Health Information and Quality Authority Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Esker Ri Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000733</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Kilnabinnia, Clara, Offaly.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>05793 30030</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@eskerri.com">info@eskerri.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Clara Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Sheila Maher</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Siobhan Kennedy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Sheila Doyle</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>78</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
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.
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 Quality 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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 09 February 2016 13:00
To: 09 February 2016 18:00
From: 10 February 2016 09:30
To: 10 February 2016 15:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

The purpose of the inspection was threefold:

- To follow up on unsolicited information received by the Health Information and Quality Authority (the Authority). This alleged poor practice in relation to the delivery of care to residents, management of complaints and insufficient staffing levels to meet the needs of residents.
- To examine an application to vary the registration of the centre, which entailed changing the use of a room (formerly referred to as the physiotherapy room) for use as a twin bedroom. This would increase the number of residents the centre can accommodate from 78 to 80.
- To meet and assess the fitness of a recently recruited staff member as a person participating in management.
From an examination of documentation, communication with staff and residents and observation of practices the inspectors did not find evidence to substantiate the allegations highlighted in the unsolicited information.

Residents and staff were positive in their comments regarding the receipt and delivery of care. There was evidence of good nursing care and appropriate medical and allied health care. Each resident had an individual care plan that reflected residents’ ongoing and changing needs, interests and capacities.

The inspectors found that there were policies, procedures systems and practices in place for the management of complaints. The complaints policy was publicised throughout the designated centre and residents who communicated with the inspectors were aware of the process and some identified the person with whom they would communicate an issue of concern. The complaints log highlighted satisfactory resolution of complaints. It was noted that an issue had been investigated, however, it had not been recorded in the complaints log.

Inspectors found from an examination of the staff rosters, communication with staff on duty and residents that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents.

Staff who communicated with the inspectors were knowledgeable of the legislation and standards governing the provision of care in the nursing home. They could describe and explain residents’ conditions, treatment plans, social and recreational preferences and day-to-day routines.

The premises was suitably designed and laid out to meet the needs of the residents and it was maintained to a high standard.

Inspectors saw that the newly refurbished twin room was spacious and had en suite facilities. Appropriate screening is due to be installed and the provider agreed to forward to the Authority and up-to-date statement of purpose to reflect the additional accommodation.

Governance and management of the centre was satisfactory. The provider and person in charge were on duty and facilitated the inspection process. However the annual review of the quality and safety of care was not available to the inspectors and this merited a judgment of major non-compliance. Matters arising (4 actions) from the previous inspection in 15 December 2014 were reviewed. three action plans were completed and one action was not satisfactorily addressed. The information on staff working at the centre (schedule 2 of the regulations) and training of staff did not meet regulatory requirements. Not all staff had participated in training in the protection of residents from abuse, this was a recurring issue.

A recently recruited staff member has been designated as a person participating in management. This person met with inspectors and performed well at interview.

The centre was primarily not in compliance with the Health 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. Of the 13 outcomes there was compliance in 5 outcomes, moderate non-compliance in 6 outcomes and major non-compliance into 2 outcomes. The noncompliances related to governance and management, safeguarding and safety, health and safety, health and social care needs, safe and suitable premises, complaints procedure and staffing.

These are outlined in the action plan of this report.
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 Quality 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 detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations.

In respect of the application to vary the registration the provider was aware of the need to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Inspectors advised the provider to forward to the Authority an updated statement of purpose with the proposed increase in numbers to be accommodated in the centre (from 78 to 80 residents).

Judgment:
Compliant

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:**
Governance and management of the centre was satisfactory.

The provider is a registered general nurse with many years of experience of working with older people. She was on duty throughout the inspection and facilitated the inspection process by being available to the inspectors and providing information and documentation.

The inspectors found that there was a clearly defined management structure that identifies the lines of authority and accountability, specifies roles and details responsibilities for the areas of care provision. This was outlined in the statement of purpose, and staff were familiar with their duty to report to line management.

Residents and staff who communicated with the inspectors during the inspection were positive in respect of the provision of facilities and services and considered that there were sufficient staff on duty to meet the needs of residents. They highlighted that efforts were made to ensure that there was good communication between staff and residents and/or their representatives.

The registration of the designated centre was carried out in 3 phases and the provider had a plan with regard to recruiting adequate staff to meet the needs of the residents being accommodated. However the provider explained to the inspectors that not all of the staff recruited had remained in employment in the centre. This resulted in ongoing recruitment. Currently the staffing compliment is made up of staffing working full-time and a number of staff who work in the centre on a part-time basis (relief staff).

All the staff who communicated with the inspectors were aware of residents’ needs and conditions, confirmed that they participated in handover and general meetings in order to communicate residents’ needs to incoming staff and were satisfied that they work as a staff team in order to provide consistent care to residents.

The provider informed the inspectors that all incidents/accidents were reviewed and if necessary, corrective action taken to mitigate against the risk of re-occurrence of the incident.

There was evidence of consultation with residents and their representatives in a range of areas, for example, the assessed needs of residents, the care planning and review process, involvement in social and recreational activities and meals provided.

Although audits were carried out and analysed for example in relation to accidents, complaints and skin care a report of an annual review of the quality and safety of care was not available to the inspectors. This merited a judgment of major non-compliance

**Judgment:**
Non Compliant - Major
### Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors read the Residents' Guide and noted that it met the requirements of the Regulations. It was available to all residents and there were additional copies in the front hall.

Inspectors read a sample of completed contracts which had been agreed with each resident. This had been identified as an area for improvement at a previous inspection. Inspectors noted that the contracts included details of the services to be provided and the fees to be charged.

**Judgment:**
Compliant

### Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The centre was being managed by a suitably qualified and experienced nurse who has authority and is accountable and responsible for the provision of the service.

She is a registered psychiatric nurse, has experience of working with older persons and works full time.

During the inspection she demonstrated that she had knowledge of the regulations and Standards pertaining to the care and welfare of residents in the centre.

She is supported in her role by nursing, care, administration, maintenance, kitchen and
housekeeping staff, who report directly to her and she in turn to the registered provider.

The person in charge and the staff team including the proprietor/registered provider had facilitated the inspection process by providing documents and had good knowledge of residents’ care and conditions. Staff confirmed that good communications exist within the staff team and residents highlighted the positive interactions and support provided by the entire team.

**Judgment:**
Compliant

---

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
In the main, inspectors found that the records listed in the legislation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. However, the following records were not comprehensively maintained.

- The information to be held in respect of some members of staff as per schedule 2. For example, a full employment history, together with a satisfactory history of any gaps in employment and necessary references.
- The directory of residents did not include all the information specified in Schedule 3.
- Records of supervision of residents identified inaccurate information and in some instances a "block" signature was noted that was not in accordance with the designated centre’s policy.
- A record of all money or other valuables deposited by a resident for safekeeping was maintained, however, there were gaps in the documentation, for example in some instances residents were not given a receipt for monies lodged and the signatures of 2 staff were not always available.
- A record of complaints was available, however inspectors were informed of a complaint which had not been investigated in accordance with the centres policy but the issue had been recorded.
The registered provider confirmed that all the written operational policies as required by schedule 5 of the legislation were available. Inspectors found the policy in relation to residents’ finances and personal possessions was not up-to-date and the policy in respect of the protection of residents from abuse was not in accordance with the national policy as the guidance did not reference the dedicated officer's role.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 06: Absence of the Person in Charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The provider/person in charge was aware of the responsibility to notify the Chief Inspector of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her/his absence.

A recently recruited staff member has been designated as a person participating in management. A fit person interview was carried out by the inspectors and found to be satisfactory.

This staff member will deputise in the absence of the person in charge. The staff member is a nurse with a minimum of 3 years experience in nursing older people with in the previous 6 years and has experience of providing care to older people.

**Judgment:**
Compliant

---

**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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Measures were in place to protect residents from being harmed or suffering abuse.

There was a policy which provided guidance for staff to manage incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences. See outcome 5 and the action plan for further information.

Staff members confirmed that they had attended training and they were knowledgeable about the protection of residents from abuse. They described the various types of abuses and their duty to report any incident about actual, alleged, or suspected abuse. However an examination of the training records showed that all staff had not participated in training and this matter was identified during the previous inspection.

Great emphasis was placed on residents’ safety and the inspectors saw that a number of measures had been taken to ensure that residents felt safe while at the same time had opportunities for maintaining independence and fulfilment. For example there was a keypad lock on the main entrance to ensure the safety of vulnerable residents. This enabled resident to move around freely within the centre.

The person in charge clearly demonstrated her knowledge of the designated centre’s policy and was aware of the necessary referrals to external agencies.

Inspectors reviewed the procedures in place for responding to behaviours that challenge. Training had been provided to staff and additional training was planned.

There was a policy in place which provided guidance to staff. Inspectors read a sample of care plans and saw that behaviour assessments had been completed. These included details of possible triggers and interventions. During the inspection staff approached residents with behaviour that challenged in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. Additional support and advice were available to staff from the psychiatry of later life services and the psychiatric services.

A restraint-free environment was promoted and inspectors were satisfied that appropriate risk assessments were in place and there was evidence that alternatives had been considered before restrictive devices were used. Alternatives available included low-low beds, crash mats, sensor alarms and various other equipment. Regular checks were carried out when bed rails were in use. The use of any restrictive device was reviewed on a daily basis.

Small amounts of money were managed for some residents at their request. Inspectors were satisfied that this was managed in a safe and transparent way and the procedures in place were guided by a policy. Additional measures were being implemented at the time of inspection to make the system more robust. This included providing paper receipts to relatives for monies received.
**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):**
No actions were required from the previous inspection.

**Findings:**
In the main, inspectors found that the health and safety of residents, visitors and staff was promoted and protected. There was a risk management policy and procedure and a risk register, however, inspectors found free standing screening in twin bedrooms had not been risk assessed for use by residents and were inadequate in providing sufficient screening. See outcome 12 for action plan.

Infection control precautions within the centre were satisfactory with the exception of the risk of cross infection posed by residents' sharing towels. Residents’ towels were placed on the grab rail located beside a toilet and there was no distinction between residents’ towels in the en suite of the twin rooms.

The centre was clean and household staff were able to describe the infection-control procedures in place. Hand sanitisers were strategically placed throughout the designated centre and staff and visitors were observed by the inspectors using them.

The inspectors saw that generally fire safety precautions were in place. For example these included the installation of a fire panel, fire fighting equipment which was inspected at appropriate intervals and personal emergency evacuation plan (PEEP) for each resident that identified the resident's mobility levels and requirements for assistance in the event of an emergency evacuation either during the day or night time.

In general fire doors were fitted with electronic or magnetic hold open devices which would close in the event of an emergency situation however, inspectors saw that some of these fire doors were held open and therefore would not close in the event of an emergency and other fire doors were held open but were not connected to the fire alarm system.

There was evidence that fire drills were conducted as part of staff fire safety training. However, not all staff had participated in this training.

**Judgment:**
Non Compliant - Major
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found that action required from the previous inspection relating to appropriate assessments had been completed. Relevant assessments such as falls risk assessments and nutrition assessments had been completed and reviewed at regular intervals.

Each resident’s wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical and allied health care. However the arrangements to meet each resident’s assessed needs were not consistently set out in an individual care plan and there was no documented evidence that residents or relatives were involved in the development or review of care plans.

Inspectors reviewed a sample of care plans and saw that in some cases they had not been updated to reflect the recommendations of various members of the multidisciplinary team. For example inspectors saw that a resident had been referred to a speech and language therapist (SALT) which resulted in specific recommendations being made regarding providing assistance with meals, however, the care plan had not been updated to reflect this.

Inspectors reviewed the management of a sample of clinical issues and found they were well managed. Audits were carried out to ensure that the documentation was comprehensively completed. Inspectors saw that following a recent audit, efforts were underway to ensure that the care plans were more person centred and resident specific. A resource folder was developed to assist nurses with this.

Residents were satisfied with the service provided. They had access to general practitioners (GPs) services and out-of-hours medical cover was provided. A full range of other services was available on referral including occupational therapy (OT) services, chiropody, dental and optical services. Physiotherapy services were available on site. Inspectors reviewed residents’ records and found that some residents had been referred to these services and results of appointments were written up in the residents’ notes.
Weight management is detailed in Outcome 15.

Residents were seen enjoying various activities during the inspection. Each resident’s preferences were assessed using templates such as ‘My day, my way’. This information was used to plan the activity programme.

Judgment:
Non Compliant - Moderate

---

**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The location, design and layout of the centre was suitable for its stated purpose.

The designated centre is single floor, purpose built and currently there are 70 single en suite rooms and four twin en suite rooms located in three distinct areas.

The provider submitted an application to the Authority to vary the registration of the designated centre by reconfiguring a room previously designated for use by physiotherapy to be used as a twin bedroom for residents. This would increase the number of residents to be accommodated in the designated centre by 2 resulting which would give a total capacity of 80 beds.

This bedroom has en suite facilities and is fitted with two low -low beds and ample furniture including a lockable space. Currently the screening between the single beds is inadequate, however, the provider told inspectors that appropriate screening will be installed.

In addition inspectors noted that screening in the shared/ twin rooms is portable and required manoeuvring into place if needed. It was insufficient in length and width to ensure that residents' privacy and dignity was protected.

Otherwise inspectors found that the premises met the requirements of the Regulations. The centre is maintained to a high standard. A variety of communal day and dining spaces were provided. These rooms were bright with large windows and tasteful
decoration. In addition there was a fully equipped kitchen. The corridors were wide to allow residents to easily move about when using assistive equipment such as walking frames and wheelchairs. Handrails were provided in all corridor areas to promote independence. There was a call bell system throughout the premises.

There were assisted toilets and bathrooms throughout the premises located along corridors and near communal areas. There were several fully equipped sluice rooms. Other areas included a laundry, activities rooms, hair dressing salon and an oratory. Staff facilities were located on the first floor.

There was adequate storage space provided to ensure that equipment and assistive devices were stored in a safe and discreet manner. Adequate arrangements were in place for the disposal of general and clinical waste.

There were several internal courtyards and extensive grounds around the centre. Ample parking was provided.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 13: Complaints procedures**

*The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The Authority was in receipt of unsolicited information which alleged poor practice in relation to the management of complaints.

The inspectors did not find evidence to concur with this viewpoint.

Inspectors saw that there were policies, procedures systems and practices in place for the management of complaints.

The complaints procedure was publicised throughout the designated centre and residents who communicated with the inspectors were aware of the process and some identified the person with whom they would communicate with if they had an issue of concern.

The procedure identified the nominated person to investigate a complaint and the appeals process.
The inspectors examined the complaints record and found that the procedures were followed and records highlighted the outcome for the complainant.

Inspectors heard from the provider that a resident communicated with a relative that on one occasion the resident’s emergency alarm was not responded to by a particular staff member. Management investigated and addressed this matter from a workforce prospective but did not initiate the complaint policy/procedure on behalf of the resident.

Judgment:
Non Compliant - Moderate

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors were satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

Residents’ dietary requirements were met. Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition on admission and were regularly reviewed thereafter. Weights were also recorded on a monthly basis or more frequently if required. Food diaries were completed for residents who appeared to have reduced appetites and records showed that some residents had been referred for dietetic review. The treatment plan for the residents was recorded in the residents’ files. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

Inspectors saw that the menu which was on a four-week cycle had been reviewed by a dietician to ensure that it was sufficiently wholesome and nutritious. Any recommendations made by the dietician were implemented.

Inspectors saw that snacks and refreshments were available at all times. Although most residents went to one of the dining rooms they had a choice as to where to have their meals. The person in charge discussed recent changes which included having two sittings for tea time which ensured adequate assistance was available for residents who required it.
A coffee dock was available in the front hall. Inspectors saw that it was a popular spot with residents and relatives. At tea time, inspectors noted one family sitting with their relative and enjoying pancakes.

The catering staff discussed on-going improvements in the choice and presentation of meals that required altered consistencies. Inspectors saw that in the main residents who required their meal in an altered consistency had the same choices as other residents.

All residents who shared their views with the inspectors commented on the availability of homemade cakes and desserts.

**Judgment:**
Compliant

---

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The matter arising from the previous action related to insufficient opportunities for staff to participate in relevant training. This matter had not been satisfactorily addressed. While there was evidence that staff had participated in training, inspectors noted that there were some gaps in the training records, for example, in relation to fire safety training and the protection of residents from abuse.

See action plan outcome 7 and 8.

The Authority was in receipt of unsolicited information which alleged the following:
- inadequate staffing levels to meet the needs of residents
- some staff working in other facilities
- staff members involved in the direct provision of care not working collaboratively
- inequitable distribution of workload
- some staff working 12 hour shifts up to 13 consecutive days
- staff sleeping during night duty and removing resident’s call bell and
• staff nurses taking their break at the same time leaving no nurses to attend to residents.

From communication with residents and staff the inspectors found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. The inspectors were informed that initially it was difficult to recruit and retain appropriate staffing. However, currently the designated centre has permanent core staff supplemented by additional staff working part-time (relief staff).

On the day of the inspection the following staff were involved in direct care of residents:

• During the morning and afternoon the person in charge, 3 nurses and 12 care staff. The staff nurses worked from 08.00hours to 20.00hours.
• From 15:00 hours to 20:00 hours care staff members are reduced to 10, however, the provider informed inspectors that it is hoped that this will be increased to 11 care staff members as a result of ongoing recruitment.
• Two nurses and 5 carers are rostered to work during the night from 21:00 hours to 08:00 hours. The provider informed the inspectors that care staff members will increase to 6 on night duty following further recruitment.

In addition ancillary staff consisted of activity therapists, physiotherapist, senior management, catering, cleaning and laundry, administration and maintenance staff.

The provider and some relief staff members who communicated with the inspectors acknowledged that they work in other local facilities in addition to this designated centre, however, the working hours are within the working time directive. The designated centre underwent an audit from a public body with responsibility for the workforce and this matter had not been highlighted as a matter of concern.

Staff nurses and senior care staff explained to the inspectors the processes and procedures for supervising and allocating staff. As a principle staff were allocated to residents in order to provide consistent care, however, staff were agreeable to work throughout the 3 units of the designated centre. Staff members refuted that there was any issues in relation to inequitable distribution of workloads. They confirmed that the morale in the centre is good that some staff members put this down to individual members working as a team.

Staff members also refuted the allegation that residents’ emergency alarm bells were removed at night time (with the exception of the incident highlighted in outcome 13) or that staff were sleeping on night duty. Inspectors heard residents’ alarm bells sounding and noted that they were promptly responded to by staff. However, management did not have a robust system in place to monitor or supervise staff on night duty.

None of the staff worked 12 hour shifts up to 13 consecutive days.

The person in charge confirmed that on one occasion staff nurses took their break at the same time, however since it was highlighted the practice has ceased.

The provider and person in charge informed the inspectors of the importance of recruiting competent, confident and caring staff who have a person centred approach to
the provision of resident care. There were arrangements for the supervision and development of staff which included induction, probationary period and an appraisal system. Some staff who were recruited no longer work in the designated centre.

The inspectors saw that management have maintained records in relation to staff recruitment and note that the staffing levels have become more stable during this year. The provider informed inspectors that recruitment is ongoing.

Recently a clinical nurse manager (CNM) has been appointed and will be responsible in consultation with the person in charge and provider for the supervision of staff.

Inspectors saw that residents chose the time that they wished to get up and seek assistance with personal care and dressing and this was facilitated by the care team. Some residents in discussions with the inspectors confirmed that staffing levels were satisfactory and that staff were supportive and helpful. Residents were full of praise for the staff team and spoke highly of their ability to deliver care in a friendly and supportive manner. Inspectors observed staff interacting with residents and this was carried out in a respectful manner.

Staff who communicated with the inspectors demonstrated that they had a good knowledge of the residents in the centre and were familiar with the standards underpinning residential care.

**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:**

Siobhan Kennedy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Esker Ri Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000733</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>09/02/2016 and 10/02/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26/02/2016</td>
</tr>
</tbody>
</table>

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority had not been compiled and therefore a copy of the review had not been made available to residents and the inspectors.

1. Action Required:

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
A review of the quality and safety of care delivered to residents from May 2014 to February 2016 is currently being processed.

**Proposed Timescale:** 30/03/2016

---

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy and procedure in respect of residents' finances and personal possessions was not up-to-date and the policy in respect of the protection of residents from abuse was not in accordance with the national policy.

**2. Action Required:**
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Receipt books in all three nurses stations for out of hour use. [CNM and Staff Nurses aware of same].
Policy updated.

**Proposed Timescale:** 04/03/2016

---

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The directory of residents had not been maintained in accordance with the schedule.

**3. Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All records were not being maintained in accordance with the regulations as follows:
– information in relation to staff working at the designated centre (schedule 2)
– records pertaining to the supervision of residents and
– records of residents’ finances.

4. **Action Required:**
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

**Please state the actions you have taken or are planning to take:**
All Staff records have been updated.
Training dates :
Fire - Feb 15th - Feb 26th- March 1st [ongoing training monthly].
M/Handling –Tues 15th March –[onsite trainer].
CPR – Feb 19th –March 2nd – [ongoing training].
Elder Abuse – March 7th –[onsite trainer –ongoing monthly].
Challenging behaviour – Feb 8th –Feb 29th –April 4th [ongoing bookings ]
End of Life workshop with Irish Hospice Foundation ;Feb 23rd –April 6th –[ongoing bookings ].
Dementia awareness training [2 day programme] : March 14th –March 29th.[ongoing bookings ].

15-30 minute checklist has been reviewed and updated.Spot checks are being carried out daily by the Staff Nurses,same will be audited.

All residents finances updated.

Proposed Timescale: 30/03/2016

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff had not participated in training in the protection of residents from abuse.
5. **Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
All Staff have attended Elder Abuse training.
Ongoing training: Next date March 7th [and monthly thereafter for updates].

**Proposed Timescale:** 26/02/2016

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Infection control precautions had not been taken as clean towels were placed on the grab rail located beside a toilet and there was no distinction between residents’ towels in the en suite of the twin rooms.

6. **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:**
Tracking rails for curtains have been installed around each bed in the five double rooms.
two towel rails - two mirrors - two shelves have been installed in each double bathroom.

**Proposed Timescale:** 26/02/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Suitable precautions in relation to fire safety had not been taken as some fire doors fitted with electronic or magnetic hold open devices were held open and therefore would not close in the event of an emergency situation.

Other fire doors were held open but were not connected to the fire alarm system.

7. **Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the
risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Magnets have been fitted to dining room doors.
Door closers to be fitted to the office doors and hair salon.

Proposed Timescale: 30/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not participated in fire safety training.

8. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
All Staff will have completed Fire Training for 2016 by March 1st.
Training booked for March 1st.

Proposed Timescale: 01/03/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements to meet each resident’s assessed needs were not consistently set out in an individual care plan.

9. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Care plans are being reviewed and updated.
Proposed Timescale: 30/03/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of resident or relative involvement in the development or review of the care plans.

10. 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:
We have commenced the production of a resident leaflet to explain care plans. All care plans are being reviewed and updated to reflect resident family input.

Proposed Timescale: 30/03/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate screening in the shared/twin bedrooms including the twin bedroom for which variation of registration is being sought.

11. Action Required:
Under Regulation 17(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
Curtain tracks have been installed in each double room. Awaiting curtains same ordered.

Proposed Timescale: 10/03/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although a complaint was investigated and addressed from a workforce prospective, management did not initiate the complaints policy and procedure on behalf of the resident.

12. **Action Required:**
Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

**Please state the actions you have taken or are planning to take:**
All complaints will be logged and investigated as per policy.

**Proposed Timescale:** 26/02/2016

---

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Senior management did not have a mechanism for the supervision of night time staff.

13. **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:**
- Night time auditing has commenced.[by Management].
- Call bell system currently being updated to monitor response to call bells.[same to be audited].
- CCTV system to be updated which will enable Provider/PIC to access same out of hours/when not on the premises

**Proposed Timescale:** 30/03/2016