**Health Information and Quality Authority**
**Social Services Inspectorate**

# Inspection report
# Designated centres for older people

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

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| **Centre name:** | Elm Hall Nursing Home |
| **Centre ID:** | 0034 |
| **Centre address:** | Loughlinstown Road<br>Celbridge<br>Co. Kildare |
| **Telephone number:** | 01 6012399 |
| **Fax number:** | 01 6273547 |
| **Email address:** | info@elmhallnursinghome.com |
| **Type of centre:** | ☒ **Private** ☐ **Voluntary** ☐ **Public** |
| **Registered provider:** | Springwood Nursing Homes Ltd |
| **Person in charge:** | Caroline Perry |
| **Date of inspection:** | 4 and 5 May 2011 |
| **Time inspection took place:** | **4 May Start:** 08:45 hrs **Completion:** 17:45 hrs<br>**5 May Start:** 07:45 hrs **Completion:** 18:30 hrs |
| **Lead inspector:** | Linda Moore |
| **Support inspector:** | Mary O Donnell |
| **Type of inspection:** | ☒ **Registration**<br>☐ **Scheduled**<br>☒ **Announced**<br>☐ **Unannounced** |

## About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

**Evidence of good practice** – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

**Some improvements required** – this means that practice was generally satisfactory but there were areas that need attention.

**Significant improvements required** – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

**Registration inspections** are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

## About the centre

### Description of services and premises

Elm Nursing Home is a purpose-built residential centre with 61 places. The provider recently converted one bedroom with accommodation for three into two single bedrooms and reduced the bed numbers from 62 to 61. It provides long-term, palliative, convalescent and respite care. It is a two story building with 58 single rooms and one three-bedded room. All bedrooms have a wheelchair accessible en suite shower, toilet and wash-hand basin. There is a sitting room and dining room on each floor and a reading room as well as a kitchen, laundry, treatment room, oratory, hairdressers' room, staff facilities and visitors' room. In addition to the en suite bathrooms there are five toilets, four of which are assisted toilets. There are two baths which are not used. Residents have access to a secure enclosed garden.

There are eighteen independent living chalets and a social centre on the grounds. Car parking is available at the side of the centre.

### Location

Elm Hall Nursing Home is situated close to the village of Celbridge. It is situated close to Elm hall Golf Club and close to the Hazel Hatch train station.

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| **Date centre was first established:** | June 2006 |
| **Number of residents on the date of inspection:** | 57 + 1 in hospital |
| **Number of vacancies on the date of inspection:** | 4 |

| **Dependency level of current residents** | **Max** | **High** | **Medium** | **Low** |
|---|---|---|---|---|
| **Number of residents** | 19 | 12 | 14 | 12 |

### Management structure

Elm Hall is owned by Springwood Nursing Homes Ltd. and Mairead Byrne, the Managing Director, is the nominated person on behalf of the provider. The Person in Charge, Caroline Perry is known as the Director of Nursing and she reports to the Managing Director. There is an assistant Director of Nursing, Amada Miller, who deputises in the absence of the Person in Charge. The two Clinical Nurse Managers (CNM), staff nurses and care assistants report to the Person in Charge. All non clinical staff report to the provider.

| Staff designation | Person in Charge | Nurses | Care staff | Catering staff | Cleaning and laundry staff | Admin staff | Other staff |
|---|---|---|---|---|---|---|---|
| **Number of staff on duty on day of inspection** | 1 | 1* | 8* | 3 | 5 | 1 | 5*** |

* There were two nurses in addition to the person in charege on day two of the inspection
** Eight care assistants reduce to six in the afternoon
*** Provider, 2 activity coordinators and 2 maintenance staff

## Summary of findings from this inspection

This was an announced registration inspection carried out over two days and the second inspection of this centre by the Health Information and Quality Authority (the Authority). The provider has made an application for the centre to be registered for the first time under the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009. As part of the registration process the provider has to satisfy the Chief Inspector that she is fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

During the inspection, separate fit person interviews were carried out with the provider and the person in charge. Inspectors also reviewed all of the information provided in the registration application form and supporting documents.

Inspectors met with residents, relatives, and staff members. They also observed practices and reviewed documentation such as care plans, medical records, accident records, complaints logs, policies and procedures and staff files.

The premises are spacious, comfortable and well maintained. Inspectors found that staff were committed to caring for residents and worked hard to look after them.

Residents' medical healthcare needs were catered for and they had access to peripatetic services. Some aspects of nursing care were not based on evidence-based practice. Staff required further training on a number of critical clinical care practices including care planning and working with residents who have behaviours that challenge.

Findings from the previous inspection of 10 November 2009 were also reviewed. The inspectors found that three actions had been completed, four areas for improvement were in progress and two actions were not addressed. The areas not fully addressed included risk management and the training or by other means of all staff in the protection of vulnerable adults.

The provider and person in charge did not meet all of the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Inspectors found that there was poor governance in relation to staffing, management of absenteeism and the fact that the person in charge had a clinical caseload adversely affected the standard of care provided. Serious concerns were identified by inspectors in the prevention and management of falls and the temperature of the water in the sinks in the residents' en suite bathrooms was too hot and posed a risk to residents. These findings required urgent attention and the person in charge was requested to submit an Immediate Action Plans to address these issues following the inspection. Satisfactory action plans were submitted to the Authority within agreed timeframes.

Other improvements were required as follows:

- risk management policies and procedures did not meet regulations and did not guide practice
- there was no formal fire training for newly recruited staff
- elder abuse awareness was lacking among non-clinical staff
- there were no formal systems in place to review the quality and safety of care
- the complaints policy did not meet requirements
- the statement of purpose did have all the required information and the provider failed to alert the Authority of amendments to the statement of purpose
- the person in charge failed to notify the authority when a resident sustained an injury following a fall.

These issues are discussed in the body of the report and are included in the Action Plan at the end of this report.

## Comments by residents and relatives

Inspectors reviewed questionnaires from sixteen residents and thirteen relatives. They interviewed residents and relatives in private and also spoke with several residents and relatives during the inspection. Comments from residents and relatives were very mixed.

Relatives and residents were satisfied with the layout of the home and the high standard to which it was maintained. Relatives and residents said the facility is always very clean, well kept, bright and airy and caters to residents' needs.

Both residents and relatives praised the calibre of staff but they expressed concerns that there were not enough staff employed to meet the needs of the residents both day and night. Residents provided examples of how they are affected when there are insufficient staff on duty, for example, "I would like more staff, it takes too long for staff to answer the bell". Relatives praised the care team, catering and cleaning staff. One comment from a relative included "the staff are very caring, considerate and kind, they work hard and are often stressed out when there is not enough on duty and they cannot carry out the patients' care with enough attention".

Relatives were satisfied that they could approach a staff member with any query and they were contacted if their relative's condition changed.

# Overall findings

## 1. Governance: how well the centre is organised

**Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.**

**Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.**

### Evidence of good practice

Measures were in place to protect residents' finances and personal property. There was a policy in place for the safeguarding of residents' finances. The provider told inspectors that family or friends usually managed residents' personal finances, but that she managed small amounts for one resident. Inspectors noted that this was kept in a digital safe and all incoming and outgoing amounts were recorded and the resident was asked to sign to confirm transactions and the balance. Residents had a lockable space in their rooms to store valuables and the provider had valid insurance cover which included indemnity for residents' personal property which was reflective of the requirements of the Regulations.

The directory of residents was up-to-date and contained all information concerning residents as required by the Regulations. Residents had contracts of care which stated terms and conditions. Services that incurred additional cost such as hair dressing and chiropody were clearly identified. These documents were viewed by inspectors and deemed satisfactory.

Inspectors were satisfied that maintenance issues were addressed appropriately. A schedule of refurbishment was in place and the maintenance personnel on the premises on the day of the inspection described this to the inspectors.

### Some improvements required

The fire training records showed that most staff had attended mandatory fire training. The most recent training was held on 13 July 2010, 24 February and 4 March 2011. Staff were knowledgeable of fire procedures and these were displayed throughout the premises. Records of fire drills carried out at least monthly were reviewed. Fire escape routes were checked daily. The fire alarm system was checked April 2011. The fire automatic release button was checked weekly and recorded. The Authority received a letter from a competent person that all statutory requirements in relation to fire safety were met. While the majority of staff had undertaken fire safety training, the recently recruited care staff who commenced employment in

March and April had not undertaken formal fire safety training. The provider told inspectors further training was planned for 16 June 2011 to bring all new staff up-to-date.

Inspectors viewed the centre-specific health and safety statement, which identified environmental hazards and outlined controls to minimise risks. For example, there was a visitors log in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The person in charge detailed the process for the total evacuation of residents from the centre should an emergency arise. However, there was no emergency plan in place to guide staff in responding to untoward events. The provider said this policy was with the health and safety consultants to be updated.

The complaints policy did not meet the requirements of the Regulations. The person in charge displayed a positive attitude towards complaints and said a significant amount of her time was spent responding to issues raised by families. She said that she viewed complaints as an opportunity to improve the service. Residents and relatives said they could raise any issues with the person in charge or any staff member but the person in charge was often busy and did not have time to talk to them. The inspectors viewed the complaints log and found that both verbal and non-verbal complaints were documented and included details of investigations and actions undertaken to resolve a complaint. However, the complainant's satisfaction with the investigation and outcome were not recorded and the complaints policy did not identify an independent appeals process.

The policy for the prevention, detection and response to abuse was comprehensive and the provider had put arrangements in place for the training of clinical staff in the prevention of elder abuse. The area of the protection of vulnerable adults was identified at the previous inspection and while clinical staff were trained as a result, and were able to define their responsibilities should they suspect an allegation of abuse and told inspectors what they would do if an allegation of abuse was made to them. However, household staff could not detail how to respond to allegations of suspected elder abuse. The protection of vulnerable adults would be enhanced if training or other means of informing staff about the elder abuse policy was extended to non-clinical staff members.

Inspectors noted that there was no formalised process in place to supervise residents in the day room. Inspectors observed at times that a staff member would stay in the day room on the first floor to supervise residents. However, this was not formalised in the morning before 10.30 am. Inspectors observed that residents with cognitive impairment and some at a high risk of falling who required high levels of supervision were left unsupervised until that time. Staff reported that they looked in when passing to check on residents.

There was no formal system in place to review the quality and safety of care such as reviewing accidents and incidents (including near misses) in order to learn from serious or untoward incidents or adverse events involving residents. While the provider and person in charge stated that they used complaints and feedback to review practices and improve the service, this was not recorded. The person in charge had attended training on auditing clinical practice but she had not

implemented this training. The person in charge confirmed that no audits had been undertaken since September 2010. Inspectors noted that audits were carried out during 2010 on falls, pressure sores and restraint but they were not used to inform service improvements as there were no areas for improvement identified.

## Significant improvements required

Inspectors had significant concerns regarding the staffing of the centre. When inspectors reviewed the planned and actual rosters for the centre, they noted that there was evidence of significant absenteeism. In addition, there was a high turn over of staff. The Chief Inspector received information of concern regarding staffing levels on 11 May 2011. The provider was issued an Immediate Action Plan to submit information regarding the staffing and skill-mix. This information was submitted to the Authority in a timely manner and was comprehensive in nature. The issue of staffing is discussed in more detail later in this report.

Inspectors were concerned regarding the governance and clinical leadership in the following areas

- risk management procedures
- falls prevention
- the management of behaviour that challenges
- processes for assessments and care planning
- obligations under the Regulations

These areas are discussed in more detail further in this report.

The provider did not have comprehensive risk management policies in place. This was identified at the last inspection and was only partly addressed. The policies specified some risks, which were being managed, but did not include all of the requirements of Regulations such as assault, self-harm and resident absent without leave. The person in charge acknowledged that the policy had not been fully implemented. Untoward incidents were not consistently documented. Staff told inspectors that episodes of challenging behaviour were not recorded as incidents. This was confirmed by inspectors who reviewed incident reports.

The statement of purpose did not comply with the Regulations. This was identified at the previous inspection in 2009 and had not been fully addressed. The provider updated this on the second day of the inspection but it still did not contain all of the requirements of the Regulations. For example, it did not fully include the arrangements made for dealing with complaints or fire precautions.

The provider and person in charge were not fully aware of their responsibilities in relation to notification of prescribed incidents. A resident who had fallen on 23 April 2011 and required transfer to hospital following an injury sustained was not notified to the Chief Inspector. The Authority received a notification for this accident on 18 May 2011.

## 2. Quality of the service

**Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.**

**A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.**

### Evidence of good practice

Residents' rights were respected and this was illustrated through lifestyle and daily routine choices and the promotion of residents' independence. Residents told inspectors that they were able to exercise choice about many aspects of life, such as the time they got up in the morning. An inspector observed that one resident chose to stay in bed until midday and others returning to their bedrooms for a rest after lunch and returning to the day room later in the afternoon to socialise with other residents. They had menu choices at their meal times and could choose where to have their meals. Staff were attentive to residents' personal appearances and some residents and relatives commented that they enjoyed regular visits by the hairdresser.

Inspectors noted that many of the residents had dementia-related conditions and inspectors saw that staff were attentive in their interactions with residents, addressing residents by the appropriate name and using a gentle tone of voice. One relative spoke at length with inspectors and indicated her family member had dementia stated "As she deteriorated activity staff picked up that she was no longer capable of playing card games which she always enjoyed, but they have introduced her to new hobbies such as art and included her in music sessions which she clearly enjoys. Staff are very responsive to all her needs". Another relative was pleased that her mother had made friends with other residents.

Residents' privacy and personal space was respected. Inspectors observed staff knocking on bedroom doors and waiting for permission to enter. Cleaning staff were observed seeking permission to enter bedrooms. Most of the residents had their own bedroom. Screens were drawn in shared bedrooms and the main door to the bedroom was closed by staff when assisting residents with their personal care.

Residents maintained social relationships and inspectors noted that many visitors called on the days of the inspection. Links were maintained with the local community through visiting transition year students, and local entertainers and groups performing for residents. Inspectors observed that a number of people who lived in the retirement village came to the centre and joined the residents for lunch, this was an opportunity to socialise and for residents who moved from independent living to maintain friendships.

Visitors primarily met with residents in the communal sitting rooms or bedrooms but access to a private space was available for those who wished to see relatives' and friends privately.

There was a structured program of activities in place which was facilitated by two dedicated activities coordinators who normally worked opposite shifts to provide activities seven days each week. The programme was flexible and was adjusted to meet the choices of residents on a daily basis. There was a range of activities to encourage physical and mental stimulation. An activity coordinator told inspectors she often used soothing music and candles to create a tranquil environment for residents to unwind. There was a weekly exercise class led by the activity personnel and residents participated in games which included bowling that promoted mobility. Residents spoken with told inspectors how they enjoy playing bingo, reading and discussing articles currently in the news. One resident appreciated the fact that staff respected her wish to spend time in her room and not engage in group activities.

The kitchen was spacious, clean and suitable in size to cater for the needs of all residents. It was well equipped and well stocked with meat, fruit and vegetables and home baking was done daily. The chef kept records of the dietary requirements and likes and dislikes of each resident including those on special diets. The chef showed an inspector the planned menu cycle which was rotated monthly and adjusted to reflect seasonal options. Inspectors observed the chef chatting with residents and ensuring that they were satisfied with their meals. Catering staff upheld the dignity of a resident by cutting his meat prior to serving him at the table. The chef told the inspector that snacks were provided should any residents require food during the night. Care assistants also had access to the kitchen at night time.

Inspectors observed residents at lunch in a bright dining room on the ground floor and a smaller dining room on the first floor. Residents were seated around small circular and rectangular tables which promoted interactive conversation between residents and staff. The menu offered nutritionally balanced, home cooked food. At a previous inspection the lack of choice for residents on modified diet was an issue and inspectors fount that this had been addressed. Residents were asked about their choice from the menu and those who required modified diets were offered a choice for dinner and evening meal. Inspectors saw that a variety of pureed meals were served to residents. Those that required help were offered assistance sensitively and discreetly. Staff in the dining room were observed encouraging residents to be as independent as possible while eating. Residents had access to drinks during the day. Water fonts were placed in communal areas where residents could help themselves and care staff offered assistance to those who required it.

## Some improvements required

There was evidence that staff made significant efforts to meet residents' needs for social engagement and occupation in meaningful ways. While there were "getting to know you" information booklets in place for residents, there was no social assessment done to ensure that activities provided met the needs of individual residents especially residents who could not participate in group activities.

Although there were adequate numbers of showers and bathrooms, staff reported that all residents had showers because the two baths were unsuitable for dependant residents. Consequently residents who preferred a bath were not offered one.

## Minor Issues to be addressed

Arrangements were in place to address residents' spiritual needs. Clergy from a range of denominations visited the centre as required. A priest said mass regularly and a communion service was held each Sunday. However, some residents expressed a wish to have mass said at least on a weekly basis at the centre. Records showed that this issue was raised at the Residents' Committee meeting in Sept 2010.

## 3. Healthcare needs

**Outcome: Residents' healthcare needs are met.**

**Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.**

### Evidence of good practice

Pre-admission assessments were completed by the person in charge to ensure the needs of the potential resident were met. The person in charge told inspectors how she went to the hospital or home to meet prospective residents. Inspectors viewed completed assessments in care plans. This assessment included liaison with the relevant medical and surgical specialities.

The centre is served by a local GP who visited twice weekly or as required and residents where possible were enabled to retain the services of his/her own GP. Out-of-hours medical services were also provided by K-Doc. Residents were also able to access physiotherapy services privately. Documentation confirmed that residents were also enabled to attend local hospitals for outpatient appointments. The community medical liaison team followed up with residents who had been in Connolly Hospital and they provided an on-site medical service on GP referral to prevent unnecessary admissions to hospital. One resident was under the care of the team at the time of inspection.

There was good emphasis placed on health promotion activities and the maintenance of independence. Residents were observed being encouraged to be active, to participate in activities, walk around the building and undertake personal tasks that they could do by themselves. Nurses promoted independence by including information about what residents were capable of doing independently in care plans. Residents had access to occupational therapy for seating assessments and to a range of assistive devices. Inspectors noted that all residents had access to a wide range of health professionals and a record of referrals and appointments were maintained in each resident's file. Dietetic and chiropody services was provided and ophthalmology services were available on an annual basis to all residents. Speech and language therapy and audiology services were available to residents by GP referral. One resident with swallowing difficulties had been referred to hospital for tests and specialist advice was obtained. Residents' records showed that vital observations such as weight, blood pressure, temperature and pulse were routinely monitored.

Two residents with wound care problems were being managed appropriately. There was a wound care plan to guide staff on the provision of pain relief and dressings. In addition, care records conveyed that external expertise was obtained from a tissue viability nurse and through regular attendance at a vascular clinic to optimise healing of the wounds.

Nursing staff described how they managed end-of-life care. Nursing staff told inspectors that they had developed good links with community bereavement services and the palliative care team. Inspectors met a home care nurse who called to review a resident receiving palliative care. The team visited as required and had continued input into the residents' care. The provider informed inspectors that a bungalow in the complex was made available for family members to stay overnight. Requiem services were also provided in the centre.

All medication was reviewed by the prescribing doctor every three months or more frequently should a change in a residents' health occur. An inspector reviewed medical files and noted the medication review by the prescribing practitioner was documented in the resident's medical notes. Medication was securely stored in a locked clinical room. Medications requiring refrigeration were stored appropriately and controlled drugs were secured in a locked cabinet. An inspector viewed the controlled drugs register. Controlled drugs were checked by two nurses from opposing shifts, at the change of each shift to ensure all drugs were accounted for.

In a previous inspection the person in charge was required to review and amend the policy on medication management and this had been satisfactorily completed. Inspectors found that it included the management of all aspects of medication from ordering, prescribing, storing and administration. The policy included procedures for the disposal of unused or out-of-date medication.

**Some improvements required**

Inspectors noted that the reporting of medication errors was not in line with the policy. A nurse stated that there were no records of medication errors because errors did not occur. However, inspectors found that a resident who was underweight had not been given a prescribed nutritional supplement on three occasions. The nurse said this was because it was out of stock. This had been remedied on the second day of inspection but inspectors noted that it had not been reported as a medication error.

**Significant improvements required**

Inspectors examined care records and found that residents were comprehensively assessed on admission and had care plans in place to meet their needs. However, the ongoing assessment and reviews of care plans were poorly managed. This issue was highlighted at the previous inspection and the person in charge had addressed this by inserting a review page for information about any changes to the plan in light of the review. However, clinical assessments were not regularly updated at the required three-monthly intervals or more frequently if needs changed. While residents' care needs were noted to be outlined in a format that described the

problem, care interventions were not routinely reviewed or sufficiently specific to guide practice. For example, a resident whose nutritional assessment placed her at risk of malnutrition did not have her care plan amended to reflect this. The provider said that nurses had received training in care planning but this was not evident from training records, which showed that the person in charge completed training in care planning in May 2007 and only one staff nurse completed this training in December 2008.

Inspectors were concerned about the provision of clinical care in the area of falls, restraint and behaviour that challenges that negatively impacted on the quality and safety of residents.

Inspectors found that falls were poorly managed. Residents were assessed for risk of falls on admission and falls diaries were usually completed when a resident fell. Nurses undertook appropriate neurological observations if they suspected a head injury following a fall. However, risk assessments were not consistently updated as part of the three-monthly care plan review. For example, two residents who had recurring falls did not have a risk assessment completed after they fell and there was no recorded evidence that additional appropriate measures had been put in place to minimise the risk of recurrent falls. A resident who sustained a serious injury from a fall did not have her care plan amended or additional interventions implemented to reduce the risk of falls or injury from falls. This resident had three subsequent falls.

Inspectors noted that in 2011 there had been 33 falls up to the day of inspection. Twenty-eight falls were unwitnessed and there had been a high number of recurrent falls. One resident suffered a serious injury that required hospitalisation for a falls related injury. As no audits had been carried out in 2011, the person in charge was not able to review the number, nature, cause or severity of incidents and accidents and subsequent outcomes for residents. The provider in the self assessment said that “incidents would be recorded and investigated and remedial action implemented as necessary”, this was not evident from the documentation reviewed. The lack of a systematic review of all falls and actions taken by staff, resulted in poor outcomes for some residents.

Inspectors reviewed the incident and accident reports and found staff did not carry out the recommendations recorded by the person in charge in the incident and accident log. For example, the person in charge recommended that a resident who fell in her bedroom should be up in the day room by 10.00 am. This instruction was not recorded in her care plan or adequately communicated to staff and the resident later fell in her room at 10.30 am. Another recommendation by the person in charge stated, “Support the resident on the right side when walking”. However, this information was not recorded in the residents care plan in order to guide staff. A staff member who told inspectors about the measures staff took to prevent these two residents from falling was not aware of the need to have the resident up by 10.00 am and did not mention the need to support the other resident on the right side when she used her walking aid.

Staff were not familiar with falls management. The inspectors spoke to a number of staff who informed them that they had not received education on falls prevention. Training records indicated that education on falls was last held in 2008. However,

due to the high turnover in staff this record would not be reflective of the current staffing compliment.

Inspectors found that in the absence of a team approach to falls prevention, staff had used restraint inappropriately to prevent a resident from falling. A nurse told inspectors that bedrails were used to prevent a resident from rolling out of bed and never to restrain, as there was a gap between the bedrails wide enough for a resident to get out should they wish. While discussing falls prevention, other staff told inspectors, they blocked the gap in the bed with furniture to restrain the resident from climbing out of bed. The nurse told inspectors that the centre promoted a restraint free environment and staff had been advised against this practice. Apart from this incident of poor management of restraint, inspectors did not observe any other resident in restraint during the inspection, but inspectors were concerned about care practices and arrangements for the supervision of care assistants, many of whom were new to the service.

The assessment for residents with behaviours that challenge were not comprehensive and did not identify trends or triggers and inform appropriate interventions to minimise the behaviour. Care plans did not provide adequate guidance for staff who worked with the residents. For example, a care plan for a resident who was described as “abusive or aggressive to staff” stated “reassurance given if resident (name) becomes aggressive/abusive”. Yet this resident had scratched a staff member’s arm. Another residents care plan stated “Resident (name) may be verbally abusive and physically aggressive”. The person in charge said this was not a true reflection of the resident as the resident did not display aggressive behaviour and the care plan should be updated to reflect this.

Staff were able to describe effective techniques for communicating with residents who had behavioural problems but this information did not form part of the care plan for these residents. In light of the high turn over of staff in the centre the documentation regarding care of residents was not sufficiently complete to set out the residents’ individual needs and provide a consistent approach to care.

Inspectors noted that some interventions resulted in poor outcomes for other residents. The care plan of a resident who wandered into bedrooms stated “Keep exits closed and redirect (resident name) if he is wandering into inappropriate areas. Allow him out to the garden”. On the second morning of inspection an inspector met a distressed resident who could not access her bedroom when returning from the bathroom because she could not recall the key pad code to open the door into the corridor. These doors had been locked to prevent this resident from wandering. Inspectors noted that there were many residents with cognitive impairment on this floor. A relative told inspectors that she was relieved that her relative had been moved to another floor after she raised concerns about her relative being pushed by another resident.

## 4. Premises and equipment: appropriateness and adequacy

**Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.**

**A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.**

### Evidence of good practice

Inspectors found the building to be clean, warm, comfortable and odour free. The premises design and layout was safe, hygienic, spacious and well maintained. There was a variety of seating in communal areas and on the corridor.

There was suitable and sufficient assistive equipment to support residents who had mobility difficulties. Each resident had their own individual equipment varying from wheelchairs, walking frames to walking sticks. There were call bells available in bedrooms, communal areas and in the smoking room.

There were sufficient toilets and showers to accommodate the needs of residents. Communal space, including sitting room space, was adequate.

A resident invited the inspectors to visit her room. Residents' bedrooms were personalised with photographs, televisions, stereos, books, ornaments and soft toys. There was plenty of storage space available in wardrobes and bedside cabinets.

Laundry and sluicing facilities were adequate and supported good hygiene practices. Inspectors noted that soiled clothing was laundered separately and at appropriate high temperatures to prevent the spread of infection. Residents' clothes were labelled to minimise mix-ups.

Inspectors found there was a well organised system in place for cleaning the building. The household staff were observed carrying out cleaning duties in a methodical manner according to the cleaning schedule.

Inspectors found that good hand hygiene practices were adhered to by staff. There were adequate hand-washing facilities and gels located in strategic areas throughout the centre.

CCTV was in use at exits, corridors and communal areas of the building, to maintain the safety of residents. Its use did not infringe on the privacy of the residents. This was highlighted in the Residents' Guide.

The building was well maintained both internally and externally. General maintenance was addressed as required. The maintenance records were viewed by inspectors and they showed that all issues were followed up.

## Some improvements required

Inspectors observed the sluice room doors to be opened on the first day of the inspection and there were cleaning chemicals in these rooms. This was brought to the attention of the provider on day one of the inspection. The provider told inspectors that locks were being fitted to these doors to address this issue.

The laundry room was cluttered, inspectors observed a box of old slippers stored on top of the dryer, there were also lots of items of clean clothing which were unmarked on shelves beside the entrance.

The cleaners' room did not meet the national standards. The cleaning staff showed the inspectors where they stored the cleaning trolleys in a shed outside.

## Significant improvements required

The temperature of the water in the sinks in the residents' en suite bathrooms was too hot and posed a risk to residents. The temperature of the water in a downstairs en suite bedroom was 51.5 degrees centigrade and the temperature of the water in a resident's en suite bathroom on the first floor was 47.3 degrees centigrade. This was brought to the attention of the provider who stated this would be addressed immediately.

## Minor issues to be addressed

Inspectors found the storage of incontinence wear on open shelves in the toilets to be undignified.

## 5. Communication: information provided to residents, relatives and staff

**Outcome: Information is relevant, clear and up to date for residents.**

**Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.**

### Evidence of good practice

Overall staff who spoke with the inspector were knowledgeable of the Regulations and the Authority's Standards. Copies of the Standards were available for staff in clinical areas.

Residents told inspectors that staff were approachable and they felt that communication was welcomed and encouraged. Relatives also told inspectors that they were informed by staff about the wellbeing of their family members, and were notified immediately of any change in health. Relatives confirmed they could approach a nurse or the person in charge with questions or concerns at any time.

There was a Residents' Guide available, which was reviewed by inspectors. It contained valuable information to assist prospective residents to make a decision regarding choosing a placement. The guide contained all the information required by the Regulations.

All residents had a phone in their room which enabled them to make and take calls in the private. Inspectors also met residents who had mobile phones. Residents had access to wireless broadband and one resident used the internet to make contact with a family member who lived abroad. Residents had access to complimentary daily newspapers, and they could also order daily papers which were delivered to their rooms.

All staff wore name badges with large print which could be easily read by residents. Each staff grade wore a different coloured uniform and residents who spoke with inspectors were aware of each staff member's role.

There were notices boards located around the building containing information on the activities planned for the month and the complaints procedure was prominently displayed.

All records including residents' records and medical notes were stored securely.

## Some improvements required

There were two operational policy/procedures on communication, one which related to communication with residents and this was implemented by staff.
Inspectors observed good interaction and communication taking place between residents and staff. Staff demonstrated effective communication skills when dealing with residents who had behaviours that challenged. However, the operational communication policy was not reflected in practice and the arrangements for communicating with staff could be strengthened.

Inspectors found there was a strong reliance on informal verbal communication which increased the risk that information would not be provided accurately and consistently to all staff. Regular staff meetings as described in the communication policy did not take place. Records indicated that the most recent staff meetings were held on 23 February 2011 and prior to this a meeting was held on 17 June 2010. Care assistants did not attend staff handover meetings which informed the incoming staff group of the health and wellbeing of the residents. Care assistants told inspectors that the information relevant to residents' care was passed on to them by a nurse who had attended the handover meeting.

The provider said she speaks with the person in charge daily and meets at least weekly. However, there were gaps in the awareness the provider had of the service. For example, she did not know there was a problem sourcing mass.

The policies and procedures required by legislation to be kept by a designated centre were in place. While the person in charge addressed this action from the previous inspection in relation to the provision of policies to staff, the system for the roll out of policies and procedures was not robust. Inspectors noted that the sheet used by staff to indicate that they had read and understood the policies had 11 staff signatures and the sheet did not indicate the date or identify what policies staff had read. Staff who spoke with inspectors were not familiar with some of the policies relating to care practices such as falls management and restraint. Some polices were yet to be rolled out and embedded, such as the emergency policy and the risk management policy. This conflicts with the centre's policy on induction and training which stated that all staff must sign a form to state they have read and are aware of the content of the polices.

## Minor issues to be addressed

Following the last inspection the residents' committee was established in January 2010 to compliment the "family forum" and provided residents with a platform to influence decision making. The minutes of the meetings reflected the fact the meetings were chaired by a resident and provided an opportunity for residents to raise issues which were acted upon by management. The minutes indicated that a sheltered furnished area was created in the garden and the number of day trips for residents was increased in response to suggestions made at the residents' committee. Residents told inspectors that they now enjoyed more day trips including an exhibition at Leixlip library on the day of inspection. However, residents reported

that “monthly” meetings were held infrequently. Records indicated that the most recent meeting was held in September 2010.

Many residents had problems associated with dementia or confusion. While there were some pictorial signs on bathrooms and bedrooms were numbered to guide people around the building, the signage overall needed improvement to provide effective and meaningful prompts to help residents find their way to communal areas and their rooms.

## 6. Staff: the recruitment, supervision and competence of staff

**Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs.**

**Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.**

### Evidence of good practice

The person in charge had appropriate arrangements in place for the induction of newly employed staff. Staff members described the induction programme they had undergone. Inspectors spoke to the newest recruited staff member who was allocated to work along with a senior carer for a week until she were familiar with the residents and understood relevant aspects of the work. A copy of the power point programme was also provided to inspectors and found to be informative for new employees. It contained employee issues such as annual leave and time keeping. The provider told inspectors that two staff members were rostered as supernumerary on the week of inspection.

The provider had developed an employee handbook with the assistance of a human resources consultant and staff told inspectors they found it to be useful and informative.

Inspectors noted that there was comprehensive staff nurse and health care assistants' orientation assessment which must be completed by staff in one month and one week respectively. The staff nurse orientation included nursing procedures - staff nurses must have completed ten supervised medication rounds until they were deemed competent to administer medications independently.

### Some improvements required

The training records showed that very little training had been delivered in the areas such as:

- falls prevention and management
- assessment, clinical risk assessment and care planning
- clinical audit
- assessment and management of behaviours that challenge.

Due to the risks identified in the areas of falls, restraint, risk management and the high turn over of staff, the lack of a planned approach to professional development of staff has resulted in the poor outcomes for residents discussed throughout this report. The section of the staff induction and training policy dated August 2010

mentioned above stated all “appropriate training for employees will be based on the requisites of the Authority and the Regulations”. This policy was not being adhered to.

There were robust written operational recruitment policies. However, some files for existing staff members did not contain three references. While staff had a self-declaration to indicate they were fit for the purpose of, the work they are to perform there was no evidence as to why it was impracticable for the person to obtain such evidence as required by the Regulations.

## Significant improvements required

The inspectors were very concerned about the staffing in the centre due to staff turnover, sick leave and absenteeism, and dependencies of the residents. While the person in charge said she used a validated tool to determine staffing levels and skill-mix, the inspectors were unable to validate this as the documentation was not available. In discussion with the person in charge, it was evident that she did not consider the size and layout of the building when determining the roster.

Inspectors had concerns that five staff resigned from their posts and six carers were on leave since January 2011. The arrangements to provide cover for short-term absence and long-term sick leave was not adequate. Staff told inspectors the staffing levels, skill-mix and sick leave were having poor outcomes for residents. For example, staff told inspectors that some days residents waited in bed for long periods before staff could assist them to get up and more dependant residents were sometimes left in bed all day because there was not enough staff on duty. Residents reported that staff were sometimes unavailable to answer call bells in a timely manner and there were delays when they needed to use the bathroom. One resident told inspectors that she had an episode of incontinence because she could not “hold on” any longer. Two relatives confirmed that their mothers had a similar experience. One relative reported that residents, who required assistance with their cup of tea in the evening, drank cold tea because the tea went cold while residents waited for staff to assist them.

There was no evidence that the person in charge or provider carried out an investigation into the reasons for the high turn over of staff. This was further evidenced on the day of the inspection when a staff nurse rang in sick and the person in charge and the assistant director of nursing were the two nurses on duty from 7.00 am until 3.00 pm. They assumed responsibility for direct nursing care to all the residents, administration of medication and supervision of care assistants as well as their management responsibilities. The provider addressed this deficit on the second day of inspection by adding an additional nurse to allow the person in charge to manage the service. In undertaking the role of person in charge and nurse she neglected the management and governance aspects of her role as person in charge and the supervision of staff and failed to delegate more responsibility to her staff. Inspectors noted that although the person in charge did not normally cover for absent nurses she undertook all pre-admission assessments and was also the named nurse for a group of residents with responsibility for assessments, developing and reviewing care plans and communicating with relatives.

The skill-mix on night duty was inadequate considering the needs of the residents and the size and layout of the building. Inspectors read the rosters for a three week period and noted that on the week of the 28 March 2011, there was one nurse and two care assistants to 58 residents, of these 30 had a high or maximum dependency. Staffing levels at night did not change in response to the changing needs of residents and inspectors were of the opinion that three staff members at night was not adequate to meet that needs of the residents. Residents and relatives comments supported this opinion.

Inspectors reviewed rosters and sick leave records and noted that there were consistently high rates of absenteeism including a week in March 2011 when seven staff members took unscheduled leave. Inspectors found that arrangements to use existing staff to cover staff absenteeism were unsatisfactory. Issues of concern were viewed about the staffing levels which were brought to the attention of the person in charge in writing. Inspectors read a copy of this letter dated 10 April 2011. The provider said that she was addressing the staffing deficit and had recently recruited an additional five care assistants and was in the process of recruiting staff nurses.

The organisation of work was not designed to meet the needs of residents. Care assistants had responsibility for recording care they delivered. Staff said they would spend up to hour writing and they were not available during this period to spend time with residents. This practice had poor outcomes for residents. Other issues included:

- while staff completed their documentation, they were not available for residents. Inspectors observed on one occasion that 20 residents sat in the day room on the ground floor with no interaction and only the radio on for stimulation while three staff members completed documentation about care provided. Relatives confirmed that this was what happened most days they visit
- a resident identified this period as a time when the call bell went unanswered
- one relative told inspectors that information in relation their family member was not recorded until the end of the shift and some days staff had forgotten to complete this altogether. This family could not determine what care was delivered to their relative
- the information carers completed was not available to inspectors as the records were blank during the day. Staff said they completed this information at the end of the shift and not chronologically.

## Minor issues to be addressed

The person in charge had introduced a named nurse and key worker for each resident and key staff were identified in each resident's room. Residents and relatives told inspectors that while this was a good initiative, some of the staff members identified were no longer working in the centre and were not replaced.

## Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider and the person in charge, to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

### Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

### *Report compiled by*

Linda Moore and Mary O Donnell

Inspectors of Social Services
Social Services Inspectorate
Health Information and Quality Authority

18 May 2011

| Chronology of previous HIQA inspections | |
|---|---|
| **Date of previous inspection:** | **Type of inspection:** |
| 10 and 11 November 2009 | ☐ Registration<br>☒ Scheduled<br>☐ Follow-up inspection<br><br>☒ Announced<br>☐ Unannounced |

**Health Information and Quality Authority**
**Social Services Inspectorate**

**Action Plan**

## Provider's response to inspection report*

| | |
|---|---|
| **Centre:** | Elm Hall Nursing Home |
| **Centre ID:** | 0034 |
| **Date of inspection:** | 4 and 5 May 2011 |
| **Date of response:** | 22 June 2011 |

## Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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|---|
| **1. The person in charge has failed to comply with a regulatory requirement in the following respect:**<br><br>Inspectors found that the levels and skill-mix of staff were insufficient to meet the needs of residents. |
| **Action required:**<br><br>Ensure at all times the numbers of staff and skill-mix are appropriate to the assessed needs of the residents and the size and layout of the centre. |
| **Reference:**<br>Health Act, 2007<br>Regulation 16: Staffing<br>Standard 23: Staffing levels and Qualifications |

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

| Please state the actions you have taken or are planning to take with timescales: | Timescale: |
|---|---|
| Provider's response:<br><br>We have always endeavoured to maintain adequate staff numbers on all shifts.<br><br>Following an internal review which showed that there was a difficulty with 'unauthorised' staff absence, the provider and person in charge, with the assistance of an external consultant have addressed this issue in a comprehensive manner.<br><br>As discussed with inspectors, comprehensive Management Plan was initiated in March 2011 to address staff attendance issues, and our review to date indicates that has been successful.<br><br>Some nurses who had been employed for in excess of 3 years had decided to move on to other disciplines to enhance their professional development and there were initial difficulties in sourcing suitable candidates to replace them. This issue has been resolved with the successful recruitment of suitably qualified nursing staff, some of whom are currently in the process of induction having commenced employment.<br>In addition to this, we have employed additional Care Assistants with FETAC and/or Skills Net training to augment our existing staff complement.<br><br>Taking account of the individual needs of residents and the size and layout of the nursing home, staff allocations and numbers were reviewed and care staff roster alterations were implemented on 9 May 2011.<br><br>Nursing staff numbers, whilst adequate, have also been reviewed and further changes are in the process of being implemented to ensure that the person in charge does not augment the clinical compliment unless there are exceptional circumstances. The appointment of new Clinical Nurse Managers and nursing staff currently undergoing induction will ensure achievement of this objective. | Complete<br><br>Complete<br><br>Complete<br><br>End July/August 2011 |

**2. The provider has failed to comply with a regulatory requirement in the following respect:**

The risk management policy was not implemented and the policy did not fully meet the Regulations and would not guide practice.

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| Inspectors observed the sluice room doors to be opened on the first day of the inspection and there were cleaning chemicals in these rooms.<br><br>The was no emergency procedure to guide practice.<br><br>There was not a robust system in place to monitor the number, nature, cause or severity of incidents and accidents and subsequent outcomes for residents. | |
| **Action required:**<br><br>Amend and implement the risk management policies. | |
| **Action required:**<br><br>Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre. | |
| **Action required:**<br><br>Put in place an emergency plan for responding to emergencies. | |
| **Action required:**<br><br>Put systems in place to identify, investigate and learn from serious or untoward incidents or adverse events involving residents. | |
| **Reference:**<br>Health Act, 2007<br>Regulation 31: Risk Management Procedures<br>Standard 29: Management Systems | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>The implementation of a revised risk management policy commenced on 25 March 2011 and is ongoing. Individual staff training schedules in this regard are currently in process.<br><br>We have specific internal policies in relation to 'elopement', i.e. Resident absent without leave and a challenging behaviour policy which includes assessment and management of agression and assault, violence, and self harm.<br><br>For the purposes of clarity we have renamed our 'elopment policy' to 'resident absent without leave policy'. These specific policies have now been appendiced within the corporate risk management policy. In effect our risk management policy now | Complete by end October 2011<br><br>Completed |

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| incorporates both our clinical and non-clinical risks procedures.<br><br>The nursing home has a comprehensive health and safety policy which requires us to take all reasonable measures to prevent accidents to any person in the nursing home and in the grounds of the nursing home. This policy is updated annually, and was last reviewed/updated in May 2011.<br><br>The four sluice rooms within the nursing home are now accessible only to staff and doors remain locked at all times.<br><br>A comprehensive safety risk assessment was carried out by our external health and saftey consultant throughout May and June 2011, and any recommendations are being implemented.<br><br>Staff are continuing to receive further training in health and safety to incorporate a more comprehensive knowledge of risk prevention, falls, restraint and challenging behaviour - which includes recognising and responding to elder abuse, agression, assault, self-harm and other identifiable risks.<br><br>An emergency (evacuation) plan was implemented in 2010, and at the time of inspection this was with our health and safety consultants to be updated. This policy is now complete and has been implemented. All staff have been made aware of, and have received details of this Policy.<br><br>Whilst systems are in place to identify and investigate risks, a senior nurse has been appointed as a designated 'falls/risk prevention' nurse. This nurse is currently reviewing documentation to enhance mechanisms for reviewing, recording, communicating and implementing remedial actions to all members of the multi-disciplinary team. | <br><br>Completed 5/5/2011<br><br>Ongoing/Complete by September 2011<br><br>Complete by October 2011<br><br>Completed<br><br>Complete by end of September 2011 |

**3. The provider has failed to comply with a regulatory requirement in the following respect:**

There were guidelines on how risk of falls should be assessed and managed but these were not being adhered to. Some at risk residents did not have a comprehensive falls prevention and management care plan in place.

**Action required:**

Provide a high standard of evidence based nursing practice.

| **Reference:**<br>Health Act, 2007<br>Regulation 6: General Welfare and Protection<br>Standard 13: Healthcare | |
|---|---|
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>Staff are currently receiving updated training on the management of risk and individual risk assessments.<br><br>Falls prevention and management care plans for all residents are currently being reviewed to ensure that they are more comprehensive and implemented in accordance with the assessors recommendations and best practice guidelines.<br><br>Falls and risk preventation guidelines for all staff are now displayed in each residents bedroom.<br><br>All residents and/or their families have received falls and risk prevention information leaflets. | <br><br>Complete by end August 2011<br><br>Complete by End August 2011<br><br>Complete<br><br>Complete |

| **4. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>The temperature of the water in the ensuite bathrooms on the ground and first floor was too hot and posed a risk to residents. | |
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| **Action required:**<br><br>Provide at appropriate places wash-hand basins with a hot and cold supply that incorporates thermostatic control valves or other suitable anti-scalding protection. | |
| **Reference:**<br>Health Act, 2007<br>Regulation 19: Premises<br>Regulation 31: Risk Management<br>Standard 26: Health and Safety | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |

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| Provider's response:<br><br>All our wash-hand basins have hot and cold mixer taps with temperature controls. When the inspector advised of the irregularity in water temperatures of two ensuite bathrooms on the day of inspection, immediate steps were taken to address this issue.<br><br>Our heating and plumbing staff attended the nursing home and the water temperatures in all ensuite bedrooms was checked. The readings showed a water temperature in the range of 39.4 - 41.9.<br><br>To ensure additional safety of residents two 'in-line temperature control blending valves' were fitted at source to ensure that water temperatures to individual rooms does not exceed a temperature of 43 degrees, whilst maintaining a minimum storage temperature of not less than 60 degrees and a distribution temperature of not less than 50 degrees.<br><br>In addition to this, maintenance staff have commenced checking water temperatures in all bedrooms on a weekly basis and will maintain a written record of same as requested by management and advise of any problems. | Completed 06/05/2011<br><br>Ongoing |

**5. The provider has failed to comply with a regulatory requirement in the following respect:**

Recently recruited care staff who commenced employment in March and April had not undertaken formal fire safety training. There was no date planned for this training.

**Action required:**

Make arrangements to ensure that all persons working at the designated centre are aware of the procedures to be followed in the case of fire.

**Reference:**

Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
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| Provider's response:<br><br>There is a written contractual agreement with Fire Safety Consultants to provide formal fire training for staff on a three-onthly basis and/or as required.<br><br>At induction all new employees are advised of fire safety and weekly fire alarm tests and drills pending completion of a more comprehensive fire saftey training programme by external facilitators.<br><br>Previous training was held in March 2011 and further training was scheduled for 16 June 2011 to encompass employees who commenced employment in April/May 2011.<br><br>All new staff have completed a comprehensive fire training programme and all staff will continue receive regulatory updates/training as per our contractual agreement with our training provider. | Complete<br><br>Ongoing |

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| **6. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>The Chief Inspector was not notified of a serious injury to a resident as per the Regulations. | |
| **Action required:**<br><br>Give notice to the Chief Inspector without delay of the occurrence of in the designated centre of any serious injury to a resident. | |
| **Reference:**<br>Health Act, 2007<br>Regulation 36: Notifications of Incidents<br>Standard 29: Management Systems | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>The person in charge has always endeavoured to submit legislative notifications to the chief inspector within the required time frame, and will continue to do so. The person in charge advised inspectors that she had made an genuine mistake in omitting to send one notification form in relation to an incident which took place over a Bank Holiday period, which was an oversight on her part due the the timing of the incident. She | Ongoing |

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| acknowledged this oversight, apologised, and advised that she will endeavour to ensure there is no recurrence.<br><br>The relevant retrospective notification was subsequently submitted to the authority. | <br><br>Complete |

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| **7. The person in charge has failed to comply with a regulatory requirement in the following respect:**<br><br>Household staff could not detail how to respond to allegations of suspected elder abuse. The protection of vulnerable adults would be enhanced if training or other means of informing staff about the elder abuse policy was extended to non- clinical staff members. | |
| **Action required:**<br><br>Make all necessary arrangements by training staff or other measure in place aimed at preventing residents being harmed or suffering abuse | |
| **Reference:**<br>Health Act, 2007<br>Regulation 6: General Welfare and Protection<br>Standard 8: Protection | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>Whilst nursing and care staff have completed training on the protection of vulnerable adults and prevention of abuse, this has now been provided for all staff who do not have direct hands on contact with Residents.<br><br>In May and June 2011, housekeeping, maintenance, clerical, administration and catering staff received training on the protection of vulnerable adults, including recognising and responding to elder abuse.<br><br>Protection of vulnerable adults and associated training is scheduled for newly appointed nursing and care staff as they commence employment.<br><br>Training updates and staff training in recognising and responding to elder abuse will continue to be provided as required by individual staff members. | <br><br>Complete<br><br>Complete<br><br>Ongoing<br><br>Ongoing |

**8. The provider has failed to comply with a regulatory requirement in the following respect:**

Staff did not adhere to the medication management policy. Inspectors noted that the nurse had not administered a nutritional supplement to a resident on three occasions and this was not recorded as a medication error.

**Action required:**

Ensure staff are familiar with polices and procedures on medication management.

**Reference:**

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
|---|---|
| Provider's response:<br><br>All current and new nursing staff are receiving updates and training in relation to our medication management policy and the appropiate recording/documentation of same. This process includes the An Bord Altranais approved e-learning Medication Management Programme. | September 2011 |

**9. The provider has failed to comply with a regulatory requirement in the following respect:**

There was no system in place to review the quality and safety of care.

**Action required:**

Establish and maintain a system for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

**Reference:**

Health Act, 2007
Regulation 35: Review of quality and Safety of care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
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| Provider's response:<br><br>Following the completion of the induction period of newly appointed clinical nurse managers and staff nurses, plans are in progress to facilitate the implementation of a Quality Assurance Committee within the nursing home. This committee will include residents and staff, and will have a specific mandate in relation to Quality Assurance including the implementation of specific documentation which will allow us to receive feed back from Residents in a more formalised manner. | End of October 2011 |

**10. The person in charge has failed to comply with a regulatory requirement in the following respect:**

Care plans did not consistently detail the individual needs of the residents and was not updated three-monthly or when the resident's needs changed.

**Action required:**

Keep residents care plans under formal review as required by the Regulations.

**Reference:**

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 10: Assessment
Standard 11: The Resident's Care Plan

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
|---|---|
| Provider's response:<br><br>All Residents care plans are reviewed as required or on a three-monthly basis. The person in charge has addressed the appropriate documentation of this review on previous occasions and is currently examining ways of ensuring the review also includes relevant 'updating' and re-assessment of individual care needs which must be documented on Residents specific care plans rather than on review notes. | Ongoing/ Complete by end October 2011 |

**11. The provider has failed to comply with a regulatory requirement in the following respect:**

Inspectors examined a number of staff files and found that they did not meet the requirements of the regulations

**Action required:**

Obtain the information and documentation for each staff member as specified in Schedule 2 of the Regulations.

**Reference:**

Health Act, 2007
Regulation 18: Recruitment
Standard 22: Recruitment

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
|---|---|
| Provider's response: | |
| We utilise the services of an external consultant to assist with the recruitment and selection of staff and our recruitment policy includes the criteria detailed in Standard 22.2 of the Regulations. | Ongoing |
| Relevant documentation as per standard 22.2 has been obtained for all staff employed following the implementation of the Standards. | |
| All employees are required to submit a declaration of fitness on their application form. | Ongoing |
| Some staff have advised us why they do not consider it practical to obtain GP certification, and we have now requested written confirmation from individual staff to detail why they consider it is not practical for them to obtain such evidence from a GP. Upon receipt of this evidence, it will be placed in individual staff files. | Complete by end September 2011 |

**12. The person in charge has failed to comply with a regulatory requirement in the following respect:**

Staff were not provided with access to education and training to provide care in accordance with evidenced based practice in relation to falls, behaviour that challenges and restraint

**Action required:**

Provide staff with education and training to enable them to provide care in accordance with evidenced based practice.

| **Reference:**<br>Health Act, 2007<br>Regulation 17: Training and Staff Development<br>Standard 24: Training and Supervision | |
|---|---|
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>All multi-disciplinary staff are currently receiving updates and/or training in relation to falls and risks, challenging behaviour, and Restraint. Training sessions took place in May and June 2011 and further training sessions are planned.<br><br>The Assistant Director of Nursing has attended a 'Restraint Trainers' Course and is undertaking responsibility for training all staff in this area. | Complete by end of July 2011<br><br>Complete by end of October 2011 |

| **13. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>The record of complaints did not include the complainant's satisfaction with the investigation and outcome.<br><br>The complaints policy did not include details of an independent appeals process | |
|---|---|
| **Action required:**<br><br>Update the complaint policy to meet the all the requirement of the regulations | |
| **Reference:**<br>Health Act, 2007<br>Regulation 39: Complaints Procedures<br>Standard 6: Complaints | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>As requested by inspectors, the contact details of the Authority have been removed from our complaints policy and the policy now contains details of an independent appeals contact person. | Complete |

**14. The provider has failed to comply with a regulatory requirement in the following respect:**

The statement of purpose did not contain all of the requirements of the Regulations, for example, it did not fully include the arrangements made for dealing with complaints and the fire precautions were not detailed.

The provider did not notify the Chief Inspector of changes made to the statement of purpose, which affected the purpose, and function of the centre when a three-bedded room was reduced to two single bedrooms.

**Action required:**

Update the statement of purpose to include all aspects of the Regulations.

**Action required:**

Notify the Chief Inspector in writing of changes made to the statement of purpose which affected the purpose and function of the centre.

**Reference:**

Health Act, 2007
Regulation 5: Statement of Purpose
Standard 1: Information
Standard 28: Purpose and Function

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
|---|---|
| Provider's response:<br><br>The statement of purpose has been updated to include details details of an independent appeals contact person and fire precautions.<br><br>Notification of the change from a three-bedded room to provide two single ensuite bedrooms was submitted by letter to the Registration Department on 9 March 2011. | <br><br>Complete<br><br>Complete |

## Recommendations

**These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.**

| Standard | Best practice recommendations |
|---|---|
| Standard 5: Civil, political and Religious Rights | Consider ways to support Independent advocacy for residents.<br><br>Consider how residents can access religious practices more frequently in accordance with his/her wishes. |
| Standard 25: Physical Environment | Review storage in the laundry. |
| Standard 25: Physical Environment | Review access to residents' bedrooms. |
| Standard 25: Physical Environment | Review the cleaners' room in line with the Standards. |
| Standard 25: Physical Environment | Review the one three-bedded room with ensuite which was not in line with the standards. |
| Standard 17: Autonomy and independence | Consider how communication could be improved to include care assistants at handover and more frequent staff meetings.<br><br>Consider how the key workers and named nurse could be updated in residents' rooms. |
| Standard 2: Consultation and Participation | Consider ways for the residents' committee could be more frequent. |
| Standard 25: Physical Environment | Review storage of incontinence pads. Review the signage to provide effective and meaningful prompts to help residents find their way to communal areas and their rooms.<br><br>Consider how residents can access a bath. |

**Any comments the provider may wish to make:**

**Provider's response:**

The provider is considering, and will continue to give consideration to the best practice recommendations detailed above.

The provision of new assisted bathrooms, cleaners rooms, additional storage facilities, and the conversion of the remaining three-bedded room into two single en-suite rooms are part of our current service development plan which is being reviewed by the provider and board of directors who have commenced the legislative planning process in this regard.

We wish to think the inspectors for their comments and recommendations which we will utilise to enhance our service provision and assist in further promoting best practice and legislative compliance.

**Provider's name:** Mairéad M. Byrne, Managing Director, Springwood Nursing Homes Limited trading as Elm Hall Nursing Home
**Date:** 21 June 2011