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:	0135
Centre address:	Esker Place Cathedral Road, Cavan
Telephone number:	049-4375090
Email address:	info@eskerlodgenursinghome.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Esker Lodge Ltd
Person authorised to act on behalf of the provider:	Vicky McDwyer
Person in charge:	Nuala Patterson
Date of inspection:	9 April 2013
Time inspection took place:	**Start:** 09:15 hrs **Completion:** 17:45 hrs
Lead inspector:	Sheila McKevitt
Support inspector(s):	Damien Woods
Type of inspection	☒ **announced** ☐ **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 their 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
- 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with 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*.

This inspection report sets out the findings of a monitoring inspection, in which all of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☒ to inform a registration renewal decision
- ☐ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☒
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☒
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☒
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☒
Outcome 18: Suitable Staffing	☒

This monitoring inspection was announced and took place over one day. As part of the monitoring inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Overall, the centre was found to be managed well and delivering a good standard of care to residents. Residents and relatives spoken with expressed happiness with the care provided and the centre in general.

Section 41(1)(c) of the Health Act 2007

Compliance with 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*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Action(s) required from previous inspection:

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

Inspection findings

The statement of purpose updated in February 2013 accurately describes the service provided in the centre. It includes all matters listed in Schedule 1. A copy was submitted to the chief inspector prior to the registration inspection.

Outcome 2

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:

Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Action(s) required from previous inspection:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Inspection findings

Samples of contracts of care were reviewed. All residents had agreed a contract of care with the provider which included details of the services to be provided for that resident and the main fee to be charged. However, they did not include the fees and costs of additional services as outlined in the application for renewal of registration.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

The action required from the previous inspection were satisfactorily implemented.

Inspection findings

The person in charge was on duty during the inspection. She has worked in the centre since 2007, initially as a General Manager. She registered with An Bord Altranais agus Cnáimhseachais n hÉireann as a registered psychiatric nurse in 2009 and took up the role of person in charge in November 2012. Details of her nursing experience included 3/6 years of working with older people. She works fulltime, and has a post graduate qualification in management. She is supported in her role by a clinical nurse manager who manages the centre in her absence and by the provider.

The person in charge has line management responsibilities for the nursing, care staff, administration, household and catering.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Residents' Guide

Substantial compliance ☐ Improvements required * ☒

The residents' guide did not include a full summary of the statement of purpose. Inspectors noted that it did not include some relevant information for residents'. For example, staff do not wear uniforms or name badges or advise that closed circuit television was used throughout the centre.

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

As stated throughout other outcomes in this report a number of policies named iin schedule 5 did not reflect practice in the centre and/or did not meet the legislative requirements.

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

Staffing Records

Substantial compliance ☐ Improvements required * ☒

Evidence was not available in 4/6 staff files to show that the person was physically and mentally fit for the purposes of the work that they are to perform at the designated centre. Four files contained a declaration signed by the person that they were so fit. There was no written record in any of the four staff files to indicate why it was impracticable to obtain the evidence from their medical practitioner.

Medical Records

Substantial compliance ☒ Improvements required * ☐

Insurance Cover

Substantial compliance ☒	Improvements required * ☐

Outcome 5
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge had not been absent for more than 28 days which required notification to the Authority. The person in charge was aware of her reporting requirements to submit appropriate notifications. As mentioned under Outcome 3, the clinical nurse manager was nominated key senior manager to take charge in the absence of the person in charge.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
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.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Actions required from previous inspection:

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

Inspection findings

Inspectors reviewed the centre's policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse, the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse. Staff spoken to on the day of inspection were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse. Records reviewed post inspection confirmed that staff had received training on identifying and responding to elder abuse. Garda Síochána vetting was in place for staff employed by the provider. This was evidenced by a review of a sample of six staff files.

Residents spoken to confirmed that they felt safe in the centre. Entrance and exit doors were secure. There was a member of staff on the reception desk from 09:00 hrs to 17:30 hrs, where all visitors to the centre had to sign in. Closed circuit television (CCTV) was in use in corridors and communal rooms.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

The procedures to be followed in the event of fire were displayed in a number of prominent locations. However, the text font was small and the document displayed contained a lot of information which may not be efficient in informing immediate responses in an emergency.

Inspection findings

The risk management policy had been reviewed since the last inspection. It met the legislative requirements. The health and safety policy and safety statement was in place - it had been updated by qualified personnel and was signed and dated by the provider. The risk policy outlined how to undertake a risk assessment and identified that a health and safety committee was in place, it included its memberships' roles and responsibilities. Minutes of meetings were available for review. A risk register

had been completed and was continually updated by the management team. A culture of managing any identified risk was evident and resident safety was a management priority.

An emergency plan was in place to outline clear procedures to follow in the event of loss of electric power, flood, gas leak or security concerns. Inspectors spoke to staff and found they were familiar with the contents of the emergency plan, reporting structures in case of an emergency and nearby buildings where residents could be evacuated to.

The reception area was manned and the car parking areas secure. There was a visitors log in place to monitor the movement of persons in and out of the building. There was a missing person policy which included clear procedures to guide staff should a resident be reported as missing. A policy was in place to guide staff in the event of any incident of violence, aggression, self harm and assault.

Residents confirmed to inspectors in conversations that they felt safe in their day to day life at the centre and enjoyed the secure grounds of the centre.

A centre-specific infection prevention and control policies and procedures were found to be in place. Hand-washing and drying facilities and hand disinfectant gels were available at the reception and nurses' stations.

The fire alarm and fire fighting equipment was maintained, and all staff had attended fire safety and evacuation training. Means of escape were clear and unobstructed and identified. However, a lift that was suitable for use for evacuation of residents was not clearly identified as such. The procedures to be followed in the event of fire were displayed in a number of prominent locations. However, the text font was small and the document displayed contained too much information rather then immediate responses to be taken in the event of an emergency.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

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

Inspection findings

The inspector reviewed the medication management policy and noted that it included the procedure for prescribing, administering, recording, safekeeping and disposal of

unused or out of date medications. It now included clear guidance for staff who transcribed medications and used faxed prescriptions.

Inspectors reviewed medication management practice and found nursing staff were knowledgeable about medication and administration practices. The administration of medication observed by inspectors was found to be safe and in line with An Bord Altranais agus Cnáimhseachais n hÉireann guidance to nurses and midwives. Training records reviewed showed staff nurses had received training in medication management within the past year.

The prescription charts had been reviewed since the last inspection and those reviewed had discontinued medications signed and dated by the residents' general practitioner and included the maximum dosage of each PRN medication to be administered.

The centre had a medication variance report form in place for recording medication errors, near misses and omissions. A record of medications received and returned to and from pharmacy was maintained. At each shift change the medications that required strict control measures (MDAs) were checked and counted. The inspector found record keeping was to a high standard in this area and in line with best practice. The pharmacy delivered pre-packaged medication systems which were checked by two staff members on delivery.

Medication audits were carried out by the management team on a six monthly basis and the results of these audits were fed back to staff at staff meetings. It was evident that these audits had lead to improvements in practice. There was also written evidence to show that the pharmacist visited residents on an individual basis discussing and explaining their medications to them.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors cross referenced all notifications submitted to the Authority since the last inspection with records of all accidents and incidents held in the centre since the last

inspection. All serious accidents and incidents had been notified to the Authority by the person in charge in a timely manner.

Completed incident and accident forms were found to be audited by the person in charge and the management team.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Action(s) required from previous inspection:

While a number of audits are routinely carried out and documented - not all of the information collected was fully analysed.

Inspection findings

There was a system in place to audit the quality and safety of some aspects of care and quality of life for residents. For example, as mentioned under outcome 8 medication management audits were conducted on a six monthly basis and the monitoring of this practice had lead to considerable improvements and maintenance of a robust medication management system.

Audits conducted on accidents and incidents also fed into the health and safety committees reviews of potential risks and addressing these. However, further analysis of the results of these audits could be done to identify trends in practice, thereby providing a clearer view of progress or regress in the area of practice audited.

The centre was in a period of transition with nursing documentation. A new system of documentation had been introduced in Jan 2013. The management team planned to audit this practice in the fourth quarter of 2013.

The centre has adopted a new infection control system and staff were implementing same at the time of inspection. The internal infection control records viewed did not

reflect the area of practice to be audited. The infection control records dealt mainly with maintenance issue as opposed to actual infection control issues such as cleaning.

Outcome 11

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

Resident's files were not consistently integrated where each assessment done informed a care plan Some care plans did not adequately reflect all of the residents assessed needs in an easy to follow format.

Inspection findings

Residents' healthcare needs were being met. Consultation and review by allied health care professionals was sought and gained without delay. This was evident on review of a sample of resident files.

As stated under outcome 10, nursing documentation was in the initial phase of change from one system to another. Inspectors reviewed documents for a number of residents met on inspection and found that staff nurses completed a full detailed assessment of residents' on admission and there was a care plan to reflect each need identified. However, the pre-printed care plans in use did not include details of the individual care needs of the resident. They were not person-centred and the daily nurses' evaluation was not linked to the residents care plan.

Inspectors did note that resident assessments and care plans were updated on a three monthly basis and there was evidence that the resident and/or their next of kin was involved. As mentioned under outcome 10 there was no evidence that nursing documentation was audited to date.

There was written evidence now available to show that residents had been assessed and alternatives tried prior to any form of restraint been used. Documentation included the duration restraints were in use and clearly distinguished between restraints and enablers.

Activities available to residents' had been developed further since the last inspection. Each resident had a document called 'A Key to Me' completed on admission. This provided staff with an insight into their life and general interests. There was a timetable displaying activities in different units of the centre this included time for one to one activities to residents who did not wish or could not participate in group activities. Inspectors' saw residents' participating in group activities. Staff told inspectors they had received training in delivering Sonas classes which cognitively impaired residents' attended and inspectors saw their level of participation recorded. Residents confirmed that they enjoyed the activities.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

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

Inspection findings

Inspectors found the centre to be clean and tidy. Residents' confirmed their satisfaction with the level of cleaning of both their personal space and the communal areas.

Issues from the last inspection including floor covering had been addressed. Floor covering throughout the centre appeared safe, intact and clean. Inspectors saw that handrails had been installed by the side of toilets in a number of communal bathroom and communal toilets.

The height of railings on the outdoor balcony had been raised to ensure residents' safety. Residents' confirmed they could access the outdoor spaces and the person in

charge demonstrated to inspectors how this was managed to ensure both the safety and independence of residents.

The premises were found to reflect the description outlined in the centres Statement of Purpose.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

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

Inspection findings

The inspector was satisfied that there was a complaints policy was in place and the complaints procedure was on display throughout the centre. The person in charge was the complaint's officer both residents and staff spoken with were aware of this. Residents told inspectors that they would speak to the home manager or her deputy with any issue/complaint they may have. Resident questionnaires confirmed that they were satisfied that the arrangements in place to deal with complaints.

Inspectors found that all verbal complaints had been dealt with or were in the process of being investigated as per the complaints policy. A review of the complaint file showed the actions taken to investigate and resolve complaints, the outcome of the complaint and the complainants' level of satisfaction with the outcome was all recorded.

Inspectors noted that the independent appeals person mentioned on the complaints policy was the provider. As the provider is not independent of the centre this section needed to be reviewed.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The end of life policy in place did not reflect the good end of life care provided to residents' in the centre. For example, it did not mention that residents would be referred to the local palliative care team or the fact the relatives/friends could be facilitated to stay if they wished.

There was one resident receiving end of life care. A review of this residents records showed the residents' wishes were documented and updated as necessary. A care plan referencing end-of-life care was in place to inform this care. Access to Community Palliative Care Services was available to support residents requiring their services. There was a large Oratory located on the first floor which is occasionally used for removal ceremonies of deceased residents the inspector was told.

Relatives are facilitated to stay overnight with residents receiving end of life care. A coffee dock was available to facilitate them to have refreshments as they wished. The team hosted a remembrance service for deceased residents as an annual remembrance event.

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

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector observed lunch time service in the dining room. Overall, residents told inspectors they enjoyed the food and the choices available to them. The dining rooms were appropriately furnished and welcoming. Inspectors saw table settings were pleasant and included condiment, napkins and appropriate place settings for all residents. A water dispenser was available in the centre.

A menu identifying the menu choices for the day including pictures of the meals been served, was displayed in the dining room. The same menu choice was available for residents on a modified consistency diet. Staff assisted in serving meals and ensuring residents obtained their preferred food choices. Staff spoke to residents throughout attending to their requests during the meal. The inspector was satisfied the mealtime experience was enjoyed by residents who took their meals in the dining room and to those who ate their meal in their bedroom. Appropriate assistance was offered to residents who required assistance in both their own room and in the dining rooms. Inspectors observed that a high number of residents wore blue check protective clothing during the meal rather than using napkins provided. These items did not enhance the privacy or dignity of residents.

There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. Documentation showed that each resident's weight was checked on a monthly basis or more regularly if required. Nutrition assessments were used to identify residents at risk and monitor progress with nutritional supplementation.

Outcome 16
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Action(s) required from previous inspection:

CCTV monitoring in the residents communal areas requires review in respect of its impact on their privacy and dignity needs.

Although in place the Communication Policy did not contain adequate information to fully inform staff of best practice in relation to addressing residents' communication needs in the centre. The document drafted in 2009 and updated in 2012 and did not reference up to date information in all respects.

Inspection findings

There were policies in place to address communication in the centre including the communication needs of residents'. Inspectors saw several examples that demonstrated that residents were facilitated and encouraged to communicate. Minutes of residents' quarterly meetings were available for review and dealt with the issues raised by them in relation to the centre.

Inspectors saw residents' taking part a variety of activities. A range of interests were facilitated. A seven day programme was in place and displayed in both units and on notice boards throughout the centre. Staff kept records of the activities residents' took part in and their level of participation. There were also specific activity sessions targeted towards residents with dementia where personal acknowledgement, sensory and music prompts were used to help their recollections and memory recall. Residents confirmed that they were treated with respect and dignity and said that they felt valued.

Inspectors observed that residents knew the person in charge and provider by their first name and observed that interactions between all staff and residents' were friendly and positive.

Inspectors observed the bedroom doors of residents who were resting in their bed on the second floor remained fully opened. This compromised the privacy of these mainly maximum dependency residents' as any visitors to the centre could see directly into their bedroom. The more independent residents were seen moving around the centre freely. Visitors were welcomed throughout the day at times that suited residents. The reception area was welcoming with a receptionist, comfortable seating and a visitor's sign in book.

As mentioned under outcome 15 the use of blue check protective clothing did not enhance the privacy or dignity of residents'. The use of these items immediately alerted you to the fact that they may have a problem with eating neatly.

CCTV warning signs had been put place. However, they were not positioned at eye level where they could be seen by staff, residents' or visitors. They were positioned beneath the each CCTV camera where they could not be seen unless one was looking up at the CCTV camera.

Outcome 17
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Action(s) required from previous inspection:

While all residents' personal property and possessions was fully documented on admission, not all residents had this list updated at regular intervals to maintain complete and accurate records of changes as required.

The inspector viewed a written operational policy on personal belongings dated 2009, updated in July 2012 required further updating to reflect the legislative requirements in relation to personal belongings of residents.

Inspection findings

The policy on personal belongings had been reviewed and updated by the now person in charge in July 2012, post the last inspection. However, although this revised version did reflect current practices it did not reflect the legislative requirements.

Resident clothing was individually labelled by laundry staff on admission and any new clothing brought in thereafter was also sent to the laundry for labelling. Inspectors saw and residents' confirmed that they had plenty of space to store personal possessions. Residents confirmed that a lockable storage area was available to them if they wanted it and this was reflected in the policy.

A record of their personal possessions was logged on admission. However, this log was not kept up to date for all residents' and was not signed by the resident/their relative. A number of residents had not had their records of personal possessions reviewed/updated since admission in 2011.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment

Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision
Action(s) required from previous inspection: Inspectors reviewed staff files and found that the required documents were not in place in some of those files reviewed. 1/6 staff files did not contain evidence that the person was physically and mentally fit for the purposes of the work that they are to perform at the designated centre.

Inspection findings

A full review of staffing levels and skill mix had been completed in January 2013. Inspectors were satisfied that the staffing levels and skill mix were adequate to meet the needs of residents. The person in charge in the absence of the person in charge and her deputy was now highlighted on the staff roster. Residents spoken with confirmed that they did not have to wait for long periods to have their call bell to be answered. Residents who completed pre-inspection questionnaires were satisfied with current staffing levels.

Staff spoken with confirmed they had all the required mandatory training in place and records provided to inspectors post inspection confirmed this.

As mentioned under outcome four, staff files reviewed did not contain evidence that the person was physically and mentally fit for the purposes of the work that they were performing at the designated centre. This action plan remains outstanding from the last inspection in June 2012.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, and the nurse manager 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:

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Health Information and Quality Authority

23 April 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	Esker Lodge Nursing Home
Centre ID:	135
Date of inspection:	09 April 2013
Date of response:	23 May 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Governance, Leadership and Management

Outcome 2: Contract for the provision of services

The provider is failing to comply with a regulatory requirement in the following respect:

Contracts of care signed by residents did not include the fees to be charged for additional services as outlined in the application to register.

Action required:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Reference:
Health Act, 2007
Regulation 28: Contract for the Provision of Services

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

Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This action was completed. An additional schedule of fees was added to the contract of care.	17 May 2013

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: The residents guide did not include a full summary of the statement of purpose and did not include all information relevant to residents'.
Action required: Produce a Residents' Guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.
Action required: Ensure each resident has access to information to assist in decision making, including, but not limited to, the information specified in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Provide this information in an accessible format, appropriate to each resident's individual needs.
Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This action is completed. The resident guide now includes a summary of the statement of purpose; it includes a copy of the updated contract of care, details on accommodation and a summary of the complaints procedure. The new inspection report will be appended when finalised.	17 May 2013

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: A number of policies and procedures outlined in schedule 5 did not reflect the legislative requirements or/and current practices within the centre.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The policies referenced in the inspection report were residents' belongings and communications. These were both reviewed and updated in 2012 but have been reviewed again.	9 April 2013 17 May 2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect: Establish and maintain a system of reviewing all aspects of the quality and safety of care delivered to residents and ensure the information gathered is used to improve the quality of care delivered to and the quality of life provided to residents living in the centre.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
Action required: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.
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:**
Provider's response: A system of auditing was put in place after the last inspection which includes date of audit, next date of audit, audit findings & an action plan. On foot of the April inspection this format will be reviewed and linked to other quality of life and safety key performance indicators.	30 September 2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: The individual resident needs were not reflected in their care plan and not always revised when there was a change in their care needs.
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.
Action required: Revise each resident's care plan, after consultation with him/her.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All resident care plans are currently under review to ensure that all needs are reflected, care is reviewed at a minimum 3 monthly reflecting any changes and evidencing consultation with the resident / significant other. To date a new medical/clinical care plan has been created to replace current medical condition care plans which will be person-centred around individual resident's needs. This is being externally reviewed and based on evaluation feedback will be rolled out.	30 September 2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect:

The provider was the named appeals person therefore not independent as per the legislative requirement.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We have updated the complaints procedure to include an appeals officer who is not involved onsite on a daily basis, as per the inspectors request. This action is completed.	13 April 2013

Outcome 14: End of life care

The provider is failing to comply with a regulatory requirement in the following respect:

The end of life policy was not reflective of end of life practices in the centre.

Action required: Put in place written operational policies and protocols for end of life care.	
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The End of Life Policy was updated to reflect practices within the centre.	11 April 2013

Outcome 16: Residents' rights, dignity and consultation

The provider is failing to comply with a regulatory requirement in the following respect: The use of blue check protective clothing at mealtimes did not ensure the privacy and dignity of residents who wore them.	
Action required: Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.	
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident survey is due and we will include a special section to obtain feedback from families and residents in relation to use of the blue check protective clothing. The issue will be raised in the next residents' forum. The issue will be raised in the next newsletter.	30 July 2013 31 May 2013 31 July 2013

Outcome 17: Residents' clothing and personal property and possessions

The provider is failing to comply with a regulatory requirement in the following respect: The policy on personal possessions did not reflect the legislative requirements. An up-to-date record of each resident's personal property signed by the resident was not available for each resident.
Action required: Put in place written operational policies and procedures relating to residents' personal property and possessions.
Action required: Maintain an up-to-date record of each resident's personal property that is signed by the resident.
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The policy on resident's possessions has been updated in line with legislative requirements. All resident's property records are being updated to include the signature of the resident / next of kin / significant other.	 9 April 2013 31 July 2013

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: Evidence was not available in all staff files to show that they were physically and mentally fit for the purposes of the work which they are to perform.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.

Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Going forward Esker Lodge will obtain GP reports for mental and physical fitness for new employees until such time as there is a change in the regulations. A copy of the IGCP letter provided to the Health Information and Quality Authority as part of this report will be placed in existing employee files to demonstrate that as per the regulation, schedule 2 section 10: "Evidence that the person is physically and mentally fit for the purposes of the work that they are to perform at the designated centre or, where it is impracticable for the person to obtain such evidence, a declaration signed by the person that they are so fit." because it is impracticable to have the declaration signed the employee has completed a self declaration.	31 May 2013