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Esker Lodge Nursing Home, OSV-0000135, 4 September 2017

Item Type	report
Citation	Ireland. Health Information and Quality Authority, 'Esker Lodge Nursing Home, OSV-0000135, 4 September 2017', [report], Health Information and Quality Authority, 2018-03-05, Older People Inspection Report, Nursing Homes, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-04-13 04:31:11
Link to Item	https://hdl.handle.net/20.500.14765/88318

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Esker Lodge Nursing Home
Centre ID:	OSV-0000135
Centre address:	Esker Place, Cathedral Road, Cavan.
Telephone number:	049 437 5090
Email address:	vicky@eskerlodgenursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Esker Lodge Limited
Provider Nominee:	Vicky McDwyer
Lead inspector:	PJ Wynne
Support inspector(s):	
Type of inspection	Unannounced
Number of residents on the date of inspection:	70
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 04 September 2017 09:15 To: 04 September 2017 17:20

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection, carried out by the Health Information and Quality Authority (HIQA). The centre can accommodate a maximum of 70 residents who need long-term care, convalescent or respite services. The inspector reviewed progress on the action plan from the previous inspection.

The areas identified for improvement in the action plan of the last inspection were satisfactorily completed. Notifications of incidents received since the last inspection was assessed on this visit.

There was evidence of effective leadership and management. The provider is involved in the governance and operational management of the centre on a consistent basis. The centre is being managed by a qualified and experienced director of care. There were systems and practices in place that promoted health and safety.

The inspector found that residents' health care needs were appropriately assessed

and addressed with good access to general practitioners (GP's). There was access to allied health professionals for residents who were identified as being at risk of poor nutrition or with a swallowing difficulty and the palliative care team.

Bedroom accommodation consists of 36 single and 17 twin bedrooms. All of the bedrooms are en-suite. Bedrooms are suitable in size to meet the needs of residents. The centre is divided into two units. On the ground floor is a dementia specific unit primarily for people living with dementia that are mobile. Bedroom furniture, fixtures and fitting were of a high standard and good quality. All parts of the building were well lit adequately heated and ventilated.

There was a varied and meaningful activity programme provided suitable to resident's capacity and life stage. Staff were knowledgeable about the care to be provided and familiar with residents' daily routines and individual care requirements.

Ten outcomes were inspected. Six outcomes were judged as compliant with the regulations and four as substantially complaint. The action plan at the end of this report identifies the two areas where improvements are required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a defined management structure in place with which staff were familiar. There have been no changes to the governance arrangements in place since the last inspection.

The lines of accountability and responsibility for the provision of the service were well established. The provider is involved in the governance and operational management of the centre on a consistent basis. She has a role in the health and safety committee and human resource management. She is a qualified trainer in safeguarding and delivers training to staff in this area.

There is a system to review the quality and safety of care and quality of life in place. Management had systems in place to capture statistical information. There is a schedule of audits planned yearly in advance. The inspector viewed audits completed on the management of medicines, care planning, any accident or incident to include near miss events.

The aim, objective and methodology for all audits are defined. An action plan for improvement is developed based on the audit findings and to address any identified risk or trend noted. On completion of the care plan audit the template was revised to improve the process with the addition of check list for each residents' immunisation status and dietary requirements on admission.

Key quality performance indicators in relation to GP visits, any incident of wounds, the usage of psychotropic and night sedative medicines and the number of residents with a bedrail raised are collated weekly. The data is monitored in relation to individual residents to ensure ongoing risk assessment of individual care needs and implementation of care plans.

There was evidence of effective leadership and management. Regular staff meetings were held with staff from each department to ensure staff understand their role and responsibilities and are informed of policies and procedures.

An annual report on the quality and safety of care was compiled reviewing and providing information on aspects of the service provision for the previous year. The annual report was discussed at the residents' meetings.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The centre is being managed by a qualified and experienced nurse. She has appropriate qualifications, sufficient practice and management experience to manage the residential centre and meet its stated purpose, aims and objectives.

The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. She is supported in her role and responsibilities by a clinical nurse manager rostered five days each week.

She maintained her professional development and attended mandatory training required by the regulations. There was evidence the person in charge has engaged in ongoing professional development training and attended study days and seminars. A valid and up to date registration with An Bord Altranais is agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) was available.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older

People) Regulations 2013.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval.

The centre had all operational policies as per schedule 5 of the regulations.

A sample of resident's files reviewed contained all of the health and medical information as listed in schedule 3. Incidents, falls and accidents, physical restraint management (the use of bedrails) were maintained accurately and kept up to date.

All other records as per schedule 4 were maintained and available.

Appropriate insurance cover was in place with regard to accidents and incidents, out sourced providers and residents' personal property.

The certificate of registration was displayed prominently as required by the regulations.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Policies and procedures were in place for the prevention, detection and response to abuse. The safeguarding policy has been revised to take account of the HSE national policy on safeguarding vulnerable adults. The provider has completed a trainer the train course on the Health Service Executive (HSE) national safeguarding policy and trained all staff in safeguarding and the revised adult protection procedures in the centre.

Staff with whom the inspector spoke were knowledgeable of the types of possible

abusive situations and what to do in the event of an allegation, suspicion or disclosure of abuse. Staff stated that they received regular training sessions in this area. Records were reviewed and these indicated that all staff had received training. Residents stated they felt safe and attributed this to the attentiveness and kindness of staff. Two notifiable incidents in relation to staff conduct which are a statutory reporting requirement to HIQA have been reported since the last inspection. However, as discussed under Outcome 10 Notification of Incidents the statutory notifications in relation to allegations of misconduct were not submitted to HIQA within the required three day timeframe as specified in the regulations. The matters were investigated by the management team. Responsive measures were implemented to address concerns raised.

The provider is not an agent to manage pensions on behalf of any residents. Property lists were maintained to record all resident's personal possessions

In line with national policy a restraint free environment was promoted. There were three residents wearing security monitoring cotags. A risk assessments and a plan of care is developed to outline the need with consent obtained. There was evidence of multi disciplinary involvement in the restraint decision making process, including the nursing team, GP and the physiotherapist. A risk balance tool was completed in each case where a resident had their bedrails raised. The rationale why alternatives trialled were unsuccessful was documented. The enabling function of the bedrails was outlined in the care plan for residents, for example as a psychological safety aid or 'helps the resident to sit up', 'or turn in bed'. A restraint or enabler register was maintained. All residents were checked periodically throughout the night.

There is a policy on the management of responsive behaviour. Staff had received training in responsive behaviours, which included caring for older people with cognitive impairment or dementia. There was a program of scheduled training planned on a yearly basis to ensure the training needs of all staff are met in caring for residents with dementia or responsive behaviours. The person in charge had completed a train the trainer course in the management of actual and potential aggression (MAPA).

There was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health. The community mental health nurse visited the centre regularly to review residents.

Judgment:
Substantially Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

A health and safety statement was in place. This was revised in February 2017. There was a defined organisational health and safety governance structure in place. Two safety representatives were appointed and a health and safety committee is well established. Risk assessments carried out were specific to the centre and to residents' safety.

Policies were also available to provide guidance to staff on specific areas required by the legislation including the risks of absconding, assault, self harm and accidental injury.

Measures were in place to prevent accidents in the centre and within the grounds. The building was secure and all exit doors were alarmed to minimise the risk of a resident leaving the centre unaccompanied.

There was a contract in place to ensure hoists and other equipment including electric beds and air mattresses used by residents were serviced and checked by qualified personnel to ensure they were functioning safely. Internal safety checks were completed by staff on all fire evacuation sheet, electric bed, call bells and sensor mats to ensure they were operating and functioning correctly.

The procedures in place for the prevention and control of infection were satisfactory. Hand gels were in place and hand-wash facilities were easily accessible. A contract was in place for the disposal of clinical waste. A duvet was stored in the bathroom and the storage of soiled linen trolley in one bathroom requires review to minimise the risk of cross infection.

The fire policy, revised in 2016 provided guidance to reflect the centre's procedures of progressive horizontal evacuation. Staff had completed refresher training in fire safety. An external trainer visits the centre at intervals annually to train staff on fire safety.

The frequency of fire drills has been increased as required by the action plan of the previous inspection report and the procedure to document fire drills has been amended. Records of fire drill practices undertaken detailed the scenario or type of simulated practice the number of staff involved and the time taken to complete the evacuation. There was documented evidence of learning from fire drills completed to help staff understand what worked well or identify any improvements required

There were arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Fire safety equipment was serviced in accordance with fire safety standards. Fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed around the building and in residents' bedrooms. Evacuation sheets were fitted to each resident's bed. Each resident has a personal emergency evacuation plan developed. These were updated at regular interval and included on each resident's safe moving and handling risk assessment.

There were procedures to undertake and record internal fire safety checks. Daily checks

of fire exits were completed to ensure they were free of obstruction. Monthly checks of the fire extinguishers were undertaken to ensure they were in place and intact. Training records evidenced that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents' needs. Each resident's moving and handling needs were identified in plans of care and changes communicated to staff at shift handover. The type of hoist and sling size required was specified in risk assessments and inside the hoist storage area.

The temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to all windows. Access to work service areas to include the kitchen and sluice room was secured in the interest of safety to residents and visitors

Falls and incidents were well documented. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury. A post incident review was completed by the clinical nurse manager to determine the root cause or any contributing factors. Action taken to minimise the risk of repeat injury included a review of medication, including (prn) medicine (a medicine only taken as the need arises), hip protectors and low beds with a crash mat in place alongside the bed. All residents were reviewed by the physiotherapist post fall.

Judgment:

Substantially Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a policy on the management of medicines which was centre-specific and in line with legislation and guidelines. Systems for the prescribing, receipt, administration, storage and accounting for medicines were satisfactory. Medicines were being stored safely and securely in a room which was locked at all times.

All medicine was dispensed from blister packs. These were delivered to the centre by the pharmacist. On arrival, the prescription sheets from the pharmacist were checked against the blister packs to ensure all prescription orders were correct for each resident.

Nursing staff transcribed medicine orders. Transcribed medicines were countersigned by a second nurse in each of the sample of records examined except in the case of one prescription. A second nurse signature was not in place for p.r.n medicine in one kardex reviewed. There was a system to audit transcribed kardex's to ensure accuracy as part of the audit on the management of medicines.

Photographic identification was available on the medicine chart for each resident to ensure the correct identity of the resident receiving the medicine and reduce the risk of medicine error. The prescription sheets reviewed were legible. The maximum amount for p.r.n medicine was indicated on the prescription sheets examined.

The administration sheets viewed were signed by the nurse following administration of medicine to the resident and recorded the name of the medicine and time of administration. There was space to record when a medicine was refused on the administration sheet.

Medicines were being crushed for a small number of residents at the time of this inspection. Signed consent by the GP and pharmacist was available on each kardex for medicines being crushed. Alternative liquid or soluble forms of medicine were sought where possible through consultation with the pharmacy.

Medicine that required strict control measures were kept in a secure cabinet which was double locked. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of medicine balances and found them to be correct.

The pharmacist was facilitated to meet their regulatory responsibilities to residents. The pharmacist completed audits of medicines. Advice from pharmacy of reviews of prescription kardex's to guide nursing staff on contraindications and other forms of a medicine for those with swallowing difficulty or blood screening for residents on a particular medicine over a prolonged timeframe was ensured.

Judgment:

Substantially Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre.

Quarterly notifications had been submitted to HIQA as required and notifications in relation injuries. However, statutory notifications in relation to allegations of misconduct were not submitted to HIQA within the required three day timeframe as specified in the regulations.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were 18 residents with maximum dependency care needs. Twenty one were assessed as highly dependent and 19 had medium dependency care needs. Eleven residents were assessed as low dependency. All residents were residing in the centre for continuing care.

Each resident's wellbeing and welfare was maintained by an appropriate standard of nursing, medical and allied health care. Pre-admission assessments are completed by senior staff nurses, the clinical nurse manager or the person in charge.

The majority of residents were in advanced old age some with complex medical conditions. Forty three residents had a diagnosis of dementia, cognitive impairment or Alzheimer's as either their primary or secondary diagnosis. Twenty residents required either full or partial assistance with their meals.

On admission, a comprehensive nursing assessment and additional risk assessments were completed for all residents. There was evidence of regular nursing assessments using validated tools for issues such as falls risk, dependency level, risk of pressure ulcer formation and nutritional deficit. Risk assessment and care plans were reviewed at a minimum of the required four monthly intervals or in response to a changing need or circumstances. Care plans were developed based on the assessments. There were plans of care in place for each identified need.

Care plans for responsive behaviours were revised since the last inspection. Those reviewed on this inspection were more personalised and outlined in detail the full extent the issues being managed for residents with complex mental health problems. The detail of potential triggers and deescalating techniques were personalised to guide staff interventions for residents with responsive behaviours.

There was evidence of consultation with residents or their representative in care plans reviewed of agreeing to their care plan. The daily nursing notes as required by Schedule

3 (4) (C) provided a clear account of the resident's health, condition and treatment given.

Residents had access to GP services and there was evidence of medical reviews. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre or on returning from hospital. The GP's reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards. The clinical nurse maintained a register of GP visits for each resident to ensure all residents were reviewed at a minimum period of every three months. Clinical observations such as temperature, blood pressure, pulse were assessed routinely.

There was one resident with a vascular wound at the time of this inspection and one resident with a pressure wound. The inspector reviewed these files. There was evidence in the files of access to a vascular clinic. Professional expertise provided was followed. Wound care plans were in place and a wound assessment chart completed to reflect the status of the wound following each dressing.

A physiotherapist is employed privately by the provider and visits the centre once a week. The physiotherapist reviews residents at the request of nursing staff. The physiotherapist undertakes individual and group exercise to promote mobility, improve respiratory function and develops passive exercise regimes for more frail residents.

Residents had timely access to allied health professionals including opticians, dentists and chiropody services. Access to palliative care specialists, dietitian, speech and language therapist and occupational therapist. There was a good range of specialist seating equipment available to meet the needs of frail residents requiring specific support.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:
Effective care and support

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

Findings:
The building is designed to meet the needs of dependent older people. The building was well maintained, warm, comfortably decorated and visually clean. The provider

maintained a safe environment for residents' mobility, with handrails in circulation areas and suitable floor covering.

Bedroom accommodation consists of 36 single and 17 twin bedrooms. Fifty three of the bedrooms are en-suite. Bedrooms are suitable in size to meet the needs of residents. The centre is divided into two distinct units. On the ground floor is a dementia specific unit primarily for people living with dementia that are mobile. A maximum of 20 residents are accommodated in the dementia unit. Fifty residents are accommodated between the first and second floor with the majority of bedrooms on the first floor. Residents on each floor of the building had access to a safe outdoor space. These areas were provided with seating and well planted with patio tubs of flowers and plants. Bedroom furniture, fixtures and fitting were of a high standard and good quality.

The dementia unit has two separate sitting and dining areas and a sensory room. Additional seating is provided in small area off the corridor providing a quieter environment for residents to relax while mobilising between the bedrooms and communal areas. The unit is built around an enclosed courtyard and the majority of bedrooms overlook the courtyard.

There were a number of dementia friendly design features throughout the building that included space for residents to walk around freely, good lighting, contrast in colours used for floors and walls. Handrails were a distinctive colour from the wall.

There were features here that prompted memory and orientation. There was a mural of a thatch cottage on the wall of the sensory room to promote reminiscence.

There were some tactile objects around. There were areas to display items to stimulate memory and provide areas of interest and diversion. The dining and sitting room was decorated and furnished in a way that prompted memory and orientation that defined its main purpose. The decor assisted to orientate residents. All residents have their photo outside their bedroom door and corridors were painted different colours. All bedrooms were painted individual colours and very well personalised by residents.

Staff facilitates were provided. Separate toilets facilitates were provided for care and kitchen staff in the interest of infection control.

Judgment:

Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a written operational policy and procedure relating to the making, handling and investigation of complaints. This was displayed inside the entrance and outlined in the residents' guide available in each bedroom.

A designated individual was nominated with overall responsibility to investigate complaints within the centre. The timeframes to respond to a complaint, investigate and inform the complainant of the outcome of the matter raised by them was detailed in the policy.

A complaints log was in place. This contained the facility to record all relevant information about complaints and the complainant's satisfaction with the outcome. The procedure identified the person appointed to receive appeals in the event of the complainant not being satisfied with the outcome of the matter, as well as contact details for the Ombudsman. There were no complaints being investigated at the time of this inspection.

The person in charge audited all complaint on an annual basis to identify any possible trends.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The action plan required by the previous inspection was satisfactorily completed in relation to staff training. The person in charge had completed a review of the effectiveness of the training, and its implementation in practice. This was supported by staff appraisals undertaken to identify training needs and reviewed at subsequent appraisals to ensure staff have the required qualities, skills and experience for their roles.

There were appropriate staff numbers and skill mix in the centre to meet the assessed needs of residents at the time of this inspection. Residents spoken with were complimentary of the staff and the support they provided with personal care, meal times and their help throughout the day.

A training matrix was maintained to identify each staff members training requirement. This assisted the management team maintain oversight and plan refresher training updates. Staff had access to a range of training to meet the needs of residents. All staff had received mandatory training in adult protection, fire safety, safe moving and handling and responsive behaviours. Professional development training undertaken included, end of life care, food and nutrition, wound care, infection control, and cardio pulmonary resuscitation techniques.

All nurses had records confirming their active registration with An Bord Altranais agus Cnáimhseachais na hÉireann.

A sample of five staff files was reviewed. The files contained all documentation required under schedule 2 of the regulations. There was evidence of vetting by An Garda Síochána for all staff. The person in charge gave verbal assurances that all staff working in the centre had a satisfactory vetting disclosure in place.

There was a policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. The inspector spoke with staff members and they undertook an interview and were requested to submit names of referees.

On commencement of employment staff are required to undertake a period of induction. They work as an additional resource alongside an experienced staff member of the same grade to become familiar with residents and their required work practices. An appraisal is completed with each staff member after there induction period. The clinical nurse manager completes a new employee proficiency review with staff after induction. This assesses their competency in safe moving and handling techniques, the delivery of personal care, oral hygiene, knowledge of infection control and completion of daily care records and policies including fire safety.

The policy of the service is to complete staff appraisals annually. There was evidence of staff appraisals being undertaken in files reviewed. There are systems in place to supervise staff. There is a team leader role on each unit to support care assistants. Staff are allocated to work in teams and have assigned duties allocated to their specific work shift. There is a clinical nurse manger who reports to the person in charge.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Esker Lodge Nursing Home
Centre ID:	OSV-0000135
Date of inspection:	04/09/2017
Date of response:	11/10/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Two notifiable incidents in relation to staff conduct which are a statutory reporting requirement to HIQA have been reported since the last inspection. However, as discussed under Outcome 10 Notification of Incidents the statutory notifications in relation to allegations of misconduct were not submitted to HIQA within the required three day timeframe as specified in the regulations.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

The centre will amend its internal procedure to ensure that notifications are submitted earlier within the HR process.

Proposed Timescale: 11/10/2017

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

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

A duvet was stored in the bathroom and the storage of the soiled linen trolley in one bathroom requires review to minimise the risk of cross infection.

2. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

All staff have been informed that no items should be stored in the bath. The storage of the linen trolley has been reviewed and the trolley is now stored in a different location.

Proposed Timescale: 11/10/2017

Outcome 09: Medication Management**Theme:**

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A second nurse signature was not in place for p.r.n medicine in one kardex reviewed.

3. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The single signature which had been omitted has now been completed. This matter has been discussed in a staff nurse meeting.

We will continue our scheduled medication management audits.

Proposed Timescale: 11/10/2017

Outcome 10: Notification of Incidents

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Statutory notifications in relation to allegations of misconduct were not submitted to HIQA within the required three day timeframe as specified in the regulations.

4. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The centre will amend its internal procedure to ensure that notifications are submitted earlier within the HR process.

Proposed Timescale: 11/10/2017