

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

**Inspection report  
Designated centres for older people**



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| <b>Centre name:</b>                     | Elm Hall Nursing Home   |
| <b>Centre ID:</b>                       | 0034  |
| <b>Centre address:</b>                  | Loughlinstown Road<br>Celbridge. Co. Kildare  |
| <b>Telephone number:</b>                | 01 6012399  |
| <b>Fax number:</b>                      | 01 6279906  |
| <b>Email address:</b>                   | info@elmhallnursinghome.com   |
| <b>Type of centre:</b>                  | <input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public  |
| <b>Registered providers:</b>            | Springwood Nursing Homes Ltd  |
| <b>Person in charge:</b>                | Caroline Perry  |
| <b>Date of inspection:</b>              | 16 August 2011  |
| <b>Time inspection took place:</b>      | <b>Start:</b> 09:00 hrs <b>Completion:</b> 17:00 hrs  |
| <b>Lead inspector:</b>                  | Mary O'Donnell  |
| <b>Support inspector:</b>               | Linda Moore and Carol Grogan  |
| <b>Type of inspection:</b>              | <input type="checkbox"/> Announced <input checked="" type="checkbox"/> Unannounced  |
| <b>Purpose of this inspection visit</b> | <input type="checkbox"/> Application to vary registration conditions<br><input type="checkbox"/> Notification of a significant incident or event<br><input type="checkbox"/> Notification of a change in circumstance<br><input checked="" type="checkbox"/> Information received in relation to a complaint or concern<br><input type="checkbox"/> Regulatory Monitoring Visit |

## About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- to carry out a regulatory monitoring visit focussing on key regulatory requirements.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

## About the centre

### Description of services and premises

Elm Nursing Home is a purpose-built residential centre with 61 places. The provider recently converted one bedroom with accommodation for three into two single bedrooms and reduced the bed numbers from 62 to 61. It provides long term, palliative, convalescent and respite care. It is a two-storey building with 58 single rooms and one three-bedded shared room. All bedrooms have a wheelchair accessible shower, toilet and wash-hand basin en suite. There is a sitting room and dining room on each floor and a reading room as well as a kitchen, laundry, treatment room, oratory, hairdressers' room, staff facilities and visitors' room. In addition to the en suite bathrooms there are five toilets, four of which are assisted toilets. There are two baths which are not used. Residents have access to a secure enclosed garden.

There are eighteen independent living chalets and a social centre on the grounds. Car parking is available at the side of the centre.

### Location

Elm Hall Nursing Home is situated close to the village of Celbridge in Kildare. It is situated close to Elm Hall Golf Club and close to the Hazel Hatch train station.

|  |           |
|--|-----------|
| <b>Date centre was first established:</b>            | June 2006 |
| <b>Number of residents on the date of inspection</b> | 53        |

| <b>Dependency level of current residents</b> | <b>Max</b> | <b>High</b> | <b>Medium</b> | <b>Low</b> |
|--|------------|-------------|---------------|------------|
| <b>Number of residents</b>                   | 15         | 10          | 16            | 12         |

### Management structure

Elm Hall is owned by Springwood Nursing Homes Ltd. and Mairead Byrne, the Managing Director is the nominated person on behalf of the provider. The Person in Charge, Caroline Perry is known as the Director of Nursing and she reports to the Managing Director. The Assistant Director of Nursing (ADON) and two CNM2s, deputise in the absence of the Person in Charge. The ADON, three clinical nurse managers (CNM2), three junior clinical nurse managers (CNM1), staff nurses and care assistants report to the Person in Charge. All non-clinical staff report to the provider.

| <b>Number of staff on duty on day of inspection:</b> | <b>Person in Charge</b> | <b>Nurses</b> | <b>Care staff</b> | <b>Catering staff</b> | <b>Cleaning and laundry staff</b> | <b>Admin staff</b> | <b>Other staff</b> |
|--|-------------------------|---------------|-------------------|-----------------------|-----------------------------------|--------------------|--------------------|
| <b>Morning</b>                                       | 1                       | 3             | 9                 | 3                     | 4 cleaning                        | 0                  | * 4                |
| <b>Afternoon</b>                                     | 1                       | 3             | 7                 | 3                     | 1 laundry                         |                    |                    |
| <b>Evening</b>                                       | 0                       | 2             | 7                 | 3                     | 0                                 |                    |                    |
| <b>Night</b>   | 0                       | 2             | 4                 | 0                     | 0                                 |                    |                    |

\*The provider, activities coordinator and receptionist. A CNM2 who was scheduled to begin at 3.00 pm came on duty at 10.00 am to assist with the inspection.

## Summary of findings from this inspection

This was an unannounced inspection and the third inspection of this centre by the Health Information and Quality Authority's (the Authority) Social Services Inspectorate (SSI). The inspection was brought forward in response to information received by the Authority regarding the following:

- inadequate staffing levels
- meals were not nutritious
- poor nursing practices as follows:
  - management of behaviours that challenge
  - prevention and management of pressure ulcers
  - continence management
  - hygiene and personal care

The Authority had initiated a provider led investigation into pressure care. The provider responded and provided the information required by the Authority. A full inspection was undertaken and all of the issues above were fully reviewed by three inspectors on the day of inspection. They also followed up on the required actions of the previous inspection of 4 and 5 May 2011.

Inspectors met with residents, relatives, and staff members during the inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Inspectors found that the provider had improved the staffing levels and the skill-mix required to meet residents' dependency needs and the size and location of the building. The person in charge was supernumerary and could focus on her managerial responsibilities. Staffing levels had increased on every shift and senior nurses presented as competent to support the person in charge to address the deficits which were identified at the previous inspection. Falls was an area of concern at the previous inspection and inspectors found that systems in place to prevent and manage falls had improved considerably. Residents were risk assessed, falls were documented and analysed to improve care and quarterly audits indicated a reduction in the incidence of falls since the last inspection. Additional training was planned and additional resources were required to ensure that the falls prevention policy was fully implemented.

Inspectors also reviewed the 14 actions from the previous registration inspection of 4 and 5 May 2011 and confirmed that six actions were fully completed and three actions which were deemed to be completed required additional work. The statement of purpose did not have the required information, the complaints policy was amended but not fully implemented and staff files did not have all the information required in Schedule 2 of the Regulations. Four actions, which were due for completion in Oct 2011 were satisfactorily progressed. Inspectors were satisfied that the risk management policy was satisfactory and an emergency plan was in place. The provider had arranged for all staff to attend fire training and had taken measures to safeguard vulnerable residents from abuse. One action had not been progressed.

The provider detailed plans to address the requirement to review the quality and safety of care. Plans were not yet implemented and the action was due for completion in October 2011.

While areas for improvement were identified, overall inspectors found that the provider and person in charge met the requirements of the Regulations and had recruited experienced nurses and put systems in place to strengthen management and leadership processes. There was evidence of progress towards improving practice in all areas. The deputising person in charge and staff demonstrated an acceptable knowledge of residents' needs, their likes, dislikes and preferences. Care teams had been reorganised to provide more person centred care. However, residents expressed frustration at not being fully informed about these changes and formal systems for consultation with residents required improvement.

The healthcare needs of residents were met to an acceptable standard. Residents had access to medical cover and to a range of other health services. Nursing assessments and care planning had improved but remained disjointed and did not support the delivery of evidence based nursing care. The assessments of behaviours that challenge, pressure ulcer prevention, hygiene and personal care and continence management all required improvement in order to deliver consistent evidence based nursing care. Residents were very happy with the quality of food. Inspectors found that menus offered a varied nutritious diet but there was variation in the quality of the service provided to residents who required a modified diet.

These areas for improvement are discussed further in the report and are included in the Action Plan at the end of this report.

## Governance

### Article 5: Statement of Purpose

Inspectors observed that the statement of purpose and the Residents' Guide had been incorporated into one document called "Information for Residents and Relatives (Statement of Purpose and Function)". The statement had been reviewed since the previous inspection but it did not have meet all of the requirements of Schedule 1 of the Regulations. For example, the statement had not been updated to include information about the senior nurses who deputised in the absence of the person in charge. It did not stipulate maximum number of residents or the gender of residents to be accommodated. Information on arrangements for fire safety did not include staff fire training, fire drills, fire alarm checks, and evacuation procedures.

The statement of purpose set out the services and facilities provided in the designated centre. The profile of the residents reflected the statement of purpose and the majority of the residents were of advanced years with disabilities associated with old age. Residents with dementia were accommodated largely on the first floor. One resident was in receipt of palliative care and one resident was receiving respite care. The centre does not cater for residents with acute psychiatric illness. Inspectors observed the centre's capacity to meet the diverse needs of residents, had improved since new staff had been recruited, senior nursing posts had been created and staffing levels had increased. There were plans for the ongoing education and training to ensure that staff are competent to provide high quality holistic care. In particular inspectors noted that activity staff played a key role to enhance the quality of life for residents and promote the friendly homely environment described in the statement.

### Article 15: Person in Charge

The person in charge was a registered nurse and worked full-time. She was on duty five days a week, normally Monday to Friday. She had been employed in Elm Hall since 2006 as a nurse manager and as person in charge since 2009. She had worked in a large specialist hospital for older people for five years prior to this. She was a manual handling instructor and had completed courses in infection control, continence and applied psychology.

The person in charge was on annual leave and the ADON had a day off and a CNM2 deputised on the day of inspection. A second CNM2 came on duty early to assist with the inspection. They were both on duty as the person in charge was on annual leave and they were qualified and presented as competent to deputise in her absence and demonstrated this both through their clinical knowledge and understanding of the residents' needs on the day of inspection. They provided documentation requested by the inspectors.

At the registration inspection the person in charge was one of two nurses on duty and carried a clinical caseload. The provider and a CNM2 confirmed that the person in charge was supernumerary and engaged full-time in her managerial role. The records of the staffing rota confirmed this.

## **Article 16: Staffing**

Inspectors were satisfied that the numbers and skill-mix of staff on duty over a 24-hour period were adequate to meet the needs of residents on the day of inspection. Staffing levels and arrangements for cover when staff were on leave were a concern at the previous inspection. The provider told inspectors that she had recruited additional staff including two CNM2s, a CNM1, five nurses and eight care assistants. Nurses worked a 40 hour week and care staff on day duty worked for 32 hours. She also had reserve bank staff to cover any unplanned leave. A review of the rota confirmed this and provided evidence that staffing levels had increased on all shifts. Inspectors noted that there were two nurses on duty at all times and an additional care assistant was rostered for night duty. Three nurses were on duty, one of which was a newly recruited nurse who was supernumerary.

Staff told inspectors that they were satisfied with the staffing levels and that rates of absenteeism had improved significantly since the previous inspection and the records viewed confirmed this. Most of the residents were satisfied that staff were available to provide assistance in a timely manner but both residents and visitors were still not familiar with new staff members or fully acquainted with the arrangements in place for them to have key workers. Residents expressed this with comments such as "You are only getting to know someone and next thing she is gone". A relative pointed to the notice identifying the liaison nurses and the care advocate displayed in her mother's room and said that "Nurse X was my mum's nurse and now I haven't a clue who these staff are". Inspectors discussed this with the provider and the deputising person in charge and were satisfied that staff turnover was not a problem and that staff were rotated to become acquainted with all the residents. The system for the allocation of nurses to specific residents had been amended to allocate an experienced nurse and a more junior nurse to each resident and each care assistant was a "care advocate" to two residents. While these arrangements should ultimately benefit residents, inspectors were of the opinion that mechanisms for communicating changes to residents and involving them in discussions about arrangements for their care required improvements.

There was a comprehensive written operational recruitment policy. Inspectors examined a number of staff files and noted they contained most of the information required by the Regulations including three references and the registration numbers of all nurses. However, only one staff member had a declaration of medical fitness signed by a medical practitioner. Other files had a self declaration of medical fitness and there was no evidence to support this and it was not in accordance with the requirements of the Regulations. One of the three personnel files examined did not have evidence that Garda Síochána vetting had been applied for and the provider was unable to provide inspectors with a personal file for a recently recruited staff member.

Staff spoken to confirmed that they were supported, encouraged and had opportunities to attend training courses appropriate to their roles. The provider and person in charge had arrangements in place for the induction and ongoing training to staff. Inspectors read the training records which indicated that staff had attended training including training on falls prevention and risk, challenging behaviour and infection control. The ADON had attended training on restraint management and had rolled out this training to 90% of the staff. The provider told inspectors that externally sourced training on falls prevention and restraint management was also planned for 2011. Care assistants had completed the eight modules of Further Education and Training Awards Council (FETAC) Level 5 training. Staff spoken with confirmed that they had attended training and their certificates of attendance were maintained on their files. Staff spoken with confirmed how much they had enjoyed doing the training and how it helped them in their work.

### **Article 23: Directory of Residents**

The directory of residents was found to contain all the required information at the previous inspections. Inspectors did not examine the directory on this occasion.

### **Article 31: Risk Management Procedures**

Inspectors found that some practices in relation to the management of risk did not sufficiently promote the safety of residents, staff and visitors. This was highlighted at the previous inspection and inspectors were satisfied that progress had been made towards completing this action plan by 30 September 2011.

There was a health and safety statement in place and a comprehensive risk management policy. Inspectors read the risk management policy and found that it covered the identification, assessments and management of environmental and clinical risks. The policy met the requirements and included measures in place if a resident was absent without leave, assault, accidental injury or self-harm. It detailed arrangements for documenting, investigating and learning from serious incidents. There was documentary evidence that staff had been provided with training on risk management and that staff had discussed and implemented action plans following an incident. Staff showed inspectors the team folders which held a risk prevention information form to inform team members about the risks and controls in place for individual residents. Inspectors noted that the risk information form detailed information about each resident's risks such as mobility, behaviours, falls and swallowing problems. Overall, inspectors were satisfied with the management of environmental risk but found that clinical risk assessments when reviewed often lacked information about how the final score and risk rating was determined. Residents did not have care plans in place to address some clinical risks identified. This is discussed further in the healthcare section.

The provider had put additional measures in place to prevent accidents to residents and visitors. However, the ongoing review of the measures in place did not form part of the process. Supervision of residents in the day room had improved and a staff member was allocated this task from 9.00 am onwards. Inspectors observed that residents were constantly supervised in both day rooms. Staff detailed arrangements

for regular checks on vulnerable residents but these were not documented. The majority of residents had bedrails in place and staff acknowledged that bedrails were often used to keep residents safe. There was no protocol for the use of bedrails and residents' records lacked information about the reason why bedrails were in use or what alternatives were explored prior to using bedrails. The ongoing use of bedrails was not part of the three-monthly care plan review and inspectors found consent forms signed by relatives which were four and five years old.

There was an emergency plan in place which contained information on the management of emergencies such as fire and identified alternative accommodation in the event of residents having to be evacuated. It also provided guidance on what to do in the event of other emergencies such as power failure, loss of heating and disruption to water supply.

Staff were knowledgeable on emergency plans and procedures to prevent cross infection. They had access to supplies of latex gloves and disposable aprons and they were observed using the alcohol hand gels which were available throughout the centre. There were arrangements in place for the segregation and disposal of waste, including clinical waste. Sluice room doors were locked and cleaning detergents and chemicals were noted to be stored securely.

Inspectors reviewed the training records and noted that all staff had received training on moving and handling. Manual handling assessments were undertaken and inspectors observed that manual handling guidance was issued for each resident. Staff spoken with were knowledgeable on the correct moving and handling techniques. Inspectors also observed staff using the equipment such as hoists appropriately.

### **Article 39: Complaints**

The action plan for management of complaints was partially met. Inspectors found that the complaints policy had been amended and met requirements but procedures for the documentation and investigation of complaints was an area for improvement.

The complaints policy met the requirements. The policy had been amended to include an independent appeals process and this was detailed in the statement of purpose and the Residents' Guide. The complaints procedure was on display in several prominent areas of the building.

The complaints log was reviewed and inspectors noted that the log did not provide details on whether the complainant was satisfied or not. While written/formal complaints were documented, verbal complaints were not recorded. The inspector followed up on verbal complaints which residents and relatives said they had raised with the person in charge or another staff member and found that these had not been documented in the complaints log. It was not possible to determine the investigation or outcome of these complaints. It also limited the use of complaints for identifying trends and quality improvement purposes.

Residents told the inspector they knew who to complain to should the need arise. Some residents and relatives detailed positive outcomes from matters they raised and others were sceptical about the process. One resident said it was futile to complain so she would not bother to do so. Another resident said that staff just use complaints as an opportunity to blame each other but she would continue to express her dissatisfaction when necessary.

### **Article 36: Notification of Incidents**

Practice in relation to notifications had improved since the previous inspection and was deemed to be satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. All relevant incidents had been notified to the Chief Inspector by the person in charge.

## **Resident Care**

### **Article 9: Health Care**

Inspectors were generally satisfied that residents' general healthcare needs were met.

The centre was served by a local general practitioner (GP) who attended twice weekly or as required. Residents could choose to retain their own GP if they so wished. There was an out-of-hours GP service available. The community liaison team from Connolly Hospital provided specialist medical services on GP referral. The medication charts confirmed that all prescribed medication was reviewed on a three-monthly basis by the GP.

Inspectors found that residents had access to a wide range of health professionals and physiotherapy was provided at an additional cost as described in the statement of purpose. Residents had access to on site occupational therapy (OT), chiropody, dental and optical services. Records of appointments and referrals maintained in residents' files confirmed this. Inspectors spoke with residents who had availed of these services and met a physiotherapist who treated residents privately. Residents said they were satisfied with the range of services provided.

The action plan to address deficits in care planning was due to be completed in October 2011. Inspectors found that this had been progressed and some improvements were evident. Nursing staff outlined the process in place to update all care plans and many of the care plan examined were updated. Inspectors found that the care plans were disjointed and assessments did not consistently inform care plans and daily nursing notes did not reference the care plans. The deputising person in charge and nursing staff acknowledged the flaws in the current process. The CNM2 who had a lead on this project showed inspectors a folder with an integrated care plan which incorporated assessments and care plans for nursing and other disciplines. She detailed how this care plan would replace the existing care plans and

promote a more integrated, holistic approach to healthcare. She detailed how the named liaison nurses had ongoing responsibility for developing care plans and involving residents in the creation and review of their care plans. They were optimistic that action plans would be completed within the agreed timeframe. Inspectors viewed a new form which care assistants used to record the care they provided and staff said they found it efficient and less time consuming than the old system they used to record care.

Inspectors reviewed a sample of residents' files including the files of residents with a history of falls, wounds and behaviours that challenge. They found that wound care was provided in line with the wound care policy. Wounds were assessed and appropriately managed. However, the wound assessment charts required improvement in order to clearly identify current wounds. One resident had a pressure sore which was appropriately managed. However, practices around pressure sore prevention did not ensure a consistent approach to care. Not all residents had a risk assessment within the last three months or when their condition changed. Inspectors found that a score was allocated to residents without using the tool and the accuracy of the assessment could not be determined. For example, a resident who had a score of 17 actually had a higher score when inspectors completed the risk assessment. Inspectors found that the care plan stated that this resident was to be turned two hourly. The records viewed showed that this was not implemented. Turning charts were not completed when the resident was turned but were entered retrospectively at the end of the shift. This could have poor outcomes for a resident. Inspectors were not satisfied that the role of nutrition in pressure sore prevention was fully appreciated by all staff.

Management of residents with behaviours that challenge required an action plan at the registration inspection and inspectors found that progress had been made but improvements were required to assess residents' individual behaviours. Training records showed that staff had attended training on managing behaviours that challenge. Staff described distraction techniques they employed to defuse situations and to calm residents. Episodes of behaviours that challenge were documented and incidents were recorded and analysed to inform care plans. However, the policy on Challenging Behaviours (2010) did not guide practice in relation to the assessment of behaviours that challenge. Inspectors found no evidence of assessments in residents' files and staff acknowledged that they did not have the assessment tool or the training to undertake assessments as outlined in the policy.

The management of falls was a concern at the last inspection and inspectors found that practice relating to the prevention and management of falls had improved and ongoing work was required.

Staff had training in falls prevention and management and there was evidence of a proactive approach to falls prevention. Inspectors found falls prevention leaflets on residents' lockers and saw environmental check lists posted up. Household staff told inspectors that training had made them more aware of their role in preventing falls and they were more vigilant about flexes and wet floors. Residents had falls risk assessments which were updated on a three-monthly basis and a care plan in place to manage the risk of falling. A sample of files reviewed provided evidence that appropriate treatment was provided following a fall and a post-falls diary assessment

completed. Increased supervision was the most frequently cited intervention and inspectors noted that one resident had his medications reviewed and dosages altered. All falls were recorded and audited. The most recent audit showed an overall reduction in the rates of falls. The falls prevention policy did not guide practice in relation to falls prevention. Inspectors found that bedrails were used to prevent residents from falling and there was no evidence that less restrictive devices were used to prevent falls or to minimise the risk of injury from a fall. The provider told inspectors that further training on falls prevention and restraint management was scheduled for autumn.

### **Article 33: Ordering, Prescribing, Storing and Administration of Medicines**

Inspectors found evidence of good medication management procedures and practices in place.

At the previous inspection the medication policy was found to be comprehensive and gave clear guidance to nursing staff on all areas of medication management including the prescribing, administration, storage and disposal of medications.

One inspector accompanied two nurses on part of a medication round. The nurse who was undergoing induction was supervised by a CNM2 as she administered medications to residents. The nurse demonstrated her competence and knowledge when outlining procedures and practices in medication management. Medications which required strict controls were managed in accordance with the legislation.

There were no residents self administering their medications but there were appropriate policies and procedures in place to ensure safe administering of medications could be undertaken by residents if appropriate.

The provider told inspectors that all nurses will have completed the e-learning medication management programme by Sept 2011.

### **Article 6: General Welfare and Protection**

Inspectors found that measures were in place to protect residents from being harmed or abused. They were satisfied that the action plan arising from the previous inspection had been completed.

Inspectors reviewed the policy on the protection of residents from abuse and responding to allegations of abuse. The policy was comprehensive and staff were able to identify the various types of abuse and what they would do if an allegation was made to them. All staff spoken to and training records reviewed confirmed that all staff including household, laundry and administrative staff had received training on identifying and responding to elder abuse. There had been no allegations of abuse. Residents spoken to confirmed to inspectors that they felt safe in the centre.

There were two full-time activities coordinators employed to cover seven days each week. They worked hard to meet residents' needs for social engagement and occupation in a meaningful way. The activity coordinator was observed providing a

range of activities for residents in the day rooms and she discussed how each resident had their social needs assessed and their interests and hobbies incorporated into the activity schedule. Inspectors noted that the information was gathered using a "getting to know you" questionnaire and some residents who did not have a next of kin did not have the questionnaire completed. The activity coordinator detailed how residents who did not attend the activities in the day rooms were visited daily. Residents who spoke with inspectors confirmed this and one resident said he enjoyed pet therapy and using his computer.

#### **Article 10: Residents' Rights, Dignity and Consultation**

Choice was promoted but some improvements were required to ensure that care practices upheld the dignity of residents.

Residents spoken with told inspectors that they were offered choices in what time they get up and return to bed. They could choose personal clothing, what they wanted to eat and what activities they wished to participate in on a daily basis.

Inspectors noted that the privacy and dignity of residents was not consistently respected. Bedroom and bathroom doors were closed when personal care was being delivered. However, inspectors observed that some staff entered residents' rooms without knocking or awaiting a response before entering. Residents, especially men, told inspectors they were pleased to have male care attendants but some female residents confided that their expressed preference for female staff to undertake personal care was not always respected. Other residents also gave examples of undignified care practices which some staff employed in order to hasten the pace of personal care tasks when getting residents up in the morning.

Systems for consultation with residents about the running of the home required improvement. According to the statement of purpose the resident and family forum endeavours to meet regularly to facilitate working together to improve care services. Inspectors found it difficult to determine how frequently the forum met. The activity coordinators facilitated the meetings and the coordinator on duty told inspectors that she thought her colleague held a meeting with residents the previous week while she was on holiday. Records of the relatives' forum and residents committee meeting were requested and the provider showed inspectors records of the most recent residents committee meeting which was held on the 8 May 2011. This meeting was attended by 16 residents and topics discussed focused on activity provision. There was evidence that the issues raised were acted upon. For example, trips out were prioritised and arrangements for Mass to take place in the centre had been improved. Inspectors were of the opinion that arrangements for consultation with residents were not inclusive. Residents interviewed who expressed dissatisfaction with aspects of service provision said they would not feel comfortable airing concerns about care provision at the residents meeting. One resident who attended described the meetings as "a bit of a cod". Relatives of residents who were unable to participate in meetings told inspectors they had not attended the forum meetings and were not informed when meetings were due to be held.

Residents were encouraged to remain active and physical independence was promoted. Residents were facilitated to go outdoors in the fine weather. Staff were observed assisting residents to mobilise and walk to the dining room and residents participated in an exercise classes. However, residents' right to autonomy was not consistently respected. Following discussions with residents and staff and reviews of residents' records it was clear that relatives were approached for consent to use bedrails and requested to complete forms about residents' routines and hobbies when residents were capable of engaging in discussions or providing the information independently.

## **Article 20: Food and Nutrition**

There were comprehensive policies on monitoring residents nutritional intake and food and nutrition. However the processes in place to monitor dependant residents nutritional welfare were inadequate.

Residents' weights were monitored, nursing staff told the inspector that all residents were nutritionally assessed on admission and weights were recorded on a monthly basis and more frequently if a resident had lost weight. Inspectors noted nutritional supplements were prescribed by the GP and administered appropriately.

Inspectors reviewed weight records and examined the files of residents who had weight loss. They noted that residents were assessed on admission and a nutritional risk score was recorded on a three-monthly basis. A copy of the nutritional assessment was not on file and it was not possible to determine how the score was awarded to a resident. Residents had nutritional care plans in place but they did not consistently guide practice. For example, a direction to monitor a resident's weight every two weeks was not implemented. Some residents at risk of malnutrition did not have a dietetic referral and there was no evidence of a comprehensive review of the plan to determine what additional interventions were required for a resident who had gradual weight loss throughout 2011. Nursing staff explained that they were in the process of updating all the residents' care plans and some residents had yet to have a comprehensive care plan review.

Inspectors saw residents being offered a variety of drinks throughout the day. Staff regularly offered drinks to residents and inspectors noted the fresh water available from dispensers on both floors but there were no cups provided.

## **Environment**

### **Article 19: Premises**

The design and layout of the purpose built facility was as described in the statement of purpose and met the individual and collective needs of the residents. Bedrooms were spacious and there were adequate numbers of communal rooms which were decorated to a high standard. The area of bedrooms and communal rooms met the

Standards and the numbers of bathrooms and toilets on each floor were in line with the requirements.

The environment was bright, clean and well maintained throughout. However, inspectors noted an unpleasant odor of urine in the first floor corridor and day room in the morning and in some bedrooms on the ground floor throughout the day. Call bell facilities were available in all bedrooms and inspectors noted that call bells were answered promptly and residents confirmed they were not left waiting for assistance.

Handrails and grab rails were provided to promote independence in the corridors and bathrooms. Hoists and all other equipment had been maintained and service records reviewed on the previous inspection were up-to-date.

Inspectors were satisfied with progress towards completing action plans from the previous inspection. Inspectors observed that the laundry area was clutter free and continence ware was stored in cupboards and not in view. The provider told inspectors that architects had plans ready to submit to the planning department to extend the building and include two new bathrooms with assisted baths and ventilated cleaning rooms. She also detailed plans to convert the three-bedded room to a twin room.

The provider detailed measures taken to regulate the temperature of the water in residents' rooms and bathrooms. A record of weekly checks indicated that water temperature ranged from 39.4 and 41.9 degrees Celsius. Checks carried out by inspectors found the water temperature was below 43 degrees and no longer posed a risk to residents.

### **Article 32: Fire Precautions and Records**

Adequate fire precautions were in place and records maintained.

The fire procedure on display gave clear guidance on what to do in the event of a fire. The fire policy was comprehensive and, on review of the training records, it was noted that all staff had received fire training. Staff were knowledgeable and able to tell inspectors what they would do in the event of a fire.

Service records showed that the fire alarm system was serviced quarterly, fire equipment on a yearly basis and emergency lighting three times a year. The inspector read the records which showed that daily inspections of fire exits were carried out along with a weekly inspection of fire doors and fire fighting equipment. The fire panels were in order and the inspector noted that fire exits were unobstructed.

## Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, and the CNM2 who deputised for the person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

### **Acknowledgements**

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

### ***Report compiled by:***

Mary O'Donnell

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

19 August 2011

## Provider's response to inspection report

|                            |                       |
|----------------------------|-----------------------|
| <b>Centre:</b>             | Elm Hall Nursing Home |
| <b>Centre ID:</b>          | 0034                  |
| <b>Date of inspection:</b> | 16 August 2011        |
| <b>Date of response:</b>   | 6 September 2011      |

### Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

#### 1. The provider has failed to comply with a regulatory requirement in the following respect:

Staff files contained a self declaration of medical fitness for staff which was not in accordance with the requirements of the Regulations.

One of the three personnel files examined did not have evidence that Garda Síochána vetting had been applied for and the provider failed to provide inspectors with full and satisfactory information and documents specified in Schedule 2 of the Regulations for a recently recruited staff member.

#### Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.



**2. The provider has failed to comply with a regulatory requirement in the following respect:**

Verbal complaints were not investigated in line with the Regulations.

The complaint's log did not provide details on whether the complainant was satisfied or not.

**Action required:**

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

**Reference:**

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

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

**Timescale:**

Provider's response:

All complaints are investigated as per our internal policies. The person in charge maintains a record of all verbal and non-verbal complaints. Whilst individual management complaint records (forms) are maintained, details and responses to complaints are also comprehensively recorded.

The person in charge, who was on leave at the time of inspection, has stated and shown that records of 'verbal' complaints are always maintained in individual resident files, as are details of any ensuing meetings with residents and/or their family members, so that nurses on duty can easily access same if required in her absence.

The person in charge has undertaken to ensure that copies of all complaints both verbal and written are also maintained in the combined 'Complaints File', as required by the Regulations and to ensure that a record of 'outcome satisfaction' is recorded on complaint management records.

Ongoing

Complete

**3. The provider has failed to comply with a regulatory requirement in the following respect:**

Appropriate healthcare was not facilitated for each resident particularly for a resident who had recurrent falls.

Practice in relation to pressure sore prevention did not ensure a consistent approach to care.

The management of behaviours that challenge was not in line with evidence based practice. The policy on Challenging Behaviours (2010) did not guide practice in relation to the assessment of behaviours that challenge.

The falls prevention policy did not guide practice in relation to falls prevention. There was no evidence that less restrictive devices before bed rails were used to prevent falls or to minimise the risk of injury from a fall.

**Action required:**

Provide suitable and sufficient care to maintain residents' welfare and wellbeing, having regard for the nature and extent of residents' dependency and needs as set out in a care plan.

**Action required:**

Provide a high standard of evidence based nursing practice.

**Reference:**

Health Act, 2007  
Regulation 6: General Welfare and Protection  
Standard 13: Healthcare

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

**Timescale:**

Provider's response:

The nursing home endeavours to provide appropriate medical care by a GP of the residents' choice or acceptable to the residents', and to provide medical intervention as detailed/recorded in individual care plans and medical records.

The action plan to address perceived deficits in care planning is due to be completed by the end of October 2011. This action has been progressed and more comprehensive recording systems are currently being implemented. This process also includes a review of all consent forms in relation to restraint measures.

The two CNMs who have a lead on this project have developed an integrated care plan which incorporates assessments and care plans for nursing and other disciplines.

|  |                            |
|--|----------------------------|
| <p>This care plan will replace the existing care plan format and promote a more integrated, holistic approach to healthcare having regard for the nature and extent of the residents dependency and needs as set out in revised individual Care Plans.</p>                                 | <p>End of October 2011</p> |
| <p>They remain optimistic that action plans will be completed within the previously agreed timeframe.</p>  | <p>End November 2011</p>   |
| <p>The nursing home utilises 'The Cohen Mansfield Agitation Inventory' (CMAI Assessment Tool) to assess challenging behaviour - and all new nursing staff have been enrolled in training in the use of this tool.</p>  |                            |
| <p>As indicated in our response of May 2011, improved reporting and documentation in relation to falls risk assessment and challenging behaviour has been successfully implemented. We will continue to develop and enhance our policies as indicated by evidence based best practice.</p> | <p>Ongoing</p>             |
| <p>A more comprehensive staff training programme has commenced and continues within the nursing home to ensure that we continue our commitment to provide a high standard of evidence based nursing practice.</p>  | <p>Ongoing</p>             |
| <p>This also includes re-training health care staff in the continued implementation of our pressure area prevention policy, the use of Waterlow Assessments and the non-retrospective recording of individual care provided.</p>   | <p>End November 2011</p>   |

**4. The provider has failed to comply with a regulatory requirement in the following respect:**

The privacy and dignity of residents was not consistently respected. For example:

- staff entered residents' rooms without knocking
- some female residents confided that their expressed preference for female staff to undertake personal care was not always respected
- residents gave examples of undignified care practices which some staff employed in order to hasten the pace of personal care tasks when getting residents up in the morning.

Systems in place for consultation with residents about the running of the home required improvement.

**Action required:**

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

|  |                   |
|--|-------------------|
| <b>Action required:</b>  |                   |
| Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.  |                   |
| <b>Action required:</b>  |                   |
| Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.  |                   |
| <b>Reference:</b>  |                   |
| Health Act, 2007<br>Regulation 10: Residents' Rights, Dignity and Consultation<br>Standard 17: Autonomy and Independence<br>Standard 18: Routines and Expectations   |                   |
| <b>Please state the actions you have taken or are planning to take with timescales:</b>  | <b>Timescale:</b> |
| Provider's response:   |                   |
| Bedroom and bathroom doors are always closed when personal care is being delivered. This is a consistent approach used within the nursing home to ensure the the privacy and dignity of residents.   | Ongoing           |
| Each resident is given freedom to exercise choice in relation to the provision of care and individual preferences. Individual care records indicate that there are currently a total of four residents in the nursing home who have expressed preference for female or male staff to undertake personal care and this preference is always adhered to. | Ongoing           |
| Whilst such preferences are clearly recorded on individual nursing records, to ensure all staff are aware of individual preferences, this has now been recorded on individual resident care charts utilised by care staff who provide personal care.   | Complete          |
| Although there are some residents who have requested staff not to do so, it is normal practice for all staff to knock on doors and/or request permission to enter a residents private bedroom.   | Ongoing           |
| The person in charge regularly meets with individual residents and/or their families, and utilises feedback from them to improve and develop services within the nursing home.   | Ongoing           |
| Residents are also encouraged to attend various resident meetings so that they are consulted and participate in the general activities of the nursing home.  | Ongoing           |

|   |                            |
|---|----------------------------|
| <p>Due to the specific care needs of some residents, their individual active participation is not always possible. However, most relatives of these residents act as their advocate and participate whenever possible.</p>  | Ongoing                    |
| <p>Notices of forum meetings are clearly displayed throughout the Nursing Home well in advance of meetings taking place, and Reception staff also verbally inform visitors of such meetings and any other scheduled events. These meetings are not usually a forum for discussing 'individual care needs' and in this regard the person in charge and or liaison nurse facilitates individual review meetings with residents and families for this purpose.</p> | Ongoing                    |
| <p>Plans for the implementation of a 'quality assurance committee' and review process have commenced in September 2011 and are currently in progress, and will be completed within the previously specified timeframe.</p>  | September 2011 and Ongoing |

|   |  |
|---|--|
| <p><b>5. The person in charge has failed to comply with a regulatory requirement in the following respect:</b></p>  |  |
| <p>The processes in place to monitor dependant residents' nutritional welfare were inadequate. Nutritional care plans did not consistently guide practice.</p>  |  |
| <p><b>Action required:</b></p> <p>Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.</p>  |  |
| <p><b>Reference:</b></p> <p>Health Act, 2007<br/>Regulation 20: Food and Nutrition<br/>Standard 19: Meals and Mealtimes</p>   |  |
| <p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>  | <p><b>Timescale:</b></p>               |
| <p>Provider's response:</p> <p>All residents are assessed utilising a recognised malnutrition screening tool - 'The MUST Tool' - and care plans utilised to indicate nutritional needs and required intervention.</p> <p>The action plan for the implementation of a more comprehensive care plan includes a review of this process and the improved recording of same.</p> | <p>Ongoing</p> <p>End October 2011</p> |



## Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

| Standard                                     | Best practice recommendations   |
|--|---|
| <p>Standard 25:<br/>Physical Environment</p> | <p>Inspectors noted some improvements could be made to enhance the signage to provide effective and meaningful prompts to help residents and visitors to find their way around.</p> <hr/> <p>Provider's response:</p> <p>All bedrooms in the Nursing Home are numbered and resident names are on individual doors. Some residents with cognitive impairment also have their photograph on their bedroom doors. There are also signs on communal room doors throughout the nursing home.</p> <p>Previous and current feedback from residents and visitors indicate that they have no difficulty with finding their way around the nursing home.</p> <p>Consideration has been given to a previous recommendation by inspectors in relation to 'colourful and/or pictorial' signage. Feedback from residents and some visitors has indicated a negative response to this, and other options are being considered in this regard.</p> <p>Residents and visitors have been asked to indicate if they feel improvements are necessary and to put forward suggestions for changes or improvements.</p> <p>Feedback and comments from residents and visitors indicate that they have 'no desire for a creche type environment' and they indicate this to be their opinion in relation to the use of colourful and/or pictorial signage.</p> <p>We are awaiting further feedback and will then address this recommendation accordingly.</p> |

**Any comments the provider may wish to make:**

**Provider's response:**

The Provider wishes to thank the lead inspector for her comments throughout the inspection process and for the positive feedback in relation to ongoing action plans.

On the day of inspection an 'on-call' clinical nurse manager attended the nursing home earlier than her allocated shift time to facilitate assisting the inspection team and to allow other nurses to carry out their normal nursing duties, as the person in charge was on scheduled leave.

The other clinical nurse manager, nurses and care staff on duty at the time of inspection fully understood the legislative requirements of the inspection process and the entitlement of inspectors in that regard. However, general feedback from staff indicate that they found the one day inspection process somewhat more time consuming than previous 'two day inspection processes' and at times disruptive to the provision of care primarily due to the constant 'interruptions' by inspectors within the short time frame allocated for the inspection process.

The provider wishes to thank inspectors for the courtesy shown to residents and staff throughout the inspection process, and for the feedback given to management at the close of the inspection.

**Provider's name:** Mairéad M. Byrne, Springwood Nursing Homes Limited

**Date:** 13 September 2011