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:	28 June 2023
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0040548

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:	126

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
Wednesday 28 June 2023	18:50hrs to 21:45hrs	Sean Ryan	Lead
Thursday 29 June 2023	09:00hrs to 18:30hrs	Sean Ryan	Lead
Sunday 2 July 2023	07:30hrs to 13:45hrs	Sean Ryan	Lead
Wednesday 28 June 2023	18:50hrs to 21:45hrs	Catherine Sweeney	Support
Thursday 29 June 2023	09:00hrs to 18:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, residents living in Esker Ri Nursing Home gave mixed feedback with regard to their experience of living in the centre. Residents told inspectors that they received a satisfactory quality of care from a team of staff who knew their individual likes and preferences. While residents were complimentary of staff, they described their daily routine as being inconsistent, and described waiting long periods of time to receive assistance from staff. Some residents also expressed dissatisfaction with aspects of the service, such as their involvement in the development of their care plans and visiting arrangements.

Inspectors arrived unannounced at the centre during the evening time and were met by a nurse in charge. Following a brief introductory meeting, inspectors walked through the centre and spent time talking to residents and staff, and observing the care provided to residents, and the care environment. A clinical nurse manager arrived at the centre to support the inspection process.

Inspectors observed a busy atmosphere during the evening of the inspection. Staff were busily attending to the arrival of visitors, while also attending to residents requests for assistance elsewhere in the centre. Residents were observed to be comfortable in a variety of communal areas. Some residents were meeting their visitors in the reception area, while other residents were enjoying refreshments in the communal dayrooms. Other residents were seen walking through the corridors, unaided and unsupervised. The inspectors spent time talking with residents in their bedrooms and in the communal dayrooms. Overall, residents were complimentary in their feedback about the staff, who they described as 'very helpful'. However, residents expressed concerns that staff were 'always rushing' and while they admired the 'hard work' that staff did, residents told the inspectors that they often experienced long delays waiting for assistance.

Inspectors observed that the supervision and allocation of staff was inadequate. While residents were seen to be supervised by staff in the communal dayrooms, inspectors observed less supervision being provided to residents in their bedrooms. This was evidenced during the evening time when residents were heard calling for assistance from staff, who were observed to be engaged in laundry duties, and attending to visitors during the evening time. Inspectors observed significant delays in responding to the residents' calls and attending to their needs.

Inspectors observed that a number of residents did not have their call bell within their reach while in bed, or when sitting out on a chair in their bedroom. A resident told inspectors that they were nervous about standing up from their chair on their own as they felt unsteady on their feet, but could not reach their call bell to call for help. On three occasions during the inspection, inspectors were required to locate staff on behalf of residents who required assistance.

Visiting was seen to be facilitated at specific times in the evening, and staff were observed busily attending to visitors awaiting access to the centre, while also attending to resident's requests for assistance in other areas of the centre. While residents and visitors told inspectors that they looked forward to meeting one another, visitors voiced their dissatisfaction about the visiting restrictions and described their experience as 'sometimes unpleasant'. Visitors described how they had to leave the centre at a specific time, and if staff were delayed answering the door bell, this shortened their visiting time with their relatives. Inspectors observed that visitors were queuing to access and exit the centre during the allocated visiting times.

The premises was warm, bright, spacious, clean, and appropriately decorated for residents. The centre comprised of six wings laid out over three floors. Bedroom accommodation consisted of 119 single rooms, and 12 twin bedrooms. Each wing had communal areas such as a dining room and dayroom. Residents could also access other communal areas located throughout the centre. This included a patio courtyard, chapel, sensory room, and a smoking room. Residents spoken with told the inspectors how they opened the windows in the smoking room because it was poorly ventilated and was uncomfortable in the warm weather. Inspectors observed that a window restrictor on one window was not securely fixed to the window frame. As the windows were positioned low to the ground, this posed a risk to the safety of residents who may seek to exit the building.

Residents bedrooms were personalised with items such as family photographs, colour coordinated soft furnishings, and ornaments. In general, residents were satisfied with their bedrooms and comfortable furnishings. Inspectors observed that some bedrooms on the ground floor did not have adequate lighting through windows that faced out into an internal courtyard. The flow of natural light was obstructed by the height of the building that comprised of the first and second floor. Staff informed inspectors that the bedrooms were not suitable for all residents and that some residents had requested alternative accommodation as a result of inadequate lighting. A number of vacant bedrooms were found to be locked, and accessible only through obtaining a key from the nurses station. This impacted on the timely access to the room in the event of a fire emergency.

Inspectors observed that residents were socially engaged during the inspection. Residents attended group activities in the main activities room on the ground floor. Group activities were also facilitated in the dayrooms of each wing. Activities staff were present to provide meaningful social engagement, and assist residents with snacks and refreshments. However, staff reported that some residents could not attend activities as a consequence of their increased supervision and safety needs.

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 over three days 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).
- follow up on the actions taken by the provider to address significant issues of non-compliance found on the last inspection in January 2023 with regard to the governance and oversight of the service.
- review the actions taken by the provider following a monitoring notification submitted to the Chief Inspector, pertaining to the unexplained absence of a resident from the designated centre.

The findings of this inspection were that the provider had failed to take the required action to address significant non-compliances that had been identified on the last inspection, and urgent action was required with regard to the governance and management of Esker Rí Nursing Home. Inspectors found that a weak organisational structure, failings in the governance and oversight including risk management systems, and inadequate staffing resources significantly impacted on the quality and safety of the care provided to the residents living in the centre. This resulted in repeated regulatory non-compliance under the following regulations;

- Regulation 4: Written policies and procedures,
- Regulation 23: Governance and management.

In addition, the following regulations were non-compliant on this inspection;

- Regulation 5: Individual assessment and care plan,
- Regulation 6: Healthcare,
- Regulation 11, Visits,
- Regulation 15: Staffing,
- Regulation 16: Training and staff development,
- Regulation 18: Food and nutrition.

Following the previous inspection in January 2023, the provider committed to take action to improve their governance and oversight of the service, and implement effective management systems to identify, monitor, and manage risks in the centre that may impact on the safety and welfare of residents. Additionally, the provider committed to reviewing the policies, and supporting procedures to ensure that safe and effective care was provided to the residents. On this inspection, inspectors reviewed the actions taken by the provider following a further significant incident relating to a resident absence from the centre. Inspectors found that the provider had failed to take action to effectively manage risks to residents' safety and welfare. Consequently, actions to protect residents assessed as requiring close supervision were not in place, and there continued to be inadequate and ineffective risk management systems in place to ensure the safe, and monitored delivery of care to residents. Furthermore, inspectors found that the systems in place to ensure effective monitoring of residents' nutritional care needs and nutritional risks were

not effective. As a consequence of these concerns, an urgent compliance plan was issued to the provider following the inspection.

Blackden Limited is the registered provider of Esker Rí Nursing Home. The board of directors, which comprise the registered provider, consists of two directors. At the time of this inspection, the Chief Inspector had been notified of a pending change to the company directors. However on the day of inspection, inspectors found that the management systems in place were not clearly defined, and the lines of authority, accountability and responsibility were not clear.

The management structure, as set out in the centre's statement of purpose consisted of a person in charge, supported by five clinical nurse managers that all worked in a management and supervisory capacity, and a general manager who worked full-time in the centre, and represented the provider. This was not in place on the day of inspection. While a general manager was identified as the person responsible and accountable for the governance and oversight of the service and to whom the person in charge reported to, inspectors found that the full-time presence of the general manager in the centre was not in place. In their absence, accountability and responsibility for key aspects of the service such as the oversight and management of risk, and that management of the staffing resources were unclear. In addition, the clinical management support for the person in charge was not maintained in line with the statement of purpose. Inspectors found that the clinical nurse managers were required to fill vacant shifts in the nursing roster, as a consequence of inadequate levels of nursing staff. This significantly reduced the ability of the clinical nurse managers to fulfil the management component of their role, and impacted on the supervision of staff, clinical oversight, and governance support for the person in charge.

Inspectors found that the provider had failed to organise and manage the staffing resource effectively within the centre. Consequently, the provider had failed to ensure that the designated centre had sufficient resources to ensure that safe care and services were provided, in accordance with the centre’s statement of purpose. A review of the staffing rosters evidenced that staffing resources were not available to cover planned and unplanned leave, or maintain planned rosters, particularly in terms of nursing staff. For example, a review of the rosters found multiple occasions where two nurses, rather than the four required, were on duty at night time to monitor and provide nursing care for up to 126 residents. Inspectors found that deficits in the nursing rosters were supplemented with health care staff who were allocated nursing care duties. Additionally, inspectors observed that health care staff were re-directed from their caring duties to support other aspects of the service, such as laundry duties. The provider was aware of the deficits in the staffing resources, and had continued to admit new residents to the centre in the absence of stable and safe staffing levels. The provider had not assessed this potential risk to residents, or progressed to consider alternative arrangements to ensure the planned staffing levels could be maintained. The impact of inadequate staffing levels is discussed further under Regulation 15: Staffing.

The management systems failed to ensure that the service provided was safe, consistent and effectively monitored. The system in place to manage risk was not

effective. The centre's risk management policy detailed the interventions that should be in place for the oversight, assessment, and monitoring of risk in the centre. This included maintaining a risk register to record all potential risks to residents' safety and welfare. However, a review of the centre's risk management systems found that they did not reflect the centre's own risk management policy. The risk register did not contain the known risks in the centre. This included the risks associated with inadequate staffing resources, and the risk associated with residents assessed as requiring high levels of supervision leaving the centre unaccompanied. Consequently, there were no effective risk management systems in place to manage the potential risk to residents' safety and welfare.

There was inadequate documentation of adverse incidents involving residents. Recorded incidents were poorly detailed and all the possible contributing factors had not been identified or considered. This meant that incidents could not be fully investigated or analysed, and no quality improvement action could be implemented to ensure that risks to residents would be reduced. This significantly impacted on the registered provider's ability to identify, respond to, and manage risk in the centre, and maintain a safe and quality care environment for residents.

Some notifiable incidents, as detailed under Schedule 4 of the regulations, were not notified to the Chief Inspector of Social Services within the required time-frame. For example, the Chief Inspector had not been notified of incidents with regard to the unexplained absence of a resident from the designated centre, or of a serious injury sustained by a resident.

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, visiting, and nutrition delivered to a resident, contained within the nursing records. However, the complaint was not appropriately documented or managed within the complaints register, or in line with the centre's own complaints management policy.

Inspectors reviewed the system of record management in the centre. Records were maintained through an electronic and paper-based system. Inspectors found that the systems and oversight of records was poor. Records were not maintained as required by Schedule 3 and 4 of the regulations. This included records with regard to incidents involving residents, of nursing care provided to a resident, and the administration of medication to residents, in accordance with relevant professional guidelines.

While all staff had attended training with regard to fire safety, and missing persons, inspectors were not assured that staff demonstrated an appropriate awareness of this training, including the procedure to commence in the event of a fire emergency or missing person. There was no system in place to evaluate the quality of the training provided, or to ensure that up-to-date training was implemented. Inspectors found that the arrangements in place to supervise and support staff to implement the centre's policies and procedures, and maintain records were not effective.

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 were implemented.

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. A review of the rosters found that there was inadequate staff available to meet the health and social care needs of the residents, and to ensure residents received safe and effective care. This was evidenced by;

- Vacant shifts in the nursing roster resulted in the clinical nurse managers being redirected from their management and supervisory role to deliver direct nursing care to the residents. This impacted on overall supervision of staff, and the supervision of the quality of care provided to residents.
- A review of the nursing staff rosters for the previous six weeks showed that up to 84 nursing care hours per week had not been filled. On the days of inspection, there were three nurses rostered on night duty, where there should be four, to provide nursing care to 126 residents, and to provide oversight and supervision of the health care assistant team. Inspectors found that the inadequate levels of nursing staff impacted on safe medication administration practices, the supervision of residents, and the timely response to residents requests for care and assistance.
- A review of the record of incidents, in conjunction with staffing rosters, found that there was insufficient nursing staff on night duty to ensure the safety and well-being of residents. There were eight occasions where there were two nurses on duty. This impacted on the supervision of residents with complex care needs. For example, on one occasion a significant incident involving a resident had occurred during a time when planned staffing levels had not been maintained.
- Residents spoken with reported having to wait a long time for care to be delivered. Inspectors observed that health care staff were carrying out laundry duties, and attending to visitors, at a time when residents reported, and were observed, waiting long periods of time to receive assistance and support from staff with their personal care needs. This meant that there was less time available for the direct care or residents, and supervision of residents with complex care needs.

Judgment: Not 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 demonstrate an appropriate awareness of their training in relation to the procedure to commence in the event of a missing person, or in relation to fire safety procedures.

Staff were not appropriately supervised. This was evidenced by the;

- failure to maintain accurate nursing care records.
- failure to administer medication, in line with the centre's own policies, and relevant professional guidelines.
- failure to implement the policies and procedures in place to support and protect residents.
- inadequate clinical supervision arrangements to ensure that care was delivered in accordance with each resident's care plan and the recommendations of allied healthcare professionals.

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;

- The nursing record for resident's health and treatment given, following an incident in which a resident suffered harm was poorly documented, and investigated. There was no documented assurance that appropriate assessment, treatment and care was delivered to a resident following a serious fall.
- A record of an incident that involved the unexplained absence of a resident who required close supervision was poorly documented and did not contain the detail required under Schedule 3(4)(j) of the regulations.
- Records of each drug and medicine administered were not signed and dated by the staff administering the medications to the residents.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that nursing notes were duplicated from previous entries over a seven day period. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.

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 provider had failed to ensure the service had sufficient staffing resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service.
- maintain adequate clinical nurse manager staff levels to ensure effective support and supervision of the nursing and health care staff teams.
- maintain adequate nursing staff levels to ensure consistent, safe, and quality care was provided to the residents, in line with the centre's statement of purpose.

The registered provider had failed to ensure that there was a clearly defined management structure in place, with clear lines of accountability and responsibility, in line with the centre's statement of purpose. For example, in the absence of a full-time general manager, accountability and responsibility for the management of the staffing resources were not clear. Furthermore, accountability and responsibility for key aspects of the service such as the oversight and management of risk in the centre were unclear. Consequently, there were poor systems in place to escalate risk to the provider. This resulted in ineffective action being taken to address risks to residents.

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

- a failure to implement the centre's risk management systems to identify and respond to the risk of residents absconding from the centre. Furthermore, the provider had failed to carry out a review of incidents where residents who required high levels of supervision had left the designated centre unaccompanied, for the purpose of ensuring that contributing factors could be identified to prevent repeated incidents, and identify opportunities for learning, and improving the quality and safety of the service for residents.
- ineffective systems to ensure key clinical information regarding residents care needs were effectively communicated to staff. For example, all staff were not informed of incidents involving residents leaving the designated centre unaccompanied, falls, or the nutritional care and support needs of residents assessed as being at high risk of malnutrition.
- poor oversight of the complaints management system, and escalation of complaints, to ensure the quality of care of residents was monitored, reviewed and improved on an ongoing basis. For example, concerns regarding medication management, nutrition, visiting, and residents' comfort had been brought to the attention of the management team. The concerns were not documented and managed within the centre's complaints register.

This meant that there was no record of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant.
- ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services, and implementing the recommendations of health care professionals.
- poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to medication management, nursing documentation, and the records of incidents were found to be poorly recorded and investigated.
- poor oversight of the submission of statutory notifications to the Chief Inspector, particularly in relation to the unexpected absence of a resident from the designated centre.

An urgent compliance plan was issued to the provider following the 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 the policies in relation to;

- Risk management,
- Management of incidents and accidents,
- Missing persons policy,
- Nutrition and hydration policy,
- Complaints management.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

Inspectors found that the interactions between staff and residents were kind and respectful throughout the inspection. Nonetheless, 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. Significant action was required in relation to the assessment of residents' needs to ensure the delivery of safe, high-quality, person-centred care to residents. Non-compliance in relation to

individual assessments and care plans, health care, and food and nutrition impacted on residents' safety and well-being.

A review of the nutritional aspects of the service found that the provider did not have robust arrangements in place to identify clinical nutritional risk and monitor the nutritional care needs of residents. While nutritional screening was in place for all residents, the care pathway for residents assessed as being at risk of malnutrition was not implemented. For example, there was no evidence of action taken for a number of residents identified as at risk of malnutrition, and experiencing weight loss. Further findings are discussed under Regulation 18: Food and Nutrition.

Inspectors reviewed a sample of assessments and care plans and found that while each resident had a care plan in place, the care plan was not informed by an assessment of the resident's care needs. The care plans of residents assessed as being at high risk of falling, and at risk of malnutrition did not reflect person-centred, evidence-based guidance on the current care requirements of the residents. This is discussed further under Regulation 5: Individual assessment and care plan.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs. However, a number of residents had not been referred to their GP for over six months despite showing signs and symptoms of physical deterioration, or following an injurious incident.

While there were arrangements in place for residents to access the expertise of other health care professionals, referrals for further expert assessment were not always timely despite this being indicated within residents' medical, and nursing notes. Furthermore, the recommendations made by health care professionals was not consistently incorporated into the residents' care plan. Consequently, these recommendations were not implemented by staff to ensure the best outcomes for residents.

Regulation 11: Visits

Inspectors found that visiting restrictions were in place on the day of inspection. Visiting was restricted to specified times in the afternoon and evening.

Where the centre was operating outside of the current national guidelines, a risk assessment to underpin this decision by the management team was not in place. In addition, residents and families spoken with were not in agreement with the restrictions in place.

Judgment: Not compliant

Regulation 18: Food and nutrition

Urgent action was required to ensure the nutritional needs of residents were met. This was evidenced by;

- Residents' dietary needs were not consistently met, as prescribed by allied health care professionals. A number of residents were prescribed a therapeutic diet, and nutritional supplements to manage and maintain their weight. The nutritional care records for those residents did not evidence that nutritional care was provided in line with the resident's assessed needs or care plan.
- Residents were not provided with adequate quantities of food and drink as prescribed by dietetic professionals. For example, nutritional care records for residents' who were dependent on a combination of oral and enteral nutrition (a tube, catheter or stoma that delivers nutrients directly to the gut) were poorly maintained, and did not evidence that nutritional care was provided in line with the resident's assessed needs or care plan.
- The food served to residents was not properly and safely prepared. Food was not prepared, or provided to residents, in line with their assessed dietary needs. For example, a resident who was prescribed a modified consistency diet was served an inappropriate diet, which posed a safety risk.

An urgent compliance plan was issued to the provider following the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents' assessments and care plans found that they were not compliant with the regulatory requirements. For example;

- Care plans were not guided by a comprehensive assessment of the residents' care needs. While comprehensive admission assessments identified risks associated with the care needs of residents with impaired mobility, there was no corresponding care plan developed to guide the appropriate care of the resident.
- Residents with complex care and supervision needs did not have an appropriate assessment of their needs completed. Consequently, the care plan developed did not detail the interventions necessary to support residents who required close monitoring and supervision.
- Care plans were not developed in a timely manner, in line with the assessed needs of a resident. For example, a resident with a five month history of weight loss, and assessed as a high risk of malnutrition, did not have a nutritional care plan developed to guide appropriate care of the resident.

- Care plans were not reviewed or updated when a resident's condition changed. For example, a care plan to support a resident's increased monitoring and supervision needs was not developed until nine days following a serious incident. Consequently, staff did not have the required information to support the resident's assessed needs.

Judgment: Not compliant

Regulation 6: Health care

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

- provide appropriate health care and timely medical review to a resident following a fall incident in the centre.
- refer residents for further expert assessment following significant weight loss, in line with the directive of health care professionals.
- implement the recommendations of health care professionals.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0040548

Date of inspection: 02/07/2023

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - All CNM's are supernumerary 7 days per week. All CNM staff remain rostered as supernumerary shifts 07.30-1800 7 days /week. This ensures the CNM have direct oversight daily of all aspects of resident care. Where required, direct supervision and support is provided to the nurse /hca team to ensure any issues/concerns are appropriately managed. Each CNM attends the morning handover and agreed actions are reviewed at a daily meeting with the PIC. At this meeting all aspects of care are reviewed and follow up actions agreed, where any risks are identified. - We have recruited 3 nurses who commenced July '23, a further 3 nurses on board in the recruitment process, expected start date Sept / Oct. - All rosters' shifts are completed in full day & night, where there are any deficits, this is supported with agency shifts when required. This will always ensure adequate levels of nursing staff, safe administration of medication, supervision of residents & a timely response for resident's request for care & assistance. - Following inspection, care staff do not complete any laundry duties, PIC has completed monitoring of nurse call responses & a noticeable improvement has been achieved. This continues to be a daily focus at team meetings & communicated to all care staff.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - All staff have completed direct supervision sessions and training on managing Missing Persons in July/Aug 2023. - Specifically: The Missing persons policy was reviewed and updated. The amended	

policy was shared with all staff, direct 1:1 supervision was also held to assess understanding of this policy. The supervision sessions assessed the actions each staff would take if a resident was missing. Training has begun on risk of absconscion, responsive behaviours, dementia care, psychotropic medication management in July + Aug 2023. This training is ongoing and further training sessions have been booked for Sept 2023.
- Missing persons drills have also been completed weekly with prompt response from staff.

- Also training on fire safety: with special emphasis on the care and management of at-risk residents during fire drills. Fire action notices were reviewed and displayed at each repeater fire panel: staff understanding was assessed, as competent by supplying direct supervision for all staff on individual Actions to be taken when:
- 1. A fire is discovered and 2. What to do on hearing the Fire Alarm.

- Nighttime fire drill scenarios have been begun and will continue monthly. Staff response to date has been prompt and PIC/CNM will continue to monitor.

- Health and safety officer has been appointed. Health and safety meeting held monthly and areas identified shared findings communicated to all staff.

- HCA supervisor remains supernumerary to support the CNM & nurses to ensure good care practices are delivered to all residents. This required direct training & supervision about call bell response, documentation of care given & recorded onto electronic touch care recording system. All resident charts have been reviewed & care staff are given clear directions on every shift, regarding specific risks/ resident's needs. The completion of all documentation will form part of the audit process.
- Daily team meetings are now held with CNM, PIC to discuss every resident & any identified risks or concerns. CNM staff are still supernumerary to directly support & oversee the quality of care provided to each resident. Additional support recommended from visiting allied health professionals is discussed at each team meeting to ensure all actions required are followed. The CNM will ensure direct oversight & follow up. Audit of care plan documentation has begun & is ongoing, where immediate issues are identified the CNM supports the nurse with required actions & update. Each resident has a named nurse assigned & all nurses are currently reviewing & updating every resident file. It is expected every care plan will be audited by 31/8/23.

- A daily risk prompt sheet has been implemented which provides a summary over 7 days of each resident. Improvements in resident care have been noted following implementation of same.

- Training began for all nurses on care planning, nurse documentation, incident management & records, dementia awareness, responsive behaviour, health & safety, risk management, fire & medication management. Several training sessions have already been completed & further training has been arranged for 18th, 23rd, 25th, 29th 30th August & 4th & 8th Sept, to capture all staff planned leave.

- Additional to the monthly care plan audits, the CNM staff will have direct oversight and governance daily to ensure all the training completed will be assessed on an ongoing

basis. Direct feedback is given daily, as required to each nurse regarding care plan records/documentation, risk management and incident recording.

- A medication audit was completed on 25th July, identified areas for improvement discussed with all Nurses, PIC and CNM will monitor daily for compliance. A further audit was completed by the pharmacist on 15th Aug, action plan shared with all nurses. Monthly medication audit will continue, and findings shared with staff nurses.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
- An incident/accident audit was completed for June /July 2023 to review records and ensure oversight and governance regarding incident management. Deficits identified were communicated to all nurses and corrective actions taken. PIC/CNM staff now review all incidents daily to ensure accurate, comprehensive details are documented, to comply with Schedule 3 (4) (j). All incidents are communicated daily to appropriate staff to ensure follow up actions are taken.

- Areas identified at the inspection were communicated directly to all staff at each shift handover.

Training was provided on responsive behaviors, incident management & record keeping in July '23. Further training has already been arranged. PIC & CNM ensure daily oversight of any identified at-risk residents & discussion on best management of same.

CNM/PIC have daily direct oversight in respect to nurse documentation: specifically reviewing electronic records, to check progress notes and MDT follow up. This will ensure person -centred records are maintained to reflect the daily care needs of each resident, as per Schedule 3(4)(c). Any deficits identified in respect of documentation are actioned immediately by CNM/PIC.

- Following completion of incident management training & direct supervision by CNM, PIC all incident documentation is completed in full to the required standards. All incidents are checked daily by PIC, CNM to ensure required standard.

- All nurses have completed medication management training, the remaining 3 staff will have completed by 18/8/23. Supervision sessions were completed with individual nurses regarding their roles and responsibilities re: administration of medications.

- At the daily team meeting identified at risk residents who require an increase supervision are discussed & agreed action plan to manage. Any required GP or other MDT is contacted as required.
- Any issues identified are documented in the daily progress notes, risk assessment, care

plan or MDT as appropriate. This will ensure the nursing records are person centred & reflect the resident care needs on that day.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- Statement of purpose has been reviewed & submitted to reflect the current management structure.
- A review of current staffing was completed, to include recruitment of any planned vacant roles. All positions are advertised, through HR support and reviewed weekly.
- Currently the 3 staff nurse vacancies have been recruited and expected to be in post by the end of September ’23.
- All CNM’s remain supernumerary; this will ensure direct oversight and completion of supervision sessions, as required for all staff. This supernumerary role includes, daily monitoring of resident care and clinical standards and record keeping, through direct observation of practices/completion of clinical audits, example: audits on care plans/nurse documentation/infection control/incidents and management/nutritional risk /responsive behaviours/medication management. The CNM role also involves management of rosters, in the PIC absence, where any vacant shifts are covered, or where required agency staff are arranged.
- All rosters are completed in full, any deficits identified are covered with Esker Ri staff or if necessary, agency staff, this will ensure consistent, safe & quality care provided to the residents in line with the Statement of purpose.

- Deputy Person In Charge role created & recruited successfully. The organsiational structure has been reviewed, a 2nd deputy person in charge (dpic) will be recruited, this will replace the general manger role. Both dpic staff will report directly to the PIC.
- Regional Operations Manager (ROM) in place 4 days per week, this supports the PIC and her team and places an experienced resource in the Home. This support will also help the PIC to review all risks in the Home, and guide required actions to be taken to support safe resident care. The ROM also supports the PIC, in respect to all aspects of Care Home management.
- Role includes: working with PIC to review all relevant documents, ensuring a systematic approach and necessary resources to carry out the reviews. Agreed required actions with the PIC to ensure achieving and maintaining full regulatory compliance. Provide oversight of the implementation of the actions required and assist in the analysis of outcomes, documentation and continuous review and audit. Assisting the PIC to implement the One drive to ensure oversight of records off site. ROM will communicate with RPR x2 weekly regarding progress.
- A review was completed July 2023 on training matrix, all identified training has been arranged; there is a training plan in place.
- The Health and safety statement was updated July 2023, a robust system is in place to

ensure safety and welfare of all residents. The facilities manager aided the PIC to review the safety of the building, environment and facilities. Specifically – all fire exit doors and windows, any identified faults were rectified, daily fire exit door checks continue to be completed. The Homes maintenance also completes a weekly maintenance check on all fire exit doors and windows.
- A review was completed of all incidences of absconscion from Dec 2022 to June 2023. This included a review + analysis on staffing/skill mix/compliance with procedures/awareness of those at risk/handover communication and training/fire exit doors+ windows /CCTV system/visiting policy/records and documentation following incident or near misses. All identified actions have been completed and shared learning communicated to staff through daily team meetings, health safety and general staff meetings.
- All incidents reviewed daily at PIC meeting and where appropriate notification to HIQA completed.

- An audit matrix has been implemented to provide governance & effective management systems. This includes completed audits in July & August on care planning, nutritional risk & weight loss, incident analysis, medication management & a review of the resident risk register & relevant risk assessments. Regular monthly staff meetings have also been held for all departments including a health & safety meeting on 4/8/23.
- All issues identified in the audits are communicated to all staff as part of the daily handovers & improvements will continue to be monitored by PIC & CNM.
- A gap analysis was completed regarding the absconsion incidents & submitted to HIQA. Any deficits identified have been addressed.
- As per previous all communications regarding any resident risk are clearly communicated daily via team meetings, shift handovers to all staff. This will ensure that all staff are informed of all risks or incidents.
- Training on complaints management was held in July ’23, further training is arranged for the 8th of Sept ’23. Any concerns or complaints are now entered into epic care, recording issues acknowledged, investigated + resolved to the satisfaction of the complainant. Any actions required are communicated at each shift handover.
- Any resident identified for MDT referral is promptly arranged, any subsequent recommendations are actioned by the nurse / CNM.
- A review of all resident risks is completed by the CNM weekly, specifically some residents are identified to require closer monitoring, eg. weekly weights /intake/output charts /repositioning and close observation checks. This information is communicated daily to the staff team. All information is now entered directly into the electronic records. Each nurse reviews these records when updating the daily progress nursing notes and will discuss with CNM/PIC if concerned.
- Weights are reviewed weekly by the CNM and discussed with the PIC, where required appropriate referral to MDT. Care plans/Risk assessments are updated following review. Discussion with resident and next of kin, where required.
- The PIC has commenced meetings with individual residents and next of kin to discuss current care needs, as recorded these meetings have been welcomed as positive addition .
- A risk review was also completed on absconscion/responsive workforce /resident care /communication and nutrition. Areas of improvement to reduce identified risk have been communicated to staff.
- A new electronic auditing system will be implemented in the Home, expected to

commence Sept 2023, this will also include Risk assessment and management. It is expected a full review of all areas will now be completed by 31.10.2023.

Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: - Training was commenced in July '23 on Risk management, management of incidents & accidents, missing persons policy, nutrition & hydration policy & complaints management, this training will continue over the next 3 months to ensure staff fully understand their role regarding these policies; to ensure residents are supported & protected. - Specifically, Policies have been reviewed on management of incidents and accidents/missing persons/nutrition and hydration/complaints management. These policies have been updated & discussed with staff, as part of the staff supervision / toolbox support sessions – through direct supervision/observation of completed documentation + handover the PIC/CNM will review understanding of same.	

Regulation 11: Visits	Not Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: - All visiting restrictors have been removed; visitors can access the home at any time. Additional reception \ support has been extended to 8 pm every day to facilitate out-of-hours phone calls & access via the Main Reception entrance.	

Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: - An audit was completed for all residents' weights and nutritional status on 5th July + 6th July 2023. A monthly audit will be completed by CNM, to continue review Nutritional risk. All identified at risk residents were appropriately referred to GP, dietitian, SALT team The dietitian reviewed all required residents on 13th July 2023, appropriate	

changes to their care needs were recorded in their care plan/risk assessment. Dietary changes recommended by the dietitian were relayed to the GP, as required, changes to the residents' scripts were implemented. All care plans, MUST risk assessments were updated to reflect same. A monthly audit has commenced to identify changes to nutritional status.
- All Nursing /Hca/catering staff are informed daily of any changes to dietary requirements, including changes to modified diets, as recommended by SALT team.
- All residents' nutritional & hydration charts were reviewed & a clear list is shared at every handover with all staff to ensure consistency & accurate monitoring. Individual training /tool box sessions were held daily to support staff on the new electronic recording system, where all resident monitoring charts are now recorded. Additional tablets were purchased to provide staff with more IT resources and to aid easy data entry, at the point of contact. Old paper charts are no longer in use.
- This new system has been verry effective & this is reflected in improved nutritional intake for residents.
- CNM staff have direct oversight daily regarding management of nutritional risks, same concerns discussed at daily team meeting with PIC.
- All catering staff are communicated with all changes regarding residents identified at nutritional risk. This resident list (prompt sheet) is displayed in the kitchen & on all serving trolleys for all catering staff to ensure the correct modified consistency diet is prepared for each resident.
- Daily nutritional intake & hydration is recorded in the resident progress notes & any concerns are communicated to the CNM, PIC.

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:
- Care plan audit has been completed -all identified deficits have been addressed.
- All care plans will be audited by 31.8.23.
- The named nurse list has been updated where required CNM is supporting the nursing staff with direct supervision regarding comprehensive assessment of residents needs. All care plans will be reviewed to ensure a comprehensive assessment & holistic care plan is in place. This will also reflect identified risks for each resident.
- Training on care planning & documentation commenced in July '23 with further onsite training planned for 4th Sept '23, all nurses will have attended this training by the 4th Sept '23. Feedback from this training has been very positive.
- All care plans will reflect individual resident's needs, risk identified & the required level of supervision. Any concerns regarding resident care are discussed at the daily team meeting & communicated to all staff.

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: - At the daily team meetings all incidents / accidents are discussed with CNM / PIC & where appropriate timely referral to GP or MDT is completed. - Any recommendations by health care professionals are discussed at the daily team meeting with CNM, PIC & appropriate actions taken. Where further investigations are required, all referrals are completed in a timely manner. - Any recommendations by healthcare professionals are clearly documented in the nursing records & same communicated to all staff as required.	

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Not Compliant	Orange	29/06/2023
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.	Not Compliant	Orange	03/07/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff	Not Compliant	Orange	30/10/2023

	have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	03/07/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	29/06/2023
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Red	05/07/2023
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 and are available	Not Compliant	Orange	19/07/2023

	for inspection by the Chief Inspector.			
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	03/07/2023
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	03/07/2023
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	Red	19/07/2023
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	09/08/2023

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	03/07/2023
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 designated centre concerned.	Not Compliant	Orange	03/07/2023
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.	Not Compliant	Orange	24/11/2023

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	31/08/2023
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.	Substantially Compliant	Yellow	03/07/2023
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.	Not Compliant	Orange	03/07/2023
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a	Not Compliant	Orange	03/07/2023

	resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			