Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Esker Lodge Nursing Home
Centre ID:	OSV-0000135
Centre address:	Esker Place, Cathedral Road, Cavan.
Telephone number:	049 437 5090
Email address:	vicky@eskerlodgenursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Esker Lodge Limited
Lead inspector:	PJ Wynne
Support inspector(s):	Nuala Rafferty
Type of inspection	Unannounced
Number of residents on the date of inspection:	69
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
12 October 2017 15:20	12 October 2017 22:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection was carried out as a result of a review of notifications and unsolicited information received. The inspection focused on the safeguarding measures in place to protect residents. The governance systems in the centre were fully reviewed on the last inspection and found to be compliant. There is an effective governance structure with accountability for the service clearly defined and reflective of the statement of purpose. The deployment of resources with forward recruitment and contingency arrangements to manage unplanned absences was found on this inspection. A safe service was provided to residents with appropriate supports and care available.

There were effective and up to date safeguarding policies and procedures in place. The safeguarding policy is based on the Health Service Executive's National Policy on 'Safeguarding Vulnerable Persons at Risk of Abuse 2014'. The provider had completed a train the trainer course on the HSE policy and trained all staff working in the centre on safeguarding procedures.

The centre had dedicated resources and staff with responsibility for delivering an activity programme. Activities provided for residents with a cognitive impairment included sensory stimulation and diversional therapy. Residents were well groomed and dressed and staff were attentive to personal hygiene. The inspectors observed the evening meal. There were a sufficient numbers of staff to assist residents requiring help with their meals. Personable interaction between residents and staff

were noted. At the time of this inspection there was a suitable staff level and skill mix on each work shift to meet the assessed health and social care needs of residents accommodated. Residents spoken with confirmed staff will come when they use the call bell.

Five outcomes were inspected. Three outcomes were compliant with the regulations and two were substantially compliant. Inspectors found that the some improvements were required to the recording and documentation of progress reviews following internal investigations and the documentation and review of the use of a mechanical chair.

The action plan at the end of this report identifies the areas where improvement is required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The governance systems in the centre were fully reviewed on the last inspection and found to be compliant. The governance structure and the management systems remained unchanged. This inspection was carried out as a result of a review of notifications and unsolicited information received. The inspection focused on the safeguarding measures in place to protect residents.

Overall accountability for the service is clearly defined. There are clear reporting lines of communication at individual and team level. Staff spoken with were aware of their responsibilities and to whom they are accountable.

The provider is actively involved in the governance and operational management of the centre. She has a role in the health and safety committee and human resource management. The provider is actively involved in the administration responsibilities of the centre and visits frequently throughout the week. She is a qualified trainer in safeguarding and delivers training to staff in the protection of vulnerable adults from risk of abuse. She is known to residents and kept appraised by the nursing team of changes or new care requirements by residents.

The management arrangements include procedures for the effective monitoring of staff training needs and systems to ensure the health, safety and welfare of residents on a continuous basis.

The post of the person in charge is full time and she is supported in her role by a clinical nurse manger also employed in a full time capacity. There are systems in place to promote staff development. A nurse is being supported by the provider to commence a course in wound care management over a two year period. Another staff member had completed a training course to be a link nurse for management and best practice on infection control procedures.

There is an established risk management framework in place. There is an up to date health and safety policy and a risk register is maintained. There is a health and safety committee in place with staff from each department involved. The staff have regular meetings and the risk register is maintained up to date. Written operational policies as required by schedule 5 of the legislation are available. In addition there is a range of internal polices to include procedures on quality monitoring and clinical governance.

There are well developed staff recruitment procedures to ensure the staff have the required skills and competencies to undertake the duties associated with their roles and responsibilities. The provider has developed an employee handbook and this was updated in June 2016. Each employee had a contract of employment in the staff files reviewed. There are procedures developed on a code of conduct for employees. There is a human resource manual in relation to conditions of employment and procedures to manage the performance of staff. Inspectors reviewed the actions taken by the provider following two recent internal investigations relating to staff conduct. The inspectors found that although the provider had taken action to address the identified learning through their internal processes, that documentation in relation to the implementation and review of the effectiveness of this plan needed improvement.

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

Findings:
There were effective and up to date safeguarding policies and procedures in place. The safeguarding policy is based on the Health Service Executive's National Policy on 'Safeguarding Vulnerable Persons at Risk of Abuse 2014'. The provider had completed a train the trainer course on the HSE policy. The provider then completed training with all staff working in the centre on safeguarding procedures.

Staff spoken with during the inspection by the inspectors was well informed on possible abusive situations. They described situations and indicators of abuse and gave examples of the action they would take and reporting responsibilities to the designated officer. The contact details of the designated officer were available for staff on the notice board.

Risks to individuals were managed to ensure that people had their freedom supported and respected. There were sufficient numbers of suitably qualified staff on each shift to promote residents independence. The inspectors spent periods of time observing staff interactions with residents. Residents including residents with dementia exhibited behaviours associated with safety and trusting relationships. Staff training, supervision and appraisals were completed. Staff had the knowledge, skills and experience they needed to carry out their roles effectively. The inspectors observed and saw that residents were treated well, with safety at the forefront of care and support provided appropriately.

There is a planned program of training in place for all staff in responsive behaviours and caring for residents with dementia to include person centred care training. This training is delivered to staff on a phased basis and staff complete refresher training in these areas. Staff spoken with were very familiar with resident's daily routines and could describe individual care requirements and approaches to deliver personal care interventions. One staff member was able to describe a low arousal approach and other staff spoken with described different distraction techniques to manage responsive behaviours.

Inspectors reviewed the use and management of restrictive practices (the use of bedrails, lapbelts and hydro tilt chairs) in the centre. It was found that the use of restraint was on evidenced based practice. A risk balance tool was completed to determine the safety of any restraint for the use of bedrails. The assessments were regularly reviewed and there was evidence in the decision making process of trialling alternatives prior to using bedrails. However, the inspectors identified the documenting and recording of the use of a hydro-tilt chair on occasions by one resident as inadequate. There were no separate records of each occasion when the hydro- tilt chair was used apart from the nurse progress notes. This was not a clear system of monitoring and reviews to determine an appropriate and consistent rationale for the use of the hydro-tilt chair.

The inspectors reviewed a sample of prescription charts. Photographic identification was available on the charts for each resident to ensure the correct identity of the resident receiving the medication. The prescription sheets reviewed were legible in print. The maximum amount for p.r.n medicine was indicated. The inspectors reviewed medication records for residents. Inspectors found examples of where anti-psychotic PRN medications were being administered, either as a single type or multiple types of antipsychotic. Inspectors discussed this with nursing staff on duty and one nurse told inspectors that they tended to use one of the medications more frequently as it appeared to work better. This was discussed with the Person in Charge during the feedback meeting.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
Inspectors reviewed the notifications submitted by the provider and found that these had been submitted in line with the regulations.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
There were no restrictive visiting arrangements and on the day of inspection visitors were observed coming and going and staff supported resident's visits. There is a coffee dock area and private visitor's room available for residents to have quiet time with families and friends away from the communal sitting areas and care environment. Relatives and visitors spoken with remarked positively on their experience and observation of care at the centre.

The centre had dedicated resources and staff with responsibility for delivering an activity programme. These staff had received training relevant to their role to support them in providing meaningful activities appropriate to resident's capacity and life stage. Records of the activities provided were maintained and included a record of the residents that attended each type of activity. Activities provided for residents with a cognitive impairment included sensory stimulation and diversional therapy. Animal therapy was also provided. There is a safe enclosed garden with a pet cat in the dementia specific unit on the ground floor of the building. The inspectors observed the resident and staff interactions and the utilisation of pet therapy within the dementia unit.

Residents were well groomed and dressed. Staff were attentive to personal hygiene and

grooming after the evening tea. The inspectors observed the evening meal. There were a sufficient numbers of staff to assist residents requiring help with their meals. Personable interaction between residents and staff were noted. There was some recently recruited staff on duty. They knew residents and addressed them by name. There was a consistent staff presence in communal areas. Interactions were social and meaningful with staff noted to check and discuss particular arrangements with residents. Frail residents and those who had significant levels of cognitive impairment were noted to be well supported with staff checking on them routinely.

There were well developed communication systems in place. Residents had access to a variety of information. A copy of the residents' guide is provided in each bedroom. Each resident has a detailed life history completed and these are available in residents' bedrooms. One staff member explained these are helpful to alleviate anxiety for some residents as they like to sit and read information and review photographs. There was useful information and good use of cues and signage to help guide and orientate residents. Each resident has their photograph on their bedroom door. The menu for the evening tea was in very large font on a board in the dining and the options were also explained by the use of pictures for each choice available. A monthly activity schedule was developed and the information was displayed in the sitting room and a copy was available in bedrooms.

A calm atmosphere was noted in the communal areas throughout the evening as staff assisted residents to retire to their bedrooms. Some residents like to sit up late and spoke to the inspectors about their life in the centre. They described the staff as kind, helpful and hardworking. Other residents who spoke with inspectors said they felt well supported by the staff team.

Residents were facilitated to practice their religious beliefs. There is an oratory available for residents use. There was a mass service on the afternoon of the inspection. Staff were knowledgeable of residents who liked to attend and ensured they were supported to go. One resident spoken with did not feel well enough to attend. Staff ensured the priest visited her, in her bedroom to receive Holy Communion. She explained to the inspectors this was very important to her and helped her greatly.

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):
No actions were required from the previous inspection.

Findings:
There were developed recruitment practices to ensure staff have the required skills and competencies to undertake the duties associated with their roles and responsibilities. There were job descriptions for each role outlining the assigned duties, responsibilities and line management reporting arrangements.

On commencement of employment staff completed a three day period of induction in a supernumery capacity. The inspectors spoke with recently recruited staff and they confirmed they worked alongside another staff member to become familiar with residents and the duties associated with their post. There was a developed induction program for staff of different grades. A senior staff member was required to document the competency of new staff and their proficiency at intervals on commencing employment. Staff who have worked at the centre for a period of time and if requested to work different shifts from their usual pattern have an induction to each new work shift. They work as an additional resource for the purposes of orientation to ensure they are familiar with the care requirements and duties of the assigned work shift.

At the time of this inspection there was a suitable staff level and skill mix on each work shift to meet the assessed health and social care needs of residents accommodated. Residents spoken with confirmed staff will come when they use the call bell. Residents who preferred to spend time in their bedroom during the day and those who had retired to bed in the evening had the call bell placed by staff so it was within easy reach for residents. There were forward recruitment plans and contingency arrangements in place to manage a short fall in staff. An additional staff member has been rostered during the day since the beginning of October from 8.00hrs to 20.00hrs to support recently recruited staff and provide cover for unplanned absences.

There are systems in place to deploy and supervise staff. There is a team leader role on each unit to support care assistants. Staff are allocated to work in teams and have assigned duties allocated to their specific work shift. There is a clinical nurse manger who reports to the person in charge.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. Staff confirmed to the inspector they undertook an interview and were requested to submit names of referees and complete Garda Siochana vetting. Inspectors reviewed a selection of personnel files and found them to contain all documentation and vetting information required under Schedule 2 of the regulations. The provider gave inspectors assurance that everyone who works in the centre is vetted by An Garda Síochána. The policy of the service is to reapply for Garda vetting for all staff every five years and this was reflected in the staff files reviewed. The centre did not use any external agency staff.

All staff were up to date on training in fire safety, manual handling, safeguarding of

vulnerable adults. There was a range of professional development training attended by staff on continence care, infection control, caring for residents with dementia, and appropriately responding to behaviours. The majority of staff had completed training in cardio pulmonary resuscitation techniques.

Judgment:
Compliant

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:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Esker Lodge Nursing Home
Centre ID:	OSV-0000135
Date of inspection:	12/10/2017
Date of response:	31/12/2017

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed the actions taken by the provider following two recent internal investigations relating to staff conduct. The inspectors found that although the provider had taken action to address the identified learning through their internal processes, that documentation in relation to the implementation and review of the effectiveness of this plan needed improvement.

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(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The supervision policy and associated procedure around documenting supervision have been updated to reflect inspectors' feedback.

Proposed Timescale: 15/2/19

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The documenting and recording of the use of a hydro-tilt chair on occasions by one resident was inadequate. There were no separate records of each occasion when the hydro- tilt chair was used apart from the progress notes. This was not a clear system of monitoring and reviews to determine an appropriate and consistent rationale for the use of the hydro-tilt chair.

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

Please state the actions you have taken or are planning to take:
The restraint register has been updated to reflect the use of specialist seating systems. A log and restraint release register has been updated to ensure separate records of each occasion when a relevant chair is used is maintained outside of the progress notes.

Proposed Timescale: 13/12/2017