.

Management systems in place at the centre to protect residents from the risk of fire were reviewed. There was a phased works plan in place to rectify issues identified by a competent consultant. The works were being overseen by the consultant, and were progressing through phases, with Phase one relating to compartmentation upgrades almost complete. Fire safety systems in place at the centre were being maintained and serviced up-to-date. There was a fully addressable fire alarm, and fire extinguishers recently serviced and useable, however, issues were identified with the emergency lighting system. The centre used Personal Emergency Evacuation Aids (PEEPs) to assist staff in evacuation of residents. These PEEPs outlined the assistance required to evacuate each resident in the event of a fire, and included day and night time scenarios. The PEEPs in place were reviewed regularly, however, the assistance required to evacuate bariatric residents living at the centre required further review to ensure the numbers of staff required to evacuate these residents was appropriate. The management of oxygen at the centre required further review. This had come up as an issue in management meetings, however, appropriate measures were not put in place to manage the risk. Inspectors found unsecured oxygen cylinders without any warning notices inside the room of a recently admitted resident. Further rooms where oxygen concentrators were in use, did not have appropriate warning signs in the areas where they were being used. Further fire safety concerns are detailed in Regulation 28: Fire Precautions.

Regulation 14: Persons in charge

The person in charge is a registered nurse and holds the appropriate experience and qualifications to meet the requirements of Regulation 14.

Judgment: Compliant

Regulation 16: Training and staff development

The following gaps were identified in training and staff development:

- 33 per cent of staff required refresher training in fire precautions
- 28 per cent of staff required refresher training in infection control

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had a number of assurance systems in place regarding the quality and safety of the service, a number of areas were identified that required action:

- there was inadequate oversight of oxygen cylinder use. Despite the safe storage of oxygen being raised in a management meeting in December 2023, this had not been actioned and was seen on the day of the inspection. A fire risk assessment referred to controls in place to reduce the risk occurring. However, these controls were not seen to be in place or accurate. For example, it referred to no residents who smoke and oxygen storage to include signage and a safety box.
- the oversight and assessment of the assistance required to evacuate bariatric residents required additional review. Assessments of assistance and the use of evacuation aids for these high dependency residents did not provide assurance that staff at the centre could evacuate the residents using the information, and aids provided.
- the oversight of medication management required review. On the day of the inspection, the medicine fridge had been out of the recommended temperature range on six occasions within the previous two weeks. There was no assurances that appropriate action had been taken to action these discrepancies. In addition, a staff member was unable to detail the correct temperature the medicine fridge should be maintained at.
- the environmental audit of October 2023 identified that fire doors were not kept closed. On the day of the inspection, this was seen to occur for many resident bedroom doors and a door to a store room was held open with a hanger.

- the oversight of mealtimes required review to ensure that feedback from residents regarding the food served was appropriately and timely responded to and actioned.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose did not contain all information regarding the services and facilities provided in the designated centre. For example:

- the statement of purpose did not reflect all facilities provided by the registered provider such as storage facilities
- the statement of purpose did not contain a description either in narrative form or a floor plan of the rooms in the designated centre including their size and primary function. For example, the floor plans did not reflect storage facilities and fire doors which had been removed.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

All but one Schedule 5 policy were available. For example, while the registered provider had a medicines policy, it had not prepared in writing a policy on the handling and disposal of unused or out-of-date medicines.

Judgment: Compliant

Quality and safety

Overall, the quality and safety of care provided to residents was of a good standard. Residents spoke positively about the care and support they received within the designated centre. Staff were observed to be respectful and courteous with the residents. However, improvements were required in some areas of quality and safety to ensure residents' safety, including the premises, infection control and fire precautions.

Residents reported to feel safe and happy within the centre. The registered provider had policies in place to safeguard residents, such as policy for safeguarding vulnerable adults at risk of abuse and a policy on residents' property and personal

money in place. The registered provider was acting as a pension agent for six residents on the day of the inspection. Evidence was reviewed which found that there were appropriate procedures in place to safeguard residents' finances.

There was a policy available to guide staff on Resident Communication effective from October 2023. Inspectors reviewed a sample of care plans on communication and found that where a resident had a specialist communication requirement that these requirements were recorded in their care plan. In addition, there was evidence of appropriate referrals to relevant medical and health care professionals.

Inspectors reviewed the premises, and overall, found the premises to be clean, and warm. There were extensive grounds, with mature gardens and trees to the rear. The setting was tranquil, with farmland and woodland surrounding the centre, while maintaining access and light to the centre. Inspectors noted some issues relating to the layout of the centre, as it did not match the registered floor plans. Further improvement was required to the maintenance of the premises to ensure that it was maintained in line with the particulars set out in schedule 6. Some areas required on going maintenance to address worn surfaces, for example to paintwork in corridors and on door frames. In addition, some cracks were seen on the walls in corridors and in one communal bathroom, and paintwork was seen to be bubbling in the conservatory area. Inspectors were told that the centre was supported by a maintenance team and they were due to have protected time to complete the necessary paint work in the coming weeks. Recent remedial works had occurred to areas such as the female staff and catering staff changing areas, outstanding works were required for the male changing area. These issues are detailed further under Regulation 17: Premises.

The risk management policy provided to inspectors was not in line with the requirements of the regulations set out in Schedule 5, this is further discussed under Regulation 26: Risk Management.

There were a number of good infection control processes within the centre. Overall the centre was clean, with the exception of a few areas that were identified during the premises walk in the morning and actioned by the end of the day. The centre had installed a bed pan washer. There was quarterly infection control meetings and an infection control nurse supported the person in charge. However, there was some wear and tear visible on items of flooring, paintwork, furniture and equipment which may impact on cleaning. In addition, the segregation of dirty and clean items required further oversight. This is discussed under Regulation 27: Infection Control.

Inspectors reviewed procedures in place to protect residents in the event of a fire. Staff were knowledgeable on the procedures to take to evacuate residents, and were familiar with the systems in place at the centre to assist evacuation. Staff spoken to were clear on the methods of evacuation including horizontal movement of residents through compartments, and the use of evacuation aids utilised at the centre including ski-sheets.

Inspectors found that storage concerns at the centre were impacting on fire safety. A storage room near the male changing area was overfilled with building materials,

paint, and timber products. A cleaners store which housed flammable chemicals was a disused cold room which opened onto the corridor. The room did not have appropriate fire detection, and inspectors could not be assured of the containment measures in place to restrict the spread of fire from this room. Externally, there was a large bin storage area a short distance across a path from an exit door from the centre. Adjacent to this bin storage area was a staff smoking shed. The risk of fire associated with bins was heightened by their proximity to this smoking area. The shed itself was a wooden construction, which was poorly maintained. There was not appropriate fire fighting equipment in place at the shed.

Inspectors noted concerns relating to the means of escape at the centre. While the centre was laid out over a ground floor only, and had numerous emergency exits, all external exit doors were locked. Staff on duty had a master key to open the doors on their person at all times during their shifts, however, some of the doors were in poor condition, and the use of keys would result in delays to evacuation which was not reflected in fire drill practice.

Containment concerns were also identified on inspection. Bedroom doors were not fitted with door closers, and while closing the doors in a fire event was clearly part of the procedure, this was not evidenced in fire drills conducted at the centre. Containment issues with doors were also evidenced by large gaps around some compartment doors, issues with smoke seals, and non fire-rated ironmongery fitted to bedroom doors. This resulted in a lack of assurance that the doors would perform to the expected rating in the event of a fire, which gave rise to concerns that containment measures may not be effective to facilitate horizontal evacuation at the centre. Further fire safety issues are detailed under regulation 28: Fire Precautions.

Regulation 10: Communication difficulties

Inspectors found that the registered provider had ensured that residents who have communication difficulties were supported to communicate freely. Requirements were seen to be recorded in person-centred care plans to ensure staff were informed of any specialist needs.

Judgment: Compliant

Regulation 17: Premises

Improvements were required of the registered provider to ensure that the premises is in line with the Statement of Purpose and the floor plans for which it is registered. For example:

- A room within a linen room, which was used for storage of resident materials was not outlined on the floor plans

- Doors within the centre had been removed, or moved in line with advice received from a competent fire safety consultant. The revised positions, of these doors required updating on the floor plans for registration.
- A storage shed in the garden at the rear of the centre was used exclusively for resident materials. This was not on the floor plans of the centre.

Improvements were required from the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:
Some areas of the premises required maintenance attention internally:

- A room which was planned to be used as a hoist storage area, was not complete. There was damage to the walls and floor, and the doors entering this room also required remedial work.
- the internal courtyard garden was poorly maintained with weeds growing within pavement slabs
- bulbs were missing in the ceiling lights within the visitors room, with only one of four fully operational on the day of the inspection
- There was damage to ceilings and walls in a number of areas for example:
    - Cracking to the ceiling in the chapel
    - Damage to the walls in the linen store room
    - Cracks in the walls at compartment doors on the corridor, which had been partially repaired
    - The carpet in the mortuary was in poor condition
    - The walls near the visitors conservatory at the Desmond wing, were water damaged and required repair.
    - The male staff changing area required upgrade, as there were holes in the walls, damaged window, and damaged ceilings in this area.

Inappropriate storage was found at the centre for example:

- The Mortuary had boxes of continence wear stored within it
- Excessive amounts of maintenance material were stored in a room near the male staff changing room. This material was stored haphazardly which made effective cleaning of this area difficult. This was removed by staff on the day of the inspection, however, on removing the items, the floor now visible, was damaged and required maintenance attention.

Judgment: Substantially compliant

Regulation 26: Risk management

While there was a risk management policy in place, it did not meet the criteria of the regulations. For example, it did not contain the following:

- The measures and actions in place to control the specified risks of abuse, the unexplained absence of a resident, accidental injury to residents, visitors or staff, aggression and violence and self-harm
- Arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Judgment: Substantially compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement. For example:

- Storage practices had the potential for cross-contamination. For example:
  - inappropriate use of red alginate (Alginate bags are a high density translucent red polythene bag that are designed to prevent the need to personally handle potential contaminated garments) bags were seen. For example, clean clothing and towels was seen to be stored in red bags.
  - a room which was labelled as storage of clean clothes was seen to store damaged and unclean crash mats along with items such as resident clothing and hip protectors.
- Some items were seen to be in a poor state of repair. For example, the carpet within the mortuary was damaged with areas missing, some furniture in residents' bedrooms was damaged and paintwork was chipped on walls and on door frames. This may impact on the effective cleaning for these surfaces.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While there were some management systems in place to protect the residents from the risk of fire, a number of improvements were required to come into compliance with Regulation 28.

The registered provider was required to take action in order to take adequate precautions against the risk of fire, equipment for example:

- There was inappropriate storage and excessive amounts of combustible materials in a storage room on the corridor at the male staff changing area. This storage included flammable items such as paint products alongside combustible materials such as wood and cardboard. This presented a

heightened risk of fire in this room. Immediate action was taken by the provider on the day of inspection to remove all of the items from this room.
- There were excessive amounts of electrical items plugged into extension leads in the nurses station in the Elmhurst wing. This overloading of electrical outlets increases the risk of fire in the room, where there was significant amounts of paper records, and other combustible materials present.
- Oxygen cylinders were placed in a resident bedroom. These cylinders were unsecured, and no warnings were in place on the doors to alert staff to the use Oxygen in the area. Oxygen enrichment as a result of a leak/rupture of an Oxygen cylinder increases the likelihood of fire in any given area.

The registered provider did not provide adequate means of escape including emergency lighting for example:

- External exit doors were locked at the centre. While it was noted that staff held a master-key to open the doors, this may result in delays to evacuation in the event of a fire, and would delay a visitor, contractor or resident capable of exiting from doing so when they reach the exit doors. This can result in confusion, or delays to evacuation.
- Emergency lighting in some areas of the centre required review, as the directional signage was not illuminated in all areas. For example, there was an exit sign sticker on the wall above a compartment door in the Elmhurst wing. This would not be illuminated and therefore may not be visible in the event of a fire at night. Emergency lighting directional signage was not in place within the dining room of the Desmond unit. An emergency light directional sign was pointing in the wrong direction at the nurses station corridor area of the Desmond unit.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example:

- Fire drills at the centre were not adequate to assure inspectors that staff were practicing evacuation of residents under various scenarios or through the use of evacuation aids in place at the centre. For example:
    - There was no record of a fire drill to reflect the evacuation of the largest compartment at the centre
    - Drills which were being carried out at the centre did not reflect periods of low staffing numbers for example at night
    - Some drills did not record the time taken to evacuate the residents.
    - There was no detail recorded on the drills of the use of ski-sheet evacuation, which is a practice at the centre.
- While it was noted that staff were discussing fire evacuation techniques, and had utilised desktop discussion scenarios which were recorded, this did not reflect the practical issues encountered during physical evacuation trials.
- There was no detail of staff trialling the evacuation of residents with high dependency needs such as bariatric residents. PEEPs identified that bariatric residents would require the assistance of 2 if in bed during an evacuation.

This had not been trialled, and the method of evacuating the residents while in bed was through the use of a ski-sheet. No evidence was available to confirm that the ski-sheet in use for these residents was suitable for use by bariatric residents.

The registered provider did not make adequate arrangements for detecting, containing and extinguishing fires. For example:

- There was no fire detection device present in the storage room near the staff changing area. This room included a chemical storage area which is an increased fire risk.
- Bedroom doors throughout the centre were not fitted with door closers. The closing of doors was not practiced in the centre, as residents bedrooms were noted throughout the centre with the doors open, while the residents were elsewhere. This would mean that effective containment would not be in place if a fire broke out in a room with an open door. A door to the linen room was held open with a wire which was tied to the handle. This wire was removed immediately by staff at the centre. The door closer which had been in place to the oratory door had been removed, and the door left open.
- Non fire-rated ironmongery was identified on doors throughout the centre.
- Some compartment doors were found to have large gapping around the perimeter. For example, cross corridor doors in the Elmhurst unit, dining room door, and doors to exit door lobbies. Doors were also found to have missing smoke seals, vents in a door to a storage room at the staff changing area, and locks and handles removed from a door to a storage room in the Desmond unit.
- An electrical services room, adjoining the servery in the Elmhurst unit, had containment issues. There were services passing through the walls which were not fire sealed. Inspectors could not be assured of the fire rating of the walls in a section of this room, as they were unfinished at the time of inspection. The door had been modified to open out, but the previous hinge placement was not repaired. The jambs of the door also required repair to ensure that the room would adequately contain fire smoke and fumes in the event of a fire.

Improvement was required to ensure that the registered provider made adequate arrangements for evacuating where necessary in the event of a fire, of all persons in the designated centre, and safe placement of residents. For example:

- The external evacuation route from a part of the Desmond Unit required evacuees to travel over a grassed area to reach the assembly point. This would present difficulties for evacuation as the surface was uneven, and may be difficult to move over in times of wet weather. The route would be difficult to use for wheelchair, or mobility aid users, which are resident in the centre.
- An evacuation route from the Desmond unit, was through a conservatory, used as a visitors room, which had a step up to gain entry to the room. The route to the assembly point from this room was outside, and down five steps which had a handrail positioned in the middle of the flight of steps. This reduced the usable width of the steps.

- The procedure for evacuation posted on the walls did not identify the compartment lines within the centre. The plans also did not identify the primary evacuation routes This may cause delays in evacuation where horizontal evacuation is the primary means of evacuation, and due to the revised placement of cross corridor doors, residents, staff or visitors may be unclear as to which doors are the compartment doors.

Judgment: Not compliant

Regulation 8: Protection

The majority of staff had completed safeguarding training and staff spoken with confirmed that they had the appropriate skills and knowledge on how to respond to allegations or incidents of abuse.

The person in charge investigated incidents or allegations of abuse with one open investigation ongoing on the day of the inspection. A sample of care plans were reviewed which evidenced that reasonable measures were in place to protect residents from abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Elmhurst Nursing Home OSV-0000134

Inspection ID: MON-0042082

Date of inspection: 30/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Additional fire training was carried out on 28th February and 6th March. All staff reminded to complete IPC training on HSELand training, and a desktop training session has been scheduled with IPC Nurse. Training compliance has been added as a standing item to the agenda for the monthly NH Forum and for the Training and Development sub-committee for ongoing monitoring of compliance levels.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Oxygen Storage: A suitable storage cage for oxygen cylinders has been ordered and location identified. This will be installed in April. Bariatric residents: The current ski sheets in use are valid up to a weight of 160kg according to manufacture guidelines. A review of residents weights was carried out in February 2024, and all residents are under 120kg. Ongoing monitoring of residents weight as part of monthly MUST score review. Resident PEEPs have been updated to reflect the number of staff necessary for a ski skeet evacuation. PEEPs are reviewed on a monthly basis. Room allocations will be revised on a needs basis, subject to weight	

change or new admission of a resident over 160kg. Fire Drills will now also take into account the evacuation needs of bariatric residents.
Medication Fridges: The clinical pharmacist is reviewing all medication fridges and remedial actions will be taken as required. The daily Safety Pause now includes a reminder to ensure temperatures are within the expected temperate ranges.

Fire Doors: The daily Safety Pause now includes a reminder to all staff members to keep bedroom doors closed, as they are fire doors, when rooms are unoccupied.

Mealtimes: The Catering Manager and Chefs will be invited on an ongoing basis to attend Resident Meetings to engage with the residents around the variety and choice of food/drinks provided. Staff have also been reminded to inform residents of alternative food options if they wish to have something other than whats they order.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
A thorough review of the floorplans to be carried out and the Statement of Purpose list of rooms will be updated. The small storage room within the linen room will be added on the floorplans. The inner corridor doors will be removed from the floor plans. This will be completed by 31st March.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Statement of Purpose and floor plans will be revised to include issues highlighted in the report. This will include:
• Adding Linen room internal storeroom
• Removal of inner corridor doors
• Adding storage shed in perimeter garden,
• Adding smoking shed in Elmhurst inner courtyard
• Any other identified errors/changes

The current staff smoking shelter is being taken out of service. A facility improvement plan will include reviewing smoking facilities. Any changes will be reflected on the floorplan and SOP as necessary.

The general environment maintenance programme is ongoing and will include:

• Ongoing painting works. Communal areas have been completed.
• Repair of cracking and damage to ceiling in chapel
• Works to hoist Storage room
• Repair of damage to walls in linen room
• Repair of cracks in the walls beside compartment doors on corridors
• Water damage on walls in Desmond visitor room/conservatory
• Maintenance to walls, windows & ceiling in the male changing room
• Repair/replacement of the floor in storeroom (off male changing room)
• Maintenance works to internal courtyard. An external contractor has provided a quote for this work.
• Refurbishment works to the bin store area.

Bulbs in visitors room have been replaced. Staff are reminded and encouraged to log onto maintenance portal.

In terms of storage, incontinence wear has been relocated to the storage shed from the mortuary and the use of the mortuary is under review.

PIC to carry out monthly spot checks of appropriate storage. The NH Forum and Support Services forum will monitor progress with the action plan above.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Policies were in place to cover all identified areas in the regulation however they did not specify risk management in the title. These policies have since been revised and the reviewed by the policy committee and approved by the executive. The policies now specify "Risk management" in the title e.g. "Risk Management: Safeguarding Policy", Risk Management: Reporting & Managing Incidents".

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The IPC Nurse has completed staff education on the appropriate usage of alginate bags (red) for disposal of soiled clothes. Reminders have been issued by local management regarding only clean clothes being stored in the clean clothes storeroom opposite the linen room and appropriate storage in general. The PIC will monitor same through spot

checks.

Damaged crash mattresses have been disposed of. A chair replacement programme is underway. Painting of bedrooms including walls and door frames is part of the current maintenance programme as identified above.

Ongoing IPC clinical audits are conducted to ensure compliance with infection prevention and control measures. Actions plans are monitored by the IPC nurse and reviewed by PIC.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

A full Fire Risk Assessment is being completed for the centre by our Fire Consultant.

Storerooms were cleared on day of inappropriate storage and all store rooms have since been reviewed and are monitored by the PIC.

Electrical items in nursing station have since been audited. Extra sockets are being put in place.

Inappropriate storage of combustible items near the male changing rooms has been removed.

Oxygen storage: Inappropriate oxygen has been removed from the resident's bedroom. Oxygen cages have been ordered for secure storage of oxygen and is expected to be installed by end of April 2024. Signage ordered for oxygen and temporary signs are currently in place.

A full audit of the fire doors has been carried out to include items identified including door closers and costings have been provided in the region of €40K. A submission is being made under the Nursing Home Resident Safety Improvement Scheme grant. We are working with our Fire Consultant to identify priority doors for this year and €20K has been allocated to this year's budget for completion of door works. All works will be monitored by the Health & Safety Committee and NH Forum.

Two residents have been identified as at high risk of absconscion based on individual Dewing Wandering Risk Assessment Tool. As a result, the PIC has identified it as a high risk to have keys available by exit doors. Therefore all staff are requested to carry a master key to open any door in the unit, and this is monitored by the PIC.

Emergency lighting was upgraded in the centre in 2022. A new emergency light will be installed in Desmond dining room. A directional emergency sign which is pointing the incorrect direction, outside the nurses' station, has since been removed.

Early morning fire drills were completed 8th February 2024 with nighttime staffing levels. These will be repeated to improve on the time taken by end of April 2024. The time taken to fully evacuate will be recorded. A full evacuation exercise is being scheduled for the centre to include both units, for completion by end of April 2024.

The current ski sheets in use are valid up to a weight of 160kg according to manufacture guidelines. A review of residents weights was carried out in February 2024, and all residents are under 120kg. Ongoing monitoring of residents weight as part of monthly MUST score review. Resident PEEPs have been updated to reflect the number of staff necessary for a ski skeet evacuation. PEEPs are reviewed on a monthly basis. Room allocations will be revised on a needs basis, subject to weight change or new admission of a resident over 160kg. Fire Drills will now also take into account the evacuation needs of bariatric residents.

A fire detection device is being installed in the cleaners room.

Electrical services room containment issue is now fixed.

The daily Safety Pause now includes a reminder to all staff members to keep bedroom doors closed, as they are fire doors, when rooms are unoccupied. Staff have received training on the inappropriate practice of wedging fire doors open. The HCA Team Leader now carries out a morning review of all doors throughout the centre to ensure no wedges are being used.

Updated procedures for evacuation of the centre will be posted on walls to identify compartment lines and evacuation routes.

Costings have been obtained for garden work outside the Desmond unit to include issues identified. Existing fire exits being reviewed with consideration of getting new paving laid to improve the surface of the exit route. Steps which are part of the escape route through the Desmond visitor/conservatory room are under review and repair works to be identified.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	31/08/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2024

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.	Substantially Compliant	Yellow	30/04/2024
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	13/03/2024
Regulation 26(1)(c)(ii)	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 unexplained absence of any resident.	Substantially Compliant	Yellow	13/03/2024
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	13/03/2024
Regulation 26(1)(c)(iv)	The registered provider shall	Substantially Compliant	Yellow	13/03/2024

	ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	13/03/2024
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	13/03/2024
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	30/04/2024

Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/03/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/04/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	30/04/2024

	evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/04/2024