

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

**Inspection report
Designated centres for older people**



Centre name:	Esker Lodge
Centre ID:	0135
Centre address:	Esker Place
	Cathedral Road
	Cavan
	Co. Cavan
Telephone number:	049-4375090
Fax number:	049-4377504
Email address:	info@eskerlodgenursinghome.ie
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered provider:	Vicky Mc Dwyer
Person in charge:	Binimole Santhosh
Date of inspection:	26, 27 January and 25 February 2010
Time inspection took place:	Day 1: Start: 11.30 hrs Completion: 17.30 hrs Day 2: Start: 09.00 hrs Completion: 17.00 hrs Day 3: Start: 11:00 hrs Completion: 14:30 hrs
Lead inspector:	Geraldine Jolley
Support inspectors:	Sonia McCague and Jude O'Neill (day 3 only)
Type of inspection:	<input checked="" type="checkbox"/> Registration <input type="checkbox"/> Scheduled <input checked="" type="checkbox"/> Announced <input type="checkbox"/> 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 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.

Acknowledgements

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

About the centre

Description of services and premises

At the time of this inspection, a major transition to incorporate a new extension to the existing premises was nearing completion. The existing building is purpose-built and designed over two floors. Accommodation is provided for 44 residents who need long term care, short term respite care, palliative care or who have problems associated with dementia.

The centre is bright, airy and well furnished. Communal space comprises two sitting rooms, a dining room, an oratory and a range of other smaller sitting areas located around the premises. There are 18 single and 13 twin rooms, all with an en suite toilet, shower and wash hand basin. All rooms were well furnished, with coordinating bed linen and curtains and had arm chairs and televisions. There is also an enclosed courtyard where residents have access to safe and secure outdoor space.

Office space is provided for administration staff and nurses and there is a treatment room and hair salon.

There are ample car parking spaces including designated disabled spaces to the front of the building for those who require it.

The new extension was in the final stages of completion but could not be fully inspected in January 2010 as builders were still on site. It was inspected on 25 February 2010. The extension will provide a designated dementia care unit for 26 residents and increase the overall occupancy level to 70. Additional communal space, assisted bathrooms and kitchen facilities are also part of this development.

The dementia care unit has been designed and equipped with a range of dementia specific features that reflect best practice in dementia care and design. Communal space is small-scale and domestic in style with sitting, dining and kitchen areas in close proximity. The use of appropriate signage to guide residents to different areas of the centre was utilised throughout.

Location

Esker Lodge is located in a residential area of Cavan town, a short drive from the shops and business premises. The bus services from Cavan to Dublin and Donegal to Dublin provides additional access if using public transport.

Date centre was first established:	September 2002
Number of residents on the date of inspection	43

Dependency level of current residents	Max	High	Medium	Low
Number of residents on day of inspection	0	23	7	13

Management structure

The registered provider is Vicky Mc Dwyer who is on site regularly and takes an active part in management activities. The person in charge, Binimole Santhosh, together with the provider and general manager, Nuala Patterson, form the management team. A member of the management team is on call outside of regular hours should staff on duty need advice or guidance.

On a day to day basis, the centre is managed by the person in charge who oversees the delivery of care and manages the nursing, care and ancillary staff.

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	2	8	3	3	1	2*

* 1 general manager plus 1 maintenance person

Summary of findings from this inspection:

The provider had been requested to apply for registration under the Health Act 2007 and 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 of Social Services of the Health Information and Quality Authority (the Authority) that he 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.

At the time of this inspection, 26 and 27 January 2010, a new extension could not be inspected as building work was still ongoing. A subsequent follow-up inspection was carried out on 25 February 2010 which confirmed that the extension had been completed to a high standard.

Inspectors met with residents, relatives, the provider, the person in charge, staff nurses, carers, the chef, catering staff, cleaning staff and the maintenance person. The range of documentation examined included the registration application, fire safety records, health and safety documents, operational policies and procedures, staff files, assessment, care plans and medication records.

The provider and person in charge completed fit person interviews during the inspection. Both were very knowledgeable about the legislation and standards and were clear about their own specific roles and responsibilities within the centre. A number of documents completed for the registration process were reviewed by inspections. These included the fit person self assessment document, key staff profiles, the statement of purpose, the Resident's Guide and other associated registration documentation. All documents submitted were of a high standard.

Inspectors were satisfied that residents received a good standard of care that was based on up to date practice. All staff were knowledgeable about their roles and told inspectors that they had a duty to provide good care and to be friendly and aware of residents' needs. A wide range of training had been provided and staff interviewed said that they had benefited from this provision.

Systems to support the management team were well developed and senior staff were proactive in addressing problems as they arose and taking remedial action. This was evident from the actions taken by management in relation to issues that arose pertaining to the management of staff.

The action plan at the end of this report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009, and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. The improvements identified included the need for enhanced risk assessment, improved supervision, a re-assessment of residents to reflect changing needs, improved monitoring of health and safety matters such as radiator temperatures and refinement of some policy documents so that they guide and inform staff more effectively.

Residents' and relatives' comments

In preparation for the inspection, 11 residents and 11 relatives completed questionnaires describing the quality of care provided and the quality of life experienced in the centre. During the inspection, inspectors spoke at length to a further ten residents and to others less formally throughout the inspection visit.

Residents described daily life using words such as "very good" and "comfortable". Staff received a lot of praise for the care provided and were described as "very good" and "kind" and "nice". Residents said the centre was well staffed and told inspectors that they felt safe and were "checked on regularly". Residents told inspectors that they were well cared for and had a comfortable place to live. One resident said, "I'm happy here and if I need help with anything there's always someone there, friendly and kind."

Residents were satisfied with the standard of catering and choice of food and snacks provided. While many residents choose to dine in their rooms, one resident said that "you can go to the dining room if you want". Residents told inspectors that the food was good and they were able to select from a menu which changed daily. Residents also said that there was always water, juice, tea and coffee with cakes and biscuits made available during the morning and after lunch."

Esker Lodge was described as warm and very clean by residents and relatives.

One relative said they were "very pleased with the staff and their attitude" while other relatives said the staff were helpful, welcoming and showed respect to residents.

Relatives told inspectors that they felt security was very good and residents could make choices regarding when they had breakfast, when they got up and went to bed and when they had baths and showers. Many relatives said residents were happy and safe.

One relative had raised a concern prior to the inspection regarding the care provided to a resident. This matter was explored with the person in charge and the provider during the inspection.

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

The provider and person in charge demonstrated that they had a good working knowledge of the Health Care Act, 2007 and associated regulations and the *National Quality Standards for Residential Care Settings for Older People*. There was a range of management systems in place to support the business and care aspects of the service provided. The general manager and an administrator supported the person in charge and assisted with the management and administration. Staff could describe the management structure and knew who was responsible for different aspects of the service. Residents and relatives knew who was in charge, who the provider was and where to find senior staff if they wanted to talk about anything.

A statement of purpose and Resident's Guide were in place, which met the legislative requirements and provided good quality information for residents and others who wish to know about the service.

Documents such as the health and safety policy, fire safety and emergency procedure were appropriate in content, described the centre's arrangements and the roles that staff had to undertake in specific situations. There was an emergency evacuation plan in place including emergency boxes. Arrangements were in place with another local centre to provide back up support in the event of a serious untoward incident or evacuation.

Personnel matters were managed in an accountable and proactive way, with recourse to a dedicated disciplinary procedure if required. The sample of staff files inspected confirmed that details of all personnel matters had been noted in staff files.

The complaints procedure met the requirements of legislation. Inspectors reviewed the complaints record and noted that all complaints had been dealt with appropriately. In the records examined, there was evidence of actions taken to rectify the issues in the feedback to the complainant.

Each resident had a written contract containing pertinent information such as the terms and conditions relating to their period of occupancy, the room to be occupied and the fees chargeable.

Fire safety precautions were of a particularly high standard. Training, including evacuations had been regularly scheduled and documented. Equipment was serviced on a contract basis and there were records in place to confirm this.

As this was a registration inspection, fit-person interviews were conducted with the provider and the person in charge. Both were clear and well informed about their specific legal roles in respect of the operation and management of the centre and had regularly attended courses to develop their knowledge and skills. The provider had established a management team (comprising provider, person in charge and general manager) to oversee all aspects of the service, and to monitor and review how the systems in place were operating and how these could be improved. This included the monitoring and review of accident records and complaints.

Significant improvements required

Although there were a number of procedures in place to manage risk, there were a number of outstanding issues that had not been addressed, such as responding to assault and self-harm and there was a need for a more thorough comprehensive risk management procedure.

A consensus approach had been adopted in the event that restraint measures such as bed rails or lap-belts were used. Inspection of the documentation confirmed that residents (whenever possible), their relative, the general practitioner (GP) and staff were involved in all decisions regarding the use of restraint. However, observation during the inspection, discussion with staff and review of care records indicated that the necessary levels of supervision were not always in place when restraint was being used, for example in the small sitting areas. Inspectors saw residents unobserved for long periods with no access to call bells. One resident was quite restless and made efforts to get out of her chair. Inspectors also noted that there was no documentary evidence in care records to affirm that the restraint was in the best interests of the resident or that other less restrictive measures had been considered.

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

Inspectors found that staff were diligent about ensuring residents had a good quality of life. There were a range of policies and procedures that provided protection for residents and these were seen to be followed by staff and to have real meaning for day-to-day work practice. For example, inspectors saw that confidentiality was respected. Residents' records were put away securely after each use and residents said they felt that staff respected their confidential details and the information they relayed to them.

The design and layout of the premises provided a range of communal spaces and a courtyard garden area where residents could meet together or meet with relatives and visitors.

Inspectors were impressed with the commitment of the person in charge and staff to accommodate people who lived locally and the level of support that was provided to enable contact with the local community. Residents were able to maintain social contact with their families, friends and community. Visitors were present throughout the day and were able to sit chatting wherever they wished. Several young people were in visiting their grandparents after school. Some residents went out to community day centres to meet their friends and to maintain links with their past lifestyles.

Inspectors observed that staff promoted residents' privacy. Staff knocked on doors and waited for permission before entering bedrooms. Doors were closed when personal care was being delivered. Inspectors observed staff interactions with residents and saw that these were appropriate, friendly and respectful.

Staff promoted the concept of independence. Many residents were being encouraged and supported to move around the centre throughout the day and to use different parts of the building.

There was a residents' charter in place which described the commitment of management and staff to implement the values of privacy, dignity, choice, fulfilment and rights. Residents said they felt safe, that staff helped them have meaningful

everyday day choices about meals, baths, showers, their clothing, and when they got up or went to bed. A residents' forum met quarterly and residents had been registered to vote.

Some improvements required

Residents were encouraged to bring in personal items but lockable cupboards were not routinely available.

Significant improvements required

The prevention and detection of abuse procedure had good detail on many aspects of elder abuse and staff had received training on this topic. However, the procedure referred to the centre's investigation team doing the preliminary investigation but did not state at what point the Gardaí Síochána, the Elder Abuse Officer in the Health Service Executive and relatives were to be informed.

A number of the small sitting areas were isolated from the main communal areas and residents were noted to be unsupervised for long periods.

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 on-going 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

A system of primary nursing and allocation of carers to a small number of residents was in place. Staff were familiar with residents' likes and dislikes, when they preferred to get up in the day and where they had their meals. Records reviewed indicated that each resident had a number of relevant assessments carried out on admission to inform care. A nutrition care plan was in place based on the Malnutrition Universal Screening Tool (MUST). Assessments of residents' weights were updated monthly and catering staff were informed of specific dietary plans. Risk assessments for falls and pressure area care had been carried out and measures such as pressure relieving equipment were in place. Specialist assessment tools such as the Mini Mental State Examination (MMSE) had been used where there was an indication that a resident had cognitive impairment.

Daily reports were detailed and included commentary on who visited residents, how residents felt and appeared from day to day. Inspectors noted that residents had the choice of retaining the services of their own GP whenever possible. Residents were registered with eleven different GPs and two GPs attended the centre weekly and as required. An on-call medical service was available out-of-hours. All referrals of residents to hospital or to allied health professional services were seen to be timely and had been recorded in residents' notes.

Activities and meaningful occupation were regarded by staff as essential for wellbeing and residents said they enjoyed the choices available to them. There was a selection of books and daily newspapers provided. Residents were observed discussing daily events with each other and with staff. Carers had completed specialist training in undertaking and promoting activities. One carer had completed an "Activities in Care" training course and two carers had completed SIMS – Sonas Individual Multi-sensory Session training. Two dedicated activity staff were available to ensure that a range of individual and group activities were organised and facilitated based on residents needs and interests.

Safe practice was observed in medication administration. The staff nurses interviewed was able to describe the medication in use by residents and were knowledgeable about the ordering, administration, storage and disposal of drugs. The pharmacist visited the centre regularly to audit and remove stock. The person in

charge informed inspectors, staff nurses had completed information and training sessions on medication management.

Care staff were observed hand washing and using hand sanitizers between procedures. Cleaning, care and catering staff informed an inspector that they had attended hand hygiene training and information sessions.

The head chef had trained as a nutritionist and told an inspector that he encouraged and facilitated the availability of food throughout the day. Snacks were available between meals. Food such as soup, juice, tea/coffee and biscuits were offered mid-morning and puddings, fresh fruit, jelly, yogurts and drinks were available and offered to residents' mid-afternoon. Fresh drinking water was available from water coolers on the ground and first floor corridors, and jugs and drinking glasses were seen in use by residents in their rooms.

Staff accurately recorded all falls. A review system was in place and the information was used to inform quality initiatives such as better monitoring and assessment to prevent future accidents.

Significant improvements required

The inspectors were told that pre-assessments were carried out prior to admission to determine whether the centre was suitable to meet the needs of prospective residents. However, a review of care records indicated that a respite resident had not been routinely assessed prior to admission. The sample of records reviewed, and observation during the inspection also confirmed that reasonable measures such as adequate supervision had not been put in place to ensure the needs of this resident and others were being met appropriately.

An inspector observed a resident displaying behaviour that was challenging and which was impacting on another resident. While the inspector informed a care assistant about the incident, there was no evidence that this staff member had reported the incident to senior care staff or nurses. A review of this resident's care records indicated that other similar incidents of challenging behaviour had occurred but there was no evidence in the records that these had been appropriately assessed or managed.

At the time of this inspection, there was no formal plan in place to detail the transfer of current residents with dementia to the new dementia-specific unit and discussion had not yet taken place with relatives and significant others involved in their care. A formal assessment had not been undertaken to determine if the new unit was appropriate to meeting their needs.

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 viewed a number of bedrooms, the kitchen, laundry facilities, sitting rooms, dining rooms and other communal areas regularly used by residents such as the oratory and small sitting rooms. The standard of furnishings, fittings and fixtures was good and had been maintained in a satisfactory condition. Hygiene standards were also noted to be of a high standard and inspectors observed staff working safely and in line with best practice standards for health and safety. Most residents' rooms were personalised with pictures, plants, rugs and books which reflected their personal tastes. A facility for relatives to stay with residents on occasion, such as during end of life care, was available.

The new extension had been completed in accordance with the relevant legislation and in accordance with the Authority's Standards. The dementia-specific unit had many design features and details to enhance the care provided to people with dementia, such as helping compensate for memory loss. Each bedroom door was a different colour, toilets had traditional flushing mechanisms rather than modern push button systems and communal areas had features such as stoves. The decoration and furnishings were of a high quality and provided an appropriate and attractive environment for people with dementia.

A review of the maintenance log conveyed that there was systematic checking of all equipment and devices and those items identified for repair were quickly attended to. There was a comprehensive range of assistive equipment available to staff to meet the needs of residents. These included electrically operated beds, hoists and pressure-relieving mattresses. This equipment was appropriately serviced on a contract basis and documentation confirmed this.

The standard of hygiene in the kitchen was noted to be of a very good standard. The chef had conducted food safety training with staff. There were records of safety measures such as temperature monitoring of fridges, freezers and blast chilling of food all of which were up to date.

Residents' call bells were activated several times during the morning period and staff were observed to respond promptly.

Significant improvements required

The storage of equipment in toilets and bathrooms presented a trip hazard to residents who may wish to use these areas independently.

The assisted bathroom on the top floor had clean and dirty linen stored together and the bathroom was also used for storage.

The inspectors noted that radiators on the upper corridor were very hot to touch, so it was not available for residents to use.

Catering and non-catering staff were using the same changing area and toilet.

There was no waste disposal facility in the sluice room.

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

The information available for residents, such as the Residents' Guide, was easy to read and contained a range of useful information. Residents each had a copy of this for their reference and also had information in their rooms on meals and mealtimes, visiting arrangements, the laundry service and how money and valuables can be protected.

There were systems in place for staff and management to meet to ensure that communication across the service was effective. There was a handover of information between staff at the end of shifts when workload allocations and other information relevant to residents' care were discussed. Staff meetings took place every two months where care staff, nurses and the person in charge met together to discuss issues relevant to care, training and other matters pertinent to the smooth operation of the centre. Staff and residents described the person in charge as helpful, approachable and always available. Records reviewed demonstrated that the person in charge had been contacted out of hours for advice and guidance.

A range of policies in line with the legislation were available. The sample of policies reviewed had implementation and review dates as well as who was responsible for their development and authorisation for use. Care staff informed inspectors that they had a system in place whereby one policy was read and discussed daily before handover. Catering staff also described a practice whereby a policy was read and discussed three to four times weekly.

Staff were observed engaging with residents and relatives in a respectful manner. Care staff described to inspectors their reporting arrangements and line management structure which included reporting to a senior carer or mentors, who in turn reported to the nurse and person in charge. This practice was observed and confirmed during the course of the inspection.

A comment box was prominently placed in the reception area. Catering staff said that surveys were carried out periodically and the findings had been recorded so that the service could be reviewed in line with the comments received.

Residents said that staff were available when they needed to talk and often sat and had a cup of tea with them. Residents chatted to inspectors and staff when they were passing by and there was an impression conveyed that people communicated with ease and that there was openness and encouragement to communicate.

Some improvements required

Inspectors observed that the use of language in a documentation and in staffs' daily contact with residents' records reflected institutional practice. This was manifested in terminology such as calling residents "pet" and referring to "feeding" residents.

While an on-call system was described by the management team, this had not been highlighted on the duty rota.

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 number and skill mix of staff on duty were appropriate to meet the needs of residents. Staff had been recruited according to best practice ongoing training was provided to meet with staff development needs and the needs of residents.

Staff told inspectors that they were very happy working with older people. They felt well supported by the person in charge whom they said had developed and fostered a good team spirit among all staff. They felt she was very capable and supportive and was a good leader. Staff said that staffing levels were adequate as they had time to care for residents without having to rush. The person in charge attended to her management responsibilities during the afternoons but was available in the mornings to supervise and support staff.

A detailed recruitment procedure was found to be in place that outlined the shortlisting and interview process and the documentation that had to be provided by candidates applying for posts. Following recruitment, there was an induction programme and staff training records confirmed that all staff spent time on induction. There were job descriptions and contracts for all posts and a staff appraisal and performance review system in place. Evidence that staff had regular appraisals had been recorded in staff files and was confirmed during discussions with staff.

There was a training policy and a programme of ongoing training in place. Fifteen staff members had completed training at Further Education and Training Awards Council Level 5. The person in charge and the general manager had completed a "train the trainer" course for Elder Abuse and the majority of staff had completed Elder Abuse Training. Staff had also received training on infection control, continence management, food hygiene and five nurses have completed Medication Management training.

Some improvements required

While some staff had attended training on dementia care, this had not been provided to all staff and in particular, those staff identified as re-deploying to the new dementia-specific care unit.

Significant improvements required

In the sample of staff files examined, some of the documentation required by legislation was not available. This included three written references, birth certificates and evidence of mental and physical fitness. An outcome of Garda Síochána vetting was outstanding for six staff.

Staff had not been appropriately deployed to provide supervision to residents where restraint measures were in place.

Report compiled by

Geraldine Jolley
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

14 April 2010

Action Plan

Provider's response to inspection report

Centre:	Esker Lodge
Centre ID:	0135
Date of inspection:	26, 27 January and 25 February 2010
Date of response:	26 April 2010

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 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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

The level of staff supervision for residents who had restraints was insufficient and failed to take into account their care needs and assessed risk of falls.

Action required:

Deploy staff appropriately to meet the assessed needs of residents particularly those at risk of falls and those subject to restraint.

Reference:

Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

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

Timescale:

<p>Provider's response:</p> <p>There is a restraint risk assessment completed internally and reviewed by the staff nurse, nurse manager, GP, next of kin & resident (as appropriate). This is recorded in the care plan.</p> <p>We review the risk assessment every two months. Any changes are discussed with the GP.</p> <p>The use of restraint in Esker Lodge is only permitted following a full assessment of the resident by nurses, doctors and physiotherapists/occupational therapists as required. The resident or their representative (in a case of diminished capacity) are also directly involved in the decision to implement restraint.</p> <p>A care plan on the use of restraint (which details the type of restraint) is implemented and stored in the residents care plan. Restraint is used to reduce the risk of injury. If it were not used the some highly dependent residents would be confined to bed on a daily basis. Additionally, restraint is required when using specialised Occupational Therapy assessed chairs which are provided for the highly dependent resident, to ensure improved posture.</p> <p>Further to the January inspection we have reviewed the staff allocation and reviewed the resident dependency.</p> <p>Based on that review we have changed staff allocations to ensure that all areas where residents may be seated have consistent staff supervision.</p> <p>In addition to this we have increased staff hours every month in line with our changing resident dependency, as is our normal practice, when resident dependency increases.</p> <p>As per action point – number 2, we plan to provide additional staff training, once we have completed our internal review of our restraint policy.</p>	<p>Completed</p>
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<p>2. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Staff did not have adequate knowledge on restraint practices as residents were not adequately supervised.</p>
<p>Action required:</p> <p>Provide training for staff on best practice in falls prevention and the use of restraint so that the requirement for adequate supervision is based on informed knowledge.</p>

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: It is important to note that staff have had falls prevention training in the past and falls prevention is an agenda item on each internal Health and Safety Committee meeting. We are currently reviewing our restraint policy using the new Health Service Executive's draft policy on physical restraint which was recently distributed by Nursing Home Ireland. On completion of this review we will make changes to our internal policy and then provide the relevant training to staff, which will include additional falls prevention training.	Three months

3. The provider has failed to comply with a regulatory requirement in the following respect: The Elder Abuse Policy did not state at what point the elder abuse officer in the Health Service Executive was to be informed or when the Garda Síochána and relatives were to be informed. Telephone numbers for the statutory services were not available in the policy.	
Action required: Revise the Elder Abuse Policy to outline the reporting arrangements and the contact details of the Elder Abuse Officer and the Garda Síochána.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: The elder abuse policy has been revised to outline the necessary reporting arrangements and contact details for the elder abuse officer and the Garda Síochána.	Completed

<p>Please note the relevant section from the Elder Abuse Policy in existence during the inspection (version 5.0), reviewed by the Health Information and Quality Authority, does make reference to informing the Garda Siochana and early consultation with the Garda Siochana in section 6.0 of the document.</p>	
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<p>4. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Assessments of potential residents care needs prior to admission were not routinely carried out to determine whether the potential resident could be facilitated within the service provisions of the centre.</p>

<p>Action required:</p> <p>Carry out assessments before admission to determine whether the potential resident can be facilitated within the service provisions of the centre.</p>

<p>Reference:</p> <p>Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment</p>

<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
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<p>Provider's response:</p> <p>A formal pre-assessment form was in use prior to the inspection for both long term and short term admissions. These forms are filed with the care plan if the resident is admitted to the home. The information contained in them is usually provided by the referring institution or the next of kin. We understand that keeping records of pre-admission assessment is not a requirement of either the standards or the regulations and therefore we do not keep records of same, if the prospective resident is not admitted to the nursing home. Our current practice regarding pre-admission assessment of residents to avoid inappropriate placement is generally in agreement with Standard 10.</p> <p>Esker Lodge routinely carries out pre-admission assessments off site for all long stay residents.</p> <p>While we endeavour to carrying out pre-admission assessments off site for short term residents, there are sometimes difficulties in carrying out these assessments, including but not limited to:</p> <ul style="list-style-type: none"> • Refusal of access to resident • Limited access to the relevant medical information required 	<p>Immediate</p>
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<p>However we have put in place an additional procedure for completion of pre-admission assessments for short term residents going forward. This involves a trial period of one week in agreement with the resident and the referring institution. During that period, providing care over a number of days, we can effectively determine whether our nursing home is the most suitable environment for the resident.</p> <p>We will continue to review the outcomes of this process and will revert back to the Health Information and Quality Authority should we continue to encounter difficulties in completing this assessment.</p>	
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<p>5. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Residents were encouraged to bring in personal items but lockable cupboards were not routinely available.</p>	
<p>Action required:</p> <p>Provide a lockable space for residents to securely store personal items.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Lockable cupboards are provided to all residents who wishes to use them.</p> <p>All residents have a lockable locker.</p>	<p>Completed</p>

<p>6. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The information listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 had not been included in all staff files. The information that was missing included; birth certificates, photographic evidence of identification, evidence of mental and physical fitness and three references.</p>	
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Action required:	
Ensure that the information listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 is available in staff files.	
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:
<p>Provider's response:</p> <p>We normally hold on site references, fitness to work certificates and Garda clearance for all employees. In reading the regulations (i.e. Schedule 2 and Schedule 4) it is not clear that all employees are required to have three references.</p> <p>However we have now amended our recruitment policy in line with current best practice for new employees. This information has also been requested from the relevant staff and is currently being collated.</p> <p>It should be noted that our staff have been experiencing some difficulties with getting physical and mental fitness to work certificates due to lack of formal Health Information and Quality Authority documentation to provide to GPs. We would kindly request that the Authority provide more guidance for local GPs so that they understand the requirements of the regulations but are also able to meet their legal obligations.</p>	Immediate

7. The provider is failing to comply with a regulatory requirement in the following respect:
Residents in the centre at present who have dementia have not been formally assessed for the new unit.
Action required:
A formal assessment of the care needs of present residents with dementia must be undertaken to determine if the new facility is appropriate to their needs.
Reference:
Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Our dementia unit is not due for completion until summertime 2010. As such a review of the condition of our residents with dementia with regard to the suitability of the unit for them was not planned to be completed in February. We do plan to complete specialised assessments much nearer to the date of completion of the unit. This is because the conditions of the residents concerned may change considerably during the period prior to completion of the dedicated unit.</p> <p>However, in February, we had engaged the services of the Dementia Services Information and Development Centre (DSIDC) in St James Hospital who are experts in the area of dementia care. We engaged their services especially to focus on dedicated and specialist assessments of our existing residents with dementia.</p> <p>The findings of this review have provided us with specialist tools to complete formalised assessments of our residents with dementia.</p> <p>The tools are currently being reviewed for application within our specific environment.</p> <p>When finalised the new assessment tools will allow us to complete more formalised assessments of our residents with dementia in advance of the dementia facility opening.</p> <p>These new dementia specific assessment tools will be used in line with specialised dementia training which has already been provided to staff.</p>	<p>Three months</p>

<p>8. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>A resident displaying episodes of challenging behaviour (that sometimes impacted on other residents) had not been appropriately assessed or managed and information regarding the events was not adequate or documented appropriately.</p>
<p>Action required:</p> <p>Assess all episodes of challenging behaviour and residents' care needs to ensure the service can adequately address and respond to the care needs identified.</p>

Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: As already discussed we have engaged Dementia Services Information and Development Centre (DSIDC) in St James Hospital to provide information on best practice in the care of individuals with dementia. As part of this expertise, guidance was also provided on the care of individuals with challenging behaviour. A number of actions were taken in January to review, assess and manage the individual displaying episodes of challenging behaviour. This included family meetings, review of the care plan, reviews by psycho-geriatrician & GP, updates for staff on managing residents with this type of behaviour and special tools to assist in managing this behaviour. It should be noted that this resident came to us for respite and during our discussions with the relevant persons we were not provided with any information regarding potential episodes of challenging behaviour that could occur. In fact the resident in question only began to display episodes of challenging behaviour in January. As soon as we became aware of these episodes we took immediate action, as detailed above, to ensure that the care provided to the resident was appropriate and also to ensure the comfort of other residents was not compromised. We believe the extent of the actions taken demonstrates our commitment to quality care for all our residents. Our use of care plans and our policy of risk assessing residents as their condition changes ensures that a resident whose behaviour changes can have their individual care reviewed to ensure it remains appropriate their care needs. Going forward we have also scheduled staff training in the care of individuals with challenging behaviour. Also we will be able to apply the new formal assessment tools provided by the DSIDC to individuals displaying challenging behaviour.	Immediate

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

Radiators were very hot to touch on the upper corridor and presented a burns risk.

Action required:

Ensure that all radiators operate at a safe surface temperature of 43 degrees.

Reference:

Health Act, 2007
Regulation 31: Risk Management
Standard 25: Physical Environment

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

Timescale:

Provider's response:

This is under review and remedial measures are being explored.

Immediate

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

The storage of equipment in toilets and bathrooms presented a trip hazard to residents who may wish to use these areas independently.

Action required:

Provide adequate storage space for equipment that does not present a risk to residents.

Reference:

Health Act, 2007
Regulation 19: Premises
Regulation 31: Risk Management Procedures
Standard 25: Physical Environment
Standards 26: Health and Safety

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

Timescale:

Provider's response:

As part of the extension and refurbishment of the existing building, we had planned for significant amounts of additional storage space. The majority of storage space is now available with the remainder becoming available on completion of on-going works.

Completed

<p>In the interim we have reviewed the equipment currently being stored in assisted bathrooms. We have relocated the majority of it and believe the remainder does not pose a hazard to our residents or impinge on their ability to use the assisted bathroom facility.</p>	
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<p>11. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Catering and non catering staff were using the same changing area and toilet.</p>	
<p>Action required:</p> <p>Provide separate changing and toilet facilities for catering staff</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 31: Risk Management Procedures Standard 25: Physical Environment</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	
<p>Provider's response:</p> <p>As part of the extension and refurbishment of the existing building, we had planned for separate changing and toilet facilities for catering staff. This is now available and in use.</p>	<p>Completed</p>

<p>12. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The assisted bathroom on the top floor had clean and soiled linen stored together and the bathroom was also used for storage. This reduced the capacity of residents to avail of the facility and reduced the choice they had for having a bath when they wished.</p>	
<p>Action required:</p> <p>Have in place an appropriate system for the management of clean and dirty laundry that is separate to the bathroom areas.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 19: Premises Regulation 13: Clothing Regulation 31: Risk Management Procedures Standard 25: Physical Environment</p>	

Please state the actions you have taken or are planning to take with timescales:	
<p>Provider's response:</p> <p>We have put in place an appropriate system for the management of clean and dirty laundry that is separate to the bathroom areas.</p> <p>The nature of an assisted bathroom means that there is a need to store some general personal care items in it. We will ensure that this does not pose a trip hazard to residents who wish to use these facilities independently i.e. without a member of staff.</p> <p>All residents also have the option to use the range of assisted toilets around the nursing home or the toilets in their bedroom.</p>	Completed

<p>13. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>There was no system of waste disposal in the sluice room.</p>	
<p>Action required:</p> <p>Provide an appropriate waste disposal system in the sluice room.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment</p>	
Please state the actions you have taken or are planning to take with timescales:	
<p>Provider's response:</p> <p>This waste disposal system has been ordered and will be installed as soon as it is delivered.</p>	Immediate

<p>14. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The use of language while conversing with residents and in some records reflected some institutional practice. This was manifested in terminology such as calling residents "pet" and referring to "feeding" residents.</p>	
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<p>Action required:</p> <p>Provide training for staff on aspects of dignity to ensure that they are competent to provide care in accordance with contemporary evidenced based practice.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 17: Training and Staff Development Standard 4: Privacy and Dignity</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	
<p>Provider's response:</p> <p>Staff training has been scheduled on aspects of dignity to ensure that care is in accordance with evidence based practice, with particular reference to the use of the word "feeding".</p> <p>It should be noted that all residents have individualised person centred care plans, which refer to how residents like to be addressed. There are many residents who have asked to be referred to as pet i.e. it is part of their personal preference.</p> <p>Where a resident has indicated that the practice of using terms of endearment makes them uncomfortable or unhappy, this is documented, staff are informed of same and this request is adhered to.</p>	<p>Ongoing</p>

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 27: Operational Management	Outline the on-call system for the management team in writing so that staff are clear as to who is available to provide advice and guidance out-of-hours.
	<p>Provider's Response</p> <p>The on-call system is noted in writing in the staff communication book and staff diary, which all staff refer to on a daily basis. There has never been any confusion as to which member of the management team is on call.</p> <p>However from May 2010, the member of management on call will be identified on a roster in addition to the staff communication book.</p>

Any comments the provider may wish to make:

Provider's response:

Esker Lodge welcomes the introduction of the new regulations and standards relating to designated centres caring for the older person. We also welcome the new inspection regime under the Health Information and Quality Authority. We found our first inspection under the Health Information and Quality Authority to be thorough. The inspectors were pleasant and we appreciated their input during the inspections.

However, there are areas where it would be beneficial to have more information provided, on best practice. Nursing homes, like ourselves could then review our policies and procedures in line with best practice in the industry and implement enhancements to policies and procedures as appropriate.

In this context we would like to ask that findings of best practice both nationally and internationally could be compiled and made available by the Health Information and Quality Authority to inform and guide the industry to ensure that the care provided to residents benefits from continuous improvement.

The availability of this information would enhance work currently being completed by nursing homes to comply with the new regulations and standards.

Provider's name: Vicky McDwyer, for and on behalf of, Esker Lodge Nursing Home
Date: 26 April 2010