Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Esker Ri Nursing Home
Name of provider:	Blackden Limited
Address of centre:	Kilnabin, Clara, Offaly
Type of inspection:	Unannounced
Date of inspection:	29 February 2024
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0042992

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Esker Ri Nursing Home is a purpose-built premises. The designated centre is situated on an elevated site off the Tullamore road on the way out of the village of Clara. The designated centre currently provides accommodation for a maximum of 143 male and female residents aged over 18 years of age. Residents' accommodation is provider on three floors. Residents are accommodated in single and twin bedrooms with full en suite facilities. The designated centre provides mainly residential care to older adults and also provides respite, convalescence and care for people with an intellectual disability, physical disability, acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, activity coordination staff, administration, maintenance, housekeeping and catering staff. The provider states in their statement of purpose for the designated centre that their aim is to provide a residential setting wherein residents are cared for, supported and valued within a care environment that promotes their health and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	135

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 29 February 2024	09:30hrs to 18:15hrs	Sean Ryan	Lead
Tuesday 5 March 2024	09:30hrs to 17:15hrs	Sean Ryan	Lead
Thursday 29 February 2024	09:30hrs to 18:15hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Resident's living in Esker Ri Nursing Home were complimentary of the staff who provided them with care and support in a caring and respectful manner. Residents spoke positively about staff as individuals who made them feel safe, and described how staff encouraged them to be independent and to engage socially through activities and with other residents. However, some residents expressed discontent with some aspects of the service that included access to medical care professionals, and the response from the management in relation to concerns they raised.

Inspectors arrived at the centre unannounced and were met by an assistant director of nursing. Following an introductory meeting, inspectors walked through the premises. Inspectors met with a number of residents during the walk around the centre, and spoke to a number of residents in detail about their experience of living in the centre. Some residents were unable to articulate their views on the quality of the service they received. Those residents appeared to be comfortable and socially engaged in the communal dayrooms throughout the days of inspection.

There was a busy atmosphere in the centre during the morning. Staff were observed attending to residents requests for assistance with their morning care in their bedrooms, and engaging with residents in a person-centred manner. Residents told inspectors that staffing levels had improved since the last inspection and that there were a number of new staff who they were getting to know.

Residents told inspectors that staff were generally responsive to their requests for assistance. They described how staff were attentive to answer their call bells, particularly during the day. However, residents reported that they would often experience delays in receiving assistance with their toileting needs. Residents described how they would wait long periods of time for assistance. Inspectors observed one resident having to wait an extended period to time for equipment such as a hoist to become available to safely transfer them. Residents reported that, while the wait was uncomfortable, staff were very apologetic when this occurred.

Some residents reported inconsistent care in the evening and night-time. Two residents told the inspectors that they occasionally experienced difficulty in 'getting help from staff' at night-time. Residents reported that while one staff member would respond to their call bell, they would have to wait for a second staff member to become available in order to safely assist the resident to mobilise. The residents reported waiting in excess of 20 minutes to receive assistance and support.

Inspectors observed that the supervision and allocation of staff was inadequate. While residents were observed to be supervised in the communal dining room, inspectors observed that residents in their bedrooms had less supervision. This was evidenced in the morning-time, and again during lunch-time, where meals were served to residents in their bedrooms. Inspectors observed that three residents did not eat their meals during breakfast and lunch, and their meals were returned to the

kitchen. The nutritional records for those residents indicated that the resident had eaten either a full meal, or half of their meal, contrary to the observations of inspectors. While staff were generally allocated to one unit, to ensure the continuity of care provided to residents, some staff had been reallocated to care for residents in other units and they were not familiar with the residents by name or their care needs.

Inspectors observed that the premises was bright, spacious, and warm. The provider had redecorated some areas of the premises including corridors. A number of other areas were prepared for painting, and redecoration of corridors was progressing on the day of inspection. However, the inspectors observed that the provider had not taken adequate precautions to ensure resident safety during these works. For example, protective coverings on the floor were not secured and posed a trip hazard to residents.

Residents reported that they were satisfied with their bedroom accommodation, and further satisfied with the storage facilities for their personal possessions.

While the centre was observed to be clean in areas occupied by residents, there were two sluice rooms that were not cleaned to an acceptable standard. This included sinks and equipment, used to decontaminate toileting aids, that were visibly unclean. Equipment used by residents, such as urinals and bedpans, were stored on a drying rack but were visibly stained and unclean. The sluice room was also observed to store equipment for painting and furniture. This created a risk of cross contamination, and therefore a risk of infection to residents This issue had been resolved by the second day of inspection.

Inspectors observed a number of doors that were held open with pieces of furniture which prevented the doors from closing. This may compromise the function of the doors to contain the spread of smoke and fire in the event of a fire emergency. This is a repeated finding from the last inspection.

Throughout the day of inspection, residents were observed to be engaged in a variety of activities including exercises, games, and music. Some residents preferred to remain in their bedroom throughout the day.

Residents were provided with opportunities to express their feedback about the quality of the service through scheduled resident meetings and through individual conversations with the management. However, residents told the inspectors that their feedback was not always acted upon in a timely manner. For example, residents had provided feedback in November 2023 with regard to the provision of services and associated additional charges, but their feedback had not been addressed.

Residents were provided with information about the services available to support them, such as independent advocacy services.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Inspectors followed up on the actions taken by the provider to address issues of non-compliance found on the last inspection in December 2023. Inspectors also reviewed unsolicited information received by the office of the Chief Inspector in relation to the governance and management of the centre, and the quality and safety of care provided to residents. Notifications submitted by the provider in relation to adverse incidents involving residents, the management of resident fall's, and the safeguarding and protection of residents were also reviewed on this inspection.

The findings of this inspection were that the provider had not fully implemented or sustained the actions of a compliance plan submitted following the previous inspection of the centre, and further non-compliance was found with regard to the governance and management of Esker Ri Nursing Home. While the provider had taken action to ensure that the clinical nurse management structure was in place and aligned to the statement of purpose, inspectors found that an unclear organisational structure and ineffective systems of monitoring and oversight continued to impact on the quality and safety of the care provided to residents. Inspectors found that, where the provider had previously implemented some systems to monitor aspects of the service and progress towards regulatory compliance, the provider had not ensured that those systems were consistently implemented and sustained. This resulted in a deterioration in compliance. The provider was not in compliance with the following regulations;

- Regulation 4; Written policies and procedures,
- Regulation 5; Individual assessments and care plan,
- Regulation 6; Health care,
- Regulation 9; Resident's rights,
- Regulation 15; Staffing,
- Regulation 16; Training and staff development,
- Regulation 21; Records,
- Regulation 23; Governance and management,
- Regulation 31; Notification of incidents.

Following the findings of day one of this inspection, a second inspection day was scheduled. A review of further unsolicited information received by the office of the Chief Inspector was completed. The information pertained to concerns regarding the governance and management of the service, the quality of care provided to

residents, the management of fall's incidents, supervision of staff, appropriate referral and access to medical professionals, and nutritional care. This information was found to be substantiated on this inspection.

Blackden Limited, a company comprised of two directors, is the registered provider of Esker Ri Nursing Home. The management structure supporting the designated centre had changed since the last inspection through an increased presence within the centre of a person participating in the management of the centre. Within the centre, the Chief Inspector had been notified of the absence of the person in charge. An assistant director of nursing deputised in their absence and facilitated the inspection supported by a newly appointed assistant director of nursing. This inspection found that the systems in place to escalate risks and concerns to the senior management remained weak. For example, there were poorly defined systems in place to demonstrate how risks and concerns were escalated to the registered provider.

Lines of accountability and responsibility for the oversight of care and safety of the residents was not clear. Inspectors found that the management systems, pertinent to supporting effective governance of the service, such as risk management, incident management, and record management systems were not known to the personnel responsible for the administration and oversight of the service. Consequently, assurances could not be provided that accountability and responsibility for key aspects of the service were robust.

While the provider had improved the clinical nurse management resources, inspectors were not assured that the nurse management resources were consistently available to effectively manage the centre. While two clinical nurse managers were on duty to provide nursing oversight of the six units, on the days of inspection, the clinical nurse managers were fully and solely engaged in the supervision of two agency staff on duty who were not fully familiar with the needs of the residents. This meant that the clinical nurse managers did not have time to supervise any other aspect of the operation of the centre or the care of the residents. This reduction in supervision impacted on nursing oversight, governance and the supervision of other staff to ensure residents received safe, quality care.

Through a compliance plan, the provider had committed to implementing management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. A revised schedule of audits was in place to evaluate the quality of some aspects of the service. However, these audits were ineffective in areas of the service such as clinical documentation, record management, and falls prevention. For example, audits of residents' falls had not analysed or identified possible contributing factors to the high incidence of falls, such as the absence of appropriate care plans, or that falls incidents were not consistently documented or managed in line with the centre’s own falls management procedure. In addition, audits did not include an analysis of the high incidence of resident transfers to hospital. Therefore, an effective or appropriate quality improvement plan could not be developed.

The provider had failed to ensure that the implementation of risk management systems was consistent and sustained, in line with the centre's risk management policy. A review of the risk register evidenced that some clinical and environmental risks were assessed and had been categorised according to their level of risk to residents. However, the provider did not manage all known risks in line with the centres risk management policy. For example, inadequate access to medical professionals was an issue impacting the care of a number of residents in the centre. The provider had not assessed the potential risks to residents or established the number of residents affected. Consequently, there was no plan in place to appropriately manage the risk and residents continued to be impacted.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were not submitted to the Chief Inspector of Social Services within the required time-frame. For example, the Chief Inspector had not been notified of an allegation of abuse, or of a serious injury sustained by a resident. This is a repeated finding from a previous inspection.

Inspectors reviewed the system of record management in the centre and found that the provider had not sustained improvements in relation to the documentation of adverse events and incidents involving residents, in line with professional guidelines, regulatory requirements, and the centre's own policy. Inspectors requested records of a number adverse incidents involving the care of residents. However, the incidents had not been documented. Consequently, inspectors could not be assured that incidents were fully investigated or analysed, and no quality improvement actions were implemented to ensure resident safety.

The provider had committed to implementing a system to ensure staff personnel files contained the information required under Schedule 2 of the regulations. Inspectors found that this system was ineffective. Information pertaining to correspondence, reports, and records of disciplinary action were not contained within staff personnel records. Additionally, records were not maintained in a manner that was accessible. Requests for information and records were required to be repeated throughout the inspection and some records were not made available for review.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. Inspectors found information consistent with a complaint regarding the quality of care contained within the nursing records. The information had not been escalated to the personnel responsible for the management of complaints. Consequently, there was no record of these issues being acknowledged, investigated or resolved to the satisfaction of the complainant.

The policies and procedures, as required by Schedule 5 of the regulations, were reviewed by the inspectors. The policies had been reviewed by the provider at intervals not exceeding three years and were made available to staff. However, the registered provider had failed to ensure that some policies and procedures such as

risk management, the management of incidents and accidents, and the prevention, detection and response to abuse were implemented.

The number and skill-mix of staff on duty during the day-time was sufficient to meet the resident's assessed care needs, and in consideration of the size and layout of the designated centre. While the planned roster was maintained on the days of inspection, a review of the rosters evidenced that planned health care staff levels were not consistently maintained. In addition, nursing staff levels were not always maintained with the centres own staffing resources. Consequently, agency staff were required to support the rosters, as the centre continued to have inadequate staffing resources to respond to planned and unplanned staff leave.

All staff were facilitated to attend training appropriate to their role, such as fire safety and fall management, however, staff did not always demonstrated an appropriate awareness of this training. For example, staff did not demonstrate an appropriate level of knowledge with regard to management of residents at risk of falls. Inspectors observed repeated poor practice whereby fire doors were held open with pieces of furniture, effectively compromising their function to contain the spread of smoke and fire.

There were ineffective systems in place to induct, orientate, and supervise staff to provide safe and effective care to the residents. A number of staff allocated to provide care to residents did not know the care needs of the residents such as their personal care, nutritional care, and mobility care needs. Additionally, staff were not appropriately supervised to implement the centre's policies and procedures, and maintain accurate records of the care provided to residents. Inspectors observed that management staff were required to support the direct care of residents. This impacted on the supervision of staff, governance and clinical oversight.

Regulation 15: Staffing

On the days of inspection, the staffing levels and skill-mix were appropriate to meet the assessed needs of residents.

However, a review of staffing rosters for the previous week showed that there were four occasions where planned health care staff levels were not maintained as a result of unplanned leave.

Additionally, there was insufficient nursing staff resources in place to sustain planned rosters, and respond to planned and unplanned leave. For example, agency support staff were required to cover up to 15 vacant nursing shifts per week. This resource issue is actioned under Regulation 23: Governance and management.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- staff did not have the required training of the residents care needs to deliver safe, effective and person-centred care. For example, some staff allocated to provide care to residents did not know the residents by name, or their care needs. This was also indicative of ineffective arrangements to induct, orientate and supervise staff.

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of all residents. This was evidenced by;

- poor supervision of staff to ensure residents received care and support in line with their assessed mobility and nutritional care needs.
- poor oversight of the residents' clinical documentation to ensure the assessment and care planning were accurate and up-to-date to reflect the current care needs of the residents.
- poor fire safety awareness as evidenced by fire doors wedged open.
- poor supervision of staff to ensure that policies and procedures in place to support and protect residents were implemented.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Records of two incidents in which residents may have suffered potential abuse or harm were not documented in line with the centre's own policy or available for inspection, as required by Schedule 3 (4)(j) of the regulations.
- Records of specialist treatment, nutritional care and nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of repositioning charts for residents of high risk of impaired skin integrity were not maintained in line with the residents care plan. Records of nutritional care and residents dietary intake did not reflect the actual nutritional care and dietary intake of residents.
- Staff personnel files did not contain the information required by Schedule 2(6). For example, staff personnel files did not contain correspondence,

reports, records of disciplinary action and any other records in relation to the staff employment.
- Records were not kept in a manner as to be accessible. Repeated requests for records were made throughout the inspection, and some required records were not provided for review.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. The number of full-time nurses employed by the provider did not reflect the number of nurses outlined in the centre's statement of purpose. While there was active recruitment processes in place, the service was dependent on the use of agency staff to support the nursing rosters.

The registered provider failed to ensure there was an effective management structure, with clear lines of accountability and responsibility in place. The organisational structure, as described in the centre's statement of purpose was not consistently available. The daily requirement for two clinical nurse managers was not consistently maintained. This impacted on the overall governance and oversight of the service. Furthermore, responsibility for monitoring key aspects of the service including the oversight of risk management, record management, and complaints were not clearly defined. This governance and management issue was identified on previous inspections and continued to impact on regulatory compliance in the centre.

Inspectors also found repeated failings in the management systems to ensure a safe, monitored and consistent service was provided. This was evidenced by;

- Ineffective systems to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care professionals. The was poor oversight and supervision of the care provided to residents to provide assurance that residents received care, support and appropriate medical and health care, in line with their assessed needs and care plans. This is described further under Regulation 5, Individual assessment and care plan, and Regulation 6, Health care.
- Risk management systems were not effectively implemented to manage risks in the centre. For example, risks that were known to the provider were not assessed or managed in line with the centre's own policy. This included the risks associated with staffing constraints and inadequate access for residents to medical professionals. Consequently, there was no effective plan in place

to manage the risk and poor systems in place to escalate risks to the provider.
- Ineffective communication systems to ensure key clinical information regarding residents care needs, complaints, and adverse incidents involving residents were effectively communicated to staff and escalated to the management.
- An ineffective system of clinical auditing was in place. For example, completed audits with regard to clinical care records and fall management failed to identify known risks and areas where improvement was required. Consequently, quality improvement action plans could not be developed and this presented a risk to residents.
- Ineffective record management systems were in place to ensure compliance with the regulations. There was poor oversight of records pertaining to staff personal files, and records of adverse incidents involving residents were not appropriately documented.
- A failure to implement the centre's policies and associated procedures that underpin the provision of safe, evidenced-based and consistent care to the residents.
- A failure to submit statutory notifications to the Chief Inspector.
- Poor oversight of the complaints management system to ensure the quality of care of residents were monitored, reviewed and improved on an ongoing basis.

Compliance plans submitted following the previous inspections were not fully implemented. Some compliance plans were found to be ineffective, and others not sustained. This resulted in repeated non-compliance in multiple regulations including governance and management, training and staff development, and individual assessment and care plans.

Judgment: Not compliant

Regulation 31: Notification of incidents

The registered provider had failed to notify the Chief Inspector of incidents occurring in the designated centre.

- Notification had not been submitted within three working days in relation to a suspected allegation of abuse, or of a serious injury to a resident that required hospital treatment.

This is a repeated non-compliance from a previous inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had failed to adopt and implement policies and procedures designed to support and protect residents. This included policies in relation to;

- The prevention, detection and response to abuse,
- Risk management,
- Monitoring and documentation of nutritional intake,
- Management of incidents and accidents.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

Inspectors found that aspects of the quality and safety of care provided to residents was impacted by inadequate governance and management as described under the Capacity and Capability section of this report. This inspection identified poor care delivery, with particular regard to residents' assessments and care plans, health care, and resident's rights.

A sample of residents individual assessment's and care plans were reviewed. All residents had a care plan, and there was evidence that residents needs had been assessed using validated assessment tools. However, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents. For example, a resident assessed as being at high risk of falls on admission did not have an appropriate care plan developed until two months after their admission, and following a significant fall incident in the centre. Furthermore, not all care plans were reviewed as the residents' condition changed.

A review of residents' records found that there was regular communication with some residents general practitioners (GP) regarding their health care needs. However, a number of residents were not provided with appropriate referral and access to medical and health care professionals, despite showing signs and symptoms of deterioration or being indicated in their medical notes following discharge from hospital. Furthermore, the recommendations of health care professionals were not consistently implemented to ensure best outcomes for residents.

The needs and preferences of residents who had difficulty communicating were identified by staff and effort was made to support residents to communicate their

views and needs. Residents who required supportive equipment to communicate were provided with such equipment.

Residents were provided with a guide to the services in the designated centre in an accessible format. The residents information guide had been updated to reflect changes to the complaints procedure, and the personnel responsible for the management of complaints. This is a completed action from the last inspection.

Residents reported that staff made them feel at home in the centre and that they were treated with dignity and respect. Residents were facilitated to access a varied and inclusive activity programme in the centre. Residents were engaged in activities on a daily basis and residents confirmed to the inspector that they were satisfied with the activities programme.

Inspectors saw that residents were free to exercise choice in how to spend their day. However, inspectors found that residents were not afforded choice with regard to the services they may choose, or not choose to avail of, and the charges for such services. For example, an additional service charge was being charged to a resident, even if the residents did not avail of the service such as activities.

While residents were consulted about their care needs and the overall quality of the service, through schedule resident forum meetings, residents told the inspector that they did not always receive an outcome or response to issues raised at resident meetings.

Visiting was found to be unrestricted, and residents could receiving receive visitors in either their private accommodation or designated area if they wished.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who experienced communications difficulties were appropriately assessed, and supported to enable residents to make informed choices and decisions.

Staff demonstrated an appropriate knowledge of each residents communications needs, and the aids and appliances required by some residents to support their needs.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared and made available to residents a guide in respect of the designated centre. The guide included the information required by the regulations.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Residents did not have a comprehensive assessment of their needs completed. For example, some residents who had experienced significant weight loss did not have an assessment of their nutritional risk completed. Consequently, the care plan did not detail the interventions necessary to support residents with their nutritional care needs. In addition, some residents who were assessed as requiring specific care interventions to manage their complex care needs did not have an appropriate care plan in place to guide the care of the residents. Consequently, staff did not have the required information to support the resident's assessed needs, necessitating transfer of the resident to the acute health care services for assessment and treatment.
- Care plans were not always developed from a comprehensive assessment of the residents care needs. For example, some resident's care plans did not identify interventions in place to protect residents when identified as being at high risk of falls. Consequently, staff did not have accurate information to guide the care to be provided to the residents or protect them from the risk of falls. This posed a significant risk to the care of the resident.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of a resident whose general condition had deteriorated had not been updated to reflect a significant increase in their care needs. Consequently, the care plan did not reflect the nursing and medical interventions required to support their needs.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

The provider failed to provide appropriate medical and health care including a high standard of evidenced-based nursing care in accordance with professional guidance. This was evidenced by a failure to;

- provide timely referral and access to general practitioner services.
- ensure arrangements were in place to appropriately monitor residents following discharge from the acute health care services, and provide timely access to medical professionals.
- provide residents with timely referral to specialist services. For example, a resident with a history of significant weight loss and assessed as being at high risk of malnutrition was not referred for further nutritional assessment and review in line with the recommendations of dietetic professionals and care plan.

This is a repeated non-compliance from a previous inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were restricted in relation to exercising choice. For example;

- Residents told inspectors that their choice was restricted with regard to access to medical professionals.
- Residents told inspectors that their choice was not respected in the context of the services they availed of in the centre, and the associated additional service charges. For example, residents were required to pay an additional weekly service charge for services, whether they availed of the service or not. This included therapies such as physiotherapy that the residents may be entitled to avail of free of charge under the general medical service.

Residents did not always receive a response to their feedback. For example, residents had not yet received an outcome to the issues raised in relation to access to medical professionals, and the additional charges for services.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0042992

Date of inspection: 29/02/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All the vacant positions have been filled for all the departments maintaining our SOP. We do not engage agency staff at the moment. The current schedule entails nurses working three days one week and four days the following week. Additionally, we've added one part-time Clinical Nurse Manager (CNM) to our team. Each day, we have two CNMs on duty, one from 8 am to 8 pm and another from 8 am to 4 pm. All nursing staff are under the supervision of CNMs. Regarding Healthcare Assistants (HCAs), we've opted not to use agency staff. Each day, a minimum of two senior HCAs are assigned to supervise junior staff. Healthcare Assistant supervisor and HCA Manager oversee both senior and junior HCA staff,with daily supervison toolbox. Both nurses and HCAs are designated to specific wings, maintaining consistency within their allocated areas. The Person in Charge meticulously reviews the roster and allocations to ensure an optimal skill mix across all departments.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We've recently introduced a new record and orientation sheet for incoming staff members, providing them with a six-week window to familiarize themselves with our policies and regulations. The orientation covers key areas such as: 1. Understanding the organization's structure. 2. Adhering to HIQA standards. 3. Learning about care planning, assessments, and policies and procedures.	

4. Training on safeguarding, health, safety, and handling complaints.

New staff members are allotted six weeks to complete this orientation. Our existing staff underwent on-site training previously, all the staff have completed mandatory assessments from online training.

Moreover, staff nurses have individually met with the Person in Charge (PIC) on 27.03 and 28.03 to discuss policies regarding falls prevention, wound care, safeguarding procedures, admission management, restraint usage, managing residents with challenging behaviour, and medication management. Each meeting was documented and signed by the nurses, accessible for inspection.

Following the individual sessions with the PIC, all nurses are scheduled for sessions with the Deputy Person in Charge (DPIC) week starting 30th.05.2024. These sessions will focus on various aspects of person centered care planning and assessments only.

To enhance communication and awareness, we've implemented weekly policy, stored at each nurse's station. Additionally, we conduct a daily 11 am meeting involving senior carers and nurses to discuss policies and address highlighted issues within their respective wings. This ensures seamless communication across all staff members, regardless of their assigned wings.

Every day at 2 pm meeting is being introduced also where nurses will discuss their concerns along withs senior HCA in pic office ,ensuring supervision is maintained. Every evening at 23 pm staff nurses meeting is conducted held by nurse in charge at night that will report any issues to CNM in the morning.

Provided syringe pump training on 13.03.2024 for CNM only at present ,feeding pump training on 24.04.2024 for nurses. Palliative care training on site ongoing.

Internal audit for falls completed on 29.03.2024 and we are continuing to audit falls incidents biweekly for the next three months. Infection prevention and control (IPC) audit carried out every Sunday and available for inspection. Wound care audit for all the existing wounds carried out on 28.03.2024 and 15.04.2024,currently all pressure sores grade 1 and higher are reviewed on every Monday by PIC/DIPC. Restraints audit was carried out on 20.04.2024 and updated weekly and all physical and chemical restraint are now in epic care along with updated care plan .Comprehensive assessments are completed. The results+ action plan are documented and stored in the CNM's folder.

Furthermore, all junior Healthcare Assistants (HCAs) are supervised by senior HCA staff, while new nurses receive supervision from CNMs during their initial days of duty. This structured approach ensures consistency and quality in our care delivery.

Staff training on fire safety protocols and procedures has been prioritized, and measures have been taken to enhance fire safety awareness, including addressing issues such as wedged open fire doors .Fire drill conducted every Monday ,records of drills are available. In house training is booked in for all the staff and all the staff in Eskerri will receive fire training by 26.04.2024.Missing persons drills are conducted every Tuesday and recorded, signed by the staff.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;
All incidents are documented and overseen by Clinical Nurse Managers (CNMs) or the Deputy Person in Charge (DPIC). Following documentation, incidents undergo review by the Person in Charge (PIC) only to ensure adherence to established policies. If incidents are found to be incomplete or improperly handled (missing notification to GP/NOK), staff nurses or CNMs are summoned for supervision sessions with the DPIC/PIC. During these sessions, staff members are guided through the correct procedures and required to read and sign relevant policies.

Incidents involving abuse or harm fall under Schedule 3(4)j protocols. Staff nurses and healthcare assistants (HCAs) undergo training emphasizing the importance of meticulous record-keeping. For instance, turning charts, accurate food and fluid intake records are audited daily by the HCA Manager and HCA Supervisor, and CNM for nurses to maintain the proper utilization of touchcare. Daily audits+action plan ensure the accuracy of records are kept for easy access.

Personnel files undergo monthly audits, with 10 files reviewed each month. All previous staff files are currently undergoing review, with completion slated for May 25, 2024. This deadline ensures thorough review and resolution of any pending issues or findings. All records are stored and retrievable in accordance with regulatory standards, ensuring accessibility and compliance.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The use of agency staff within the centre has now ceased. An intensive recruitment campaign is now complete and all vacancies within the centre have been filled by suitably appointed staff. The Clinical Nurse Managers continue to work in a Supernumerary capacity to support the Nurses in Care delivery. This is in Line with the agreed statement of purpose.

Timeframe: Complete

There are robust systems of communication in place that ensure relevant staff are provided with essential information pertinent to their role and responsibilities within the centre. Information regarding the resident's care needs, incidents or near miss events, complaints or any significant matters are discussed at the daily meeting by the PIC. The daily meeting is attended by the PIC, DPIC, CNM, HCA Manager, HCA Supervisor, Nurses, Senior Health Care Assistant, and Physiotherapist. The DPIC/CNM in their absence undertakes a handover meeting in each care area in the afternoon with the Nurse and Senior HCA in the relevant areas. This facilitates the DPIC/CNM to guide, advise and support the staff in any care related matters.

Timeframe: Complete

A head of department meeting takes place weekly, the PIC, DPIC, the newly appointed General Manager and a representative from each department attend.

Timeframe: Complete

A robust auditing system is now in place. The Audit findings and action plans will be reviewed at the local management Team meetings, attended by the PIC/DPIC/General Manager. Quality improvement plans will be introduced to evidence that our audit findings lead to continuous improvement and service developments within the centre.

Timeframe: 30/06/24.

The PIC & DPIC are aware of their requirements to submit all notifications to the Chief Inspector within the specified timeframe.

Timeframe: Complete

The complaints Policy within the center identifies the PIC as the complaints officer. All staff have signed the revised policy to acknowledge their understanding of it and the role they play in reporting and managing complaints within the center. The PIC reviews the complaints, investigates to determine the events that occurred, agrees appropriate actions to address the matter of concern and ensure the complainant is satisfied with the actions taken.

Timeframe: Ongoing

The oversight and monitoring of the service will be further enhanced with the introduction of a Quarterly review of all incidents, complaints, falls, hospital transfers, GP reviews and the residents feedback received which will be undertaken by the recently appointed General manager (PPIM). This will further enhance the governance within the centre and all findings will be shared with the PIC/DPIC and an appropriate quality improvement action plan will be agreed.

Time Frame: 30/05/24

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Person in charge will ensure all incidents are reported to HIQA within the required time frame.
PIC/DPIC will oversee the incident recording and documentation daily.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All required schedule 5 policies are available within the center. As part of the recently revised staff Induction plan the staff are now scheduled time to become familiar with these policies in advance of them commencing their duties in their assigned departments. All existing staff have signed the relevant policies to indicate they have read and understood the policy content. A policy of the week system was introduced, the policy is available at each Nurses station and discussed at the morning communication meeting each day.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All Holistic care plans have undergone auditing since the month of March, with each named nurse now tasked with documentation responsibility and educated with individual comprehensive session with DPIC . Clinical Nurse Managers (CNMs) oversee monthly audits of these care plans, record available for inspection.
Furthermore, proactive measures have been taken to address the needs of residents at high risk of falls, with safety measures in place to prevent further falls from the day of the admission. In-house audits have been conducted over the past two months following fall incidents with all risk assessments, comprehensive assessment, and care plans have been updated and are readily accessible for inspection. For new admissions, assessments

and care plans are completed, with CNMs conducting weekly audits available for inspection.
Moreover, records pertaining to residents on peg feed, stoma, and catheter are stored in CNM files, with ongoing monthly audits of care plans ensuring compliance and accessibility for inspection .

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A review of all Resident files was undertaken by the PIC to confirm the date of the residents most recent GP review. The relevant GP's were contacted and a scheduled review visit agreed.

Timeframe: Complete

The DPIC will monitor the GP Visits on a Quarterly basis. All residents have access to a General Practitioner of their own choosing. The out of hours GP service is accessible to the Resident if they make their expressed wish, their nominated support person make an expressed wish on their behalf or in the event the Nurse on duty has an identified clinical need.

The Centre has access to all the required Multi-disciplinary Team services to ensure a safe and effective service is delivered. There are two Physiotherapists employed in the center, both in a full-time capacity. The center has access to the following supporting services Dietician, Tissue viability Nurse specialist, Speech & Language Therapy, Dental, Opticians, Occupational Therapist. All of the above are accessible to all residents based on an identified need or expressed wish.

The recently revised auditing system and the review of the weekly Clinical KPI's by the local management Team offers further Governance and oversight in relation to the resident's access to services.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

A review of all Resident files was undertaken by the PIC to confirm the date of the

residents most recent GP review. The relevant GP's were contacted and a scheduled review visit agreed.

Timeframe: Complete

The Centre has access to all the required Multi-disciplinary Team services to ensure a safe and effective service is delivered. There are two Physiotherapists employed in the center, both in a full-time capacity. The center has access to the following supporting services Dietician, Tissue viability Nurse specialist, Speech & Language Therapy, Dental, Opticians, Occupational Therapist. All of the above are accessible to all residents based on an identified need or expressed wish.

A Residents meeting is held within the centre on a monthly basis, where the PIC is in attendance. All meeting minutes are available on file. Residents Feedback is also received through the resident Satisfaction surveys distributed within the center, staff daily interactions with the residents or from their Nominated support person expressing feedback on the Residents behalf. The oversight and monitoring of the service will be further enhanced with an additional analysis of all resident's feedback within the center on a Quarterly basis. This will the support the Quality improvement plans within the centre, service developments within the center will be cognisant of all feedback and the residents expressed wishes received by the management team

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	19/04/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	19/04/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	03/06/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Not Compliant	Orange	19/04/2024

	and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	19/04/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	01/05/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	01/05/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2024

Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	30/04/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	19/04/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	19/04/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the	Not Compliant	Orange	19/04/2024

	designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	19/04/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	19/04/2024
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Not Compliant	Orange	19/04/2024

Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Substantially Compliant	Yellow	19/04/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	19/04/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	19/04/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the	Substantially Compliant	Yellow	19/04/2024

	organisation of the designated centre concerned.			