Leas Cross Review

10th November, 2006

Introduction to Leas Cross Report

The exposure of problems at the Leas Cross nursing home coincided with the period of transition from the old Health Board system to the unified Health Services Executive. The Leas Cross Nursing Home was in the operational area of the former Northern Area Health Board. Given the particular public concern the acting Chief Officer of the HSE Northern Area agreed with the National Director of Primary, Community and Continuing Care that it was appropriate to commission a review of the deaths at Leas Cross.

Professor Des O'Neill, Consultant Geriatrician, was commissioned to carry out this review with the following terms of reference:

To review the deaths of residents of Leas Cross through inspection and analysis of written documentation, including:

- *Medical, nursing and prescribing notes*
- *Hospital records*
- *Post-mortem summaries*
- *Death certificates*
- *Notification to the coroner and inquests*
- *Correspondence to Eastern Regional Health Authority, Northern Area Health Board, Health Service Executive (Northern Area), Health Service Executive and Department of Health and Children regarding concerns over Leas Cross*
- *Nursing Home inspection reports*
- *And other relevant documents.*

And to a) relate these to national and international data and guidelines and morbidity and mortality to institutional care for older people, and b) make recommendations as appropriate to the HSE and Department of Health and Children arising from these findings.

On completion of his report, it has been necessary to ensure in the interest of natural justice that all parties who were named or referred to in the report would be asked to submit their observations on the report and have them taken into consideration. **These submissions are appended to Professor O'Neill's report and should be read in conjunction with it. No amendments have been made by Professor O'Neill or by the HSE to his final report as a result of these submissions and no judgement has been formed where there is a difference of opinion.**

The proprietor of the Nursing Home, the former Chief Executive Officer of the Northern Area Board and the Deputy Chief Executive Officer later acting Chief Officer of the HSE Northern Area have made detailed submissions as has the Department of Health and Children. As well as responding to specific issues arising from the report these submissions also endeavour to place the circumstances of the early 2000's and the policy on elder care in context.

The former CEO of the Northern Area Board expresses her "deepest regret that a number of patients at Leas Cross were injured during their residency in the nursing

home and that (their) Board was unable to have in place sufficient robust oversight systems that might have identified and resolved the deficiencies in care that we now know exist". The HSE shares this regret and wishes to now assure the public that it is making every effort to ensure that such circumstances do not occur again and that where sub-standard services exist they will be identified speedily and appropriate corrective action taken.

Professor O'Neill in his recommendations identifies a number of key steps which must be taken to provide this assurance. The HSE as one of the major stakeholders has accepted these recommendations and is taking active steps to make them a reality. Professor O'Neill currently chairs the national committee with responsibility for the implementation of the report on elder abuse. The HSE and DOHC are of the view that this existing process would be the most appropriate vehicle to oversee the recommendations of this report and are discussing this approach with Professor O'Neill.

In his report Professor O'Neill argues that Leas Cross is not an isolated incident. The HSE is aware (as were the former Boards) that the standard of care in all care settings may vary over time. This variation in care standard is dependant on many factors. Professor O'Neill identifies a number of issues which he believes are key, specifically:

- Failure of management to give sufficient weight to concerns expressed by interested parties;
- Weak policy, legislation and regulation;
- Deficiencies in funding;
- The speed of growth in the private sector and capacity of the regulatory bodies to keep pace

The HSE and the DOHC are committed to fully addressing these key issues through new legislation, through the development of a responsive consumer affairs function in the HSE and through the development of a national policy on the funding of long term care.

As well as the specific issues identified by Prof O'Neill, the HSE believes that many of the problems experienced by nursing homes are associated with the absence of an appropriate continuum of care in many instances. This may result in the admission to nursing homes of clients who are too sick for that particular placement and who would benefit significantly from further rehabilitation or whose needs have not been appropriately identified prior to admission. These issues require to be addressed by the whole healthcare system and not just the nursing home sector. An over reliance on the Nursing Home sector to meet all of the needs of highly dependent and very ill older people is misplaced and inappropriate. Significant work needs to be done to ensure that older peoples service are developed in such a way as to ensure that a complete continuum of care exists and that older people are directed to and through these services in a more managed way.

The HSE has recently concluded deliberations on the development of a common assessment tool for use in hospital and community settings which will assist in this process and will be implemented as soon as possible.

The extensive development of Home Care Packages across the country during 2006 is also ensuring that older people can remain safely and securely in their own homes and communities for longer periods than was possible at any earlier time.

The development of Community Intervention teams in four areas of the country this year with plans for further roll out in 2007 is a further step to ensuring that people receive an appropriate intensive intervention as early as possible into their illness thus avoiding the need for admission.

Additional capacity has also been introduced this year to address the specific needs of persons with Dementia who are poorly catered for in the non specialised nursing home environment.

The HSE is currently developing a Hospital in the Home project which again is directed at maintaining people at home in the safety and security of their own environment while receiving appropriate medical intervention and supervision.

The recent establishment by the HSE of the Expert Advisory Group on Older Persons Services chaired by Professor Declan Lyons will greatly assist in the planning and further development of a comprehensive range of services which enable older people to receive appropriate high quality services in a timely fashion and in the most appropriate setting.

The HSE has also taken determined steps to strengthen the inspection process and to make inspection and registration of nursing homes as transparent as possible. Any future Nursing Home Regulations need to provide the registering authority with the opportunity to describe more clearly the limitations of any individual nursing home on their registration certificate and also the potential to move quickly to close a nursing home down when it is not meeting the standards set.

The quality of care provided to residents in a nursing home is the responsibility of the nursing home owner. The care provided in Leas Cross was wholly unacceptable.

The work which the Inspectorate attempted to do to achieve an improvement in care standards was ineffective. We know however that similar work by the same team and other teams across the country has been very effective in other care settings. We also know that the majority of care settings provide high quality safe care to their residents and that they themselves and their families are happy with this care.

It is of critical importance that the whole of the nursing home sector is not given a bad name because of this bad nursing home. Today in nursing homes across the country highly committed, professional, well trained staff are striving to deliver excellent care. The HSE and the Nursing Home owners are working closely in many settings to improve standards and to ensure that those who don't meet these standards are exposed.

The HSE through it's Nurse Planning and Development Units are working in each of the HSE areas in delivering professional development to nurses where training is shared across the public and private sector.

Directors of Nursing from our HSE services are working with the managers of nursing homes to improve standards.

The national programme for healthcare assistants is training 1,000 health care assistants each year.

This report does not deal in the main with specific cases. The HSE is in receipt of a number of individual complaints and is dealing with these on an individual basis. We have written to those relatives known to us issuing them a copy of the report and providing them with contact details where any issues can be followed up directly with them. If there are individual clients or relatives who wish to discuss any aspect of their care or any point arising from this report we would ask them in the first instance to contact the HSE Information Line at 1850 24 1850 where their details will be taken and following which an officer of the HSE will be in contact with them as soon as practicable.

Recommendations and Current Status

Leas Cross Recommendations

Introduction

The recommendations of the Leas Cross Report are outlined below together with the HSE's current position with regard to the specific recommendations. While it is acknowledged that services for older people need to be developed further, progress has been made in a number of areas in recent times.

A National Steering group was established in 2005 to undertake a programme of development and standardization across the HSE. In advancing the national agenda on services for older people, a number of working groups have been established, including one specific to Residential care. This group has further sub groups reviewing Nursing Homes Inspection, Dementia Care, Standards of care, assessment of future needs for residential care and service level agreements for contacted beds. The first report of the working group on Nursing Homes Inspection has been adopted by the HSE and its recommendations which include standardized assessment tools, training processes, increased Inspectorate resources and published Inspection reports are currently being implemented.

In addition to this work, home support working groups have recently concluded the development of a common assessment tool which will underpin the care planning and monitoring processes for older people.

Another working group on Elder abuse is charged with the Implementation of 'Protecting our Future' a report of the working group on Elder Abuse. A national recruitment campaign is currently concluding in the appointment of 32 elder abuse officers.

All of these workgroups are on target to complete their work by the end of 2006 and their findings will form the basis of a blueprint for services for older people going forward.

In keeping with the acknowledged complex needs of older people, the HSE needs to work in partnership with the Department of Health and Children, the Department of Finance, Regulatory and professional bodies to ensure that older people receive the appropriate high quality service which is underpinned by a strong regulatory process. The establishment of HIQA will ensure that an independent inspectorate function will operate for these services.

The recommendations from Professor O'Neill's report are listed below together with a response that outlines the HSE current position in respect of that recommendation. Appendix 3 outlines the action plan for further implementation.

Recommendations (September 2006)

Recommendation 1

The Department of Health and Children and the Health Services Executive must in its policy, as a matter of urgency, clearly and formally articulate its recognition of the complex health and social care needs of older Irish people requiring long term residential care.

Response

In 2005 the HSE established a national steering group ,*Advancing the National Agenda*, to oversee the standardised development of services for all older people including those in residential care. A working group on residential services is currently addressing the areas of Nursing Homes Inspections, Standards of care and dementia specific care. A report of current and future long term needs has recently been completed as part of an interdepartmental working group on the funding of Long Term Care. A national forum with HSE and Nursing Homes representatives is working on a number of quality initiatives including the development of service levels agreements.

Recommendation 2

The provision of this care (residential care) should be clarified formally in terms of adequate numbers of adequately trained nursing and Health care assistant staff, with adequate governance structures in terms of senior nursing staff. The minimum numbers of nursing staff should be calculated using a modern instrument such as the RCN Assessment tool or the Nursing needs assessment tool, and at least half of these Nursing staff should have a diploma in Gerontological nursing. A sufficient number of middle and senior grade nursing staff relative to the size of the nursing home will be needed to be added to the calculated tool to ensure an adequate care infrastructure. Directors of Nursing in all long term facilities should have the Diploma in Gerontological nursing or equivalent. All Health care assistants should have FETAC training or equivalent. Appropriate acculturation and Gerontological training should be provided for all non national staff.

Response

- The recommendation to use a workload analysis tool is in keeping with emerging DOHC policy. The *Report of the Working Group to examine the development of appropriate systems to determine nursing and midwifery staffing levels* was published by the DOHC in Sept 2005. This report makes recommendations, which include the dependency levels of patients and quality indicators. It is proposed to have a number of pilot sites across the country that would examine and pilot a number of workload analysis tools and ascertain their applicability and use in the Irish Health care setting. Agreement on these pilot sites will be determined between DOHC, Unions and HSE.
- The recommendation that at least half of nursing staff in residential care should have Diploma in Gerontological Nursing, while highly desirable, would be difficult to action over the short term. In the interim it may be more beneficial to have a combination of approaches that includes a stated proportion of staff having a post graduate course and a regular programme of clinical updates e.g. care of leg ulcers, diabetes, peg feeding etc and professional updates, scope of professional practice, code of conduct, report writing, incident reporting etc for all staff.

- In respect of the recommendation that all Directors of Nursing have a Diploma in Gerontological Nursing. This is desirable, however cognizance would have to be taken that current Directors of Nursing may have other relevant third level qualifications.
- In relation to cultural diversity, programmes are being rolled out in many of the HSE areas. Many HSE programmes are accessible to the Nursing Home sector.

Recommendation 3
An electronic version of the minimum dataset should be made mandatory for all patients in nursing home care to assist in the development of individual care plans, the monitoring of quality and the provision of national statistics and dependency, morbidity and mortality

Response
The concept of minimum data sets is fully supported by the HSE as a means of improving information in relation to the services provided to all client groups both at local and national level. This is a complex and challenging area, which involves considerable work on standardisation of definitions and collection processes. Work has commenced on the development of a common assessment process and improved data collection within the 'Advancing the National Agenda ' programme of work.

Recommendation 4
Funding arrangements for nursing home care should be urgently reviewed by the Department of the Health and Children and HSE to ensure that it is matched to the provision of high quality care to older people in long term care.

Response
Work is ongoing in respect of the procurement of high dependency beds within the private system and systems have been put in place to ensure that Nursing homes meet the standards required to provide this higher level of care. The funding for high dependency beds has increased significantly to reflect the appropriate nursing, medical and allied professional support required. The HSE has recently introduced multi-disciplinary teams for nursing home beds in some areas (Dublin). Further work on the development of cost models is required.

Recommendation 5
The Nursing Home Legislation needs to be urgently updated to put the above provisions into place, to place the older person at the centre of its deliberations, and to adequately guide both provision of quality of care and quality of life, as well as providing timely and appropriate powers to the Social Services Inspectorate to effect change.

Response
This is an issue for the Department of Health and Children.

Recommendation 6
Pending the introduction of the Social Services Inspectorate, Nursing Home Inspection teams need to be immediately developed and staffed with relevant expertise to be able to detect poor practice patterns, and vigorously supported by the HSE in their recommendations. All written queries/concerns should have a rapid assessment and written response.

Response
A national working group on Nursing homes inspections was established in 2005 and the first phase of recommendations has been adopted by the PCCC directorate of the HSE. Currently many of the areas are in the process of establishing full time dedicated nursing home inspection teams. In Dublin North East a Nursing Home Inspectorate Manager has been appointed to coordinate and manage the inspection and complaint processes for all nursing homes within this area. Additional inspectorate posts will be in place over the coming months. Better partnership working between Public and Private Nursing homes is currently being developed in respect of Practice development and training. Standardised assessment tools have been adopted and additional training is being commissioned. HSE Inspection reports on nursing homes are now available on the HSE website. A national complaints process is currently being implemented by the HSE.

Recommendation 7
The Irish Health Services Accreditation Board process for long term care must be radically reviewed to reflect the realities of long term care in Ireland. This would include the determination of not only training but also appropriate numbers of nursing and health care assistants proportionate to the case-mix of residents, as well as congruity with MDS data from the nursing home.

Response
This is underlined within the response on Recommendation 2.

Recommendation 8
For those who are not looked after by the GP who provided their care while at home, the medical cover must be more clearly and unambiguously specified in the terms of relevant training (at least the Diploma in Medicine for the Elderly or equivalent), responsibilities and support from the HSE.

Response
A working group between the HSE and ICGP is proposed to review the role of general/practitioner/medical officer in Nursing Homes, with a view to describing best practice and make recommendations regarding the way forward.

Recommendation 9
Multi-disciplinary team support must be clearly specified in terms of both meeting need but also the facilitation of team work, and requires at a minimum: physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work.

Response
Through the recent procurement of high dependency contracts, there are specific requirements for multi-disciplinary input such as physiotherapy, occupational therapy and speech and language. These contracts are reviewed on a regular basis and paramedical input is measured to ensure a complete quantum of care for the client. Access to multidisciplinary team members in the primary and continuing care teams for clients in Nursing homes needs to be reviewed, gaps identified and an action plan put in place to ensure equal access, based on need for all older people regardless of location. The ongoing investment in services for older people and the development of Primary Care Teams will allow the HSE to make progress on multidisciplinary involvement over the coming years.

Recommendation 10
Specialist medical support (geriatric medicine and Psychiatry of Old Age) needs to be developed to provide formal support to the medical officer, nursing staff and therapists not only in the care of patients but also in the development of appropriate care guidelines and therapeutic milieu. These services need protected access to dedicated specialist in patient facilities for appropriate assessment and support of those in long term care.

Response
While there is some variation throughout the country depending on resources, access to a geriatrician is mainly through an out patient clinic in the acute hospital (referral by GP or medical officer). Only a small number of elderly care units have dedicated time or support from a Geriatrician or Psychiatrist of Old Age. It is acknowledged that the existing resource needs to be developed further, and that geriatrician led community teams will be a key element of future older persons care.

Recommendation 11
Professional bodies with regulatory responsibilities for healthcare workers should clarify the highly specialized needs of older people in residential care in guidance to their members, with particular emphasis on the scope of practice of those who accept senior positions.

Response
Professional bodies with regulatory responsibility would need to respond directly to this recommendation.

A review of the deaths at Leas Cross Nursing Home 2002-2005

Desmond O'Neill MD FRCPI AGSF

Dublin, April 2006

Contents

Page

3 Terms of reference

Materials reviewed

4 *Approach to terms of reference*

5 Executive Summary

9 Introduction

13 Specialist nursing for older people – gerontological nursing

15 Findings

Nursing Notes

Medical Notes

Drug records

Specialist Medical Input

Hospital notes

Leas Cross Guidelines/Protocols and other documentation

34 Official Oversight

- *Nursing Homes Inspection Team*
- *Complaints from family members*
- *ERHA Heavy Dependency/Intermediate Care Tender Process*
- *Correspondence from the Mental Health Services*
- *Public Health Overview*

52 The context

Dept. of Health and Children: policy, legislation and regulations

EHB/ERHA policy and Health Board reports

HSE (NA) funding for private nursing home care

Irish Health Services Accreditation Board

Private nursing home policy responses

Funding of private nursing home care

Irish Nursing Homes Organization

Professional bodies/organizations

60 Conclusions and recommendations

64 Acknowledgements

65 References

68 Appendix 1

Terms of Reference as provided by HSE (NA)

To review the deaths of residents of Leas Cross through inspection and analysis of written documentation, including:

- Medical, nursing and prescribing notes
- Hospital records
- Post-mortem summaries
- Death certificates
- Notification to the coroner and inquests
- Correspondence to ERHA, NAHB, HSE (NA), HSE and Department of Health and Children regarding concerns over Leas Cross
- Nursing home inspection reports
- And other relevant documents

And to a) relate these to national and international data and guidelines on morbidity and mortality in institutional care for older people, and b) make recommendations as appropriate to the HSE and Department of Health and Children arising from these findings.

Material reviewed

105 case notes

Death certificates

Coroner's reports

Documentation supplied by Leas Cross

Reports and correspondence from Nursing Home Inspection Team

Reports and correspondence arising from individual complaints

Correspondence to the Department of Health and Children

Correspondence from ERHA

Current Irish and international literature on standards of care in residential care for older people

Approach to terms of reference

As both medical and nursing professional practice, as well as procedures such as nursing home inspection, place a high value on accurate reporting of clinical assessment and care, review of such documentation is an appropriate starting place for a review of care practices, procedures and outcomes in nursing home care of frail and vulnerable older people. The Nursing Home regulations also specify accurate record-keeping and documentation in a number of sections (sections 18, 19, 20, 21, 22, 25, 26, 30).

The text of the terms of reference from the HSE for this review required the writer to inspect and analyse all documentation relevant to patient care at Leas Cross Nursing Home. The purpose of this review is to relate the data in this documentation to national and international guidelines on care, sickness and death. In so far as that data, as so analysed, gives rise to comment or recommendation as to appropriate standards, then such comments or recommendations are made.

This is not a report of a legal process whereby facts are found, either in general or against any particular individual: nor is it to be read as an opinion as to the culpability of any body or individual. The terms of reference from the HSE are related to an exclusively documentary review. While situations are noted in the documentation, and an analysis can be professionally extrapolated from these, the written material reviewed is dependant upon the maker(s) of the material therein. An exclusively document-based review can do no more than to analyse the reports made by others as to their work and the work of those they apparently describe. In this review, therefore, where a fact, situation or opinion is taken from the written material, this reviewer is not stating that same has been found by him: rather, this reviewer is analysing the notation of others. Based on such written material, the reviewer is asked to give his professional view. That view is as to the apparent facts that emerge from the written material: it is not an opinion as to conduct or the finding that any definite fact or situation occurred.

The reviewer is entitled, however, to expect that those creating this documentation have followed professional practice as to true reporting of patient care, inspection processes or expressions of professional concern. Whereas the ethic involved in that process might be predicted to relate to the facts that gave rise to them in documentary form, the reader of this review will need to consider whether this is in fact the case. Rather, the task of the documentary review is to analyse that written material. Any findings of fact or opinions based on a legal process are reserved to such a forum, should same ever be deemed an appropriate future exercise.

Executive Summary

The case notes for those patients who died while resident in Leas Cross between 2002 and 2005 were reviewed, in conjunction with documentation from the nursing home, health boards/HSE, coroner's offices, Registrar of Deaths and the Department of Health and Children as well as national and international literature on quality of care in nursing homes.

The principal finding was that the documentary evidence was consistent with the care in Leas Cross being deficient at many levels, and highly suggestive of inadequate numbers of inadequately trained staff, and furthermore no documentary evidence that the management of the nursing home and clinical leadership recognized the ensemble of care provision required to meet the needs of the residents. The overall documentary findings are consistent with a finding of institutional abuse: *'institutional abuse can occur which may comprise of poor care standards, lack of a positive response to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service''*. The documentation was consistent with a deficiency in the regulatory process of the Health Board/HSE (NA) at all levels in its response to the clear deficits uncovered, and in its assessment that the proprietor and senior clinical management at Leas Cross had the insight or capability to effect meaningful change. There is no record of senior management in the HSE (NA) appearing to give due weight to written concerns by senior clinicians about standards of care.

The context within which this was occurred was that of policy, legislation and regulations which have over many years failed to adequately articulate and address the complex needs of this most vulnerable and frail population of older Irish people. The revenue funding associated with long term care is also deficient and contributes to the neglect of this most vulnerable group of older people. With a few honourable exceptions there has been a systematic failure by government, health boards and professional bodies to address the issue of appropriate quality of care for older people with the highest levels of health and social needs in Irish society. Given this lack of engagement by the government and health system with the very real concerns over quality of care in long term care, it would be a very major error to presume that the deficits in care shown in Leas Cross represent an isolated incident. Rather, given the lack of structure, funding, standards, and oversight, they are very likely to be

replicated to a greater or lesser extent in institutions throughout the long term care system in the country. This is not to deny the motivation, kindness and dedication of very many who work in nursing homes, but rather represents a failure of government and the health system to address both the context and standards of care in the light of widespread national and international concern over quality of care in nursing homes. Urgent action is needed to remedy this system failure so as to ensure that vulnerable older Irish people can be confident that they will be cared for a in safe and caring environment with an optimal quality of both life and care.

Recommendations

Primary

1. The Department of Health and Children and the Health Services Executive must in its policy, as a matter of urgency, clearly and formally articulate its recognition of the complex health and social care needs of older Irish people requiring residential long term care.
2. The provision of this care should be clarified formally in terms of adequate numbers of adequately trained nursing and health care assistant staff, with adequate governance structures in terms of senior nursing staff. The minimum numbers of nursing staff should be calculated using a modern instrument such as the RCN Assessment Tool or the Nursing Needs Assessment Tool [1], and at least half of nursing staff these should have the diploma in gerontological nursing. A sufficient number of middle and senior grade nursing staff, relative to the size of the nursing home, will be needed to be added to the calculated total to ensure an adequate care infrastructure. Directors of nursing in all long term care facilities should have the diploma in gerontological nursing or equivalent. All health care assistants should have FETAC training or equivalent. Appropriate acculturation and gerontological training should be provided for all non-national staff.
3. An electronic version of the Minimum Data Set should be made mandatory for all patients in nursing home care to assist in the development of individual care plans, the monitoring of quality and the provision of national statistics on dependency, morbidity and mortality.
4. Funding arrangements for nursing home care should be urgently reviewed by the Department of Health and Children and HSE to ensure that

it is matched to the provision of high quality care to older people in long term care

5. The Nursing Home Legislation needs to be urgently updated to put the above provisions into place, to place the older person at the centre of its deliberations, and to adequately guide both provision of quality of care and quality of life, as well as providing timely and appropriate powers to the Social Services Inspectorate to effect change.

6. Pending the introduction of the Social Services Inspectorate, Nursing Home Inspection teams need to be immediately developed and staffed with relevant expertise to be able to detect poor practice patterns, and vigorously supported by the HSE in their recommendations. All written queries/concerns should have a rapid assessment and written response.

7. The Irish Health Services Accreditation Board process for long term care must be radically reviewed to reflect the realities of long term care in Ireland. This would include the determination of not only training but also appropriate numbers of nursing and health care assistants proportionate to the case-mix of residents, as well as congruity with MDS data from the nursing home.

8. For those who are not looked after by the GP who provided their care while at home, the medical cover must be more clearly and unambiguously specified in terms of relevant training (at least the Diploma in Medicine for the Elderly or equivalent), responsibilities and support from the HSE.

9. Multi-disciplinary team support must be clearly specified in terms of both meeting need but also the facilitation of team work, and requires at a minimum: physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work.

10. Specialist medical support (geriatric medicine and psychiatry of old age) need to be developed to provide formal support to the medical officer, nursing staff and therapists not only in the care of patients but also in the development of appropriate care guidelines and therapeutic milieu. These services need protected access to dedicated specialist in-patient facilities for appropriate assessment and support of those in long term care.

11. Professional bodies with regulatory responsibilities for healthcare workers should clarify the highly specialized needs of older people in

residential care in guidance to their members, with particular emphasis on the scope of practice of those who accept senior positions.

12. The public health overview must of residential care must be strengthened. The HSE must coordinate data nationwide, not only on the MDS of all residents of long term care, but also of all deaths of residents, including those that occur in hospital, and should also ensure seamless communication with coroners throughout the country.

Local recommendations

a) As this review did not replace standard complaints and redress procedures of the NAIIB/IISE (NA), the HSE (NA) must ensure that it provides a timely and appropriately supported service to address the concerns of older people and their relatives about the quality of care that they or their loved ones may have received, or are receiving in long term care in the HSE Northern Area.

b) Residents (and their families) of any nursing homes that scored poorly in the ERHA tendering process in 2005 for Heavy Dependency/Intermediate Care Beds should be informed of this as a matter of some urgency, as there is a high likelihood that there are residents with high or maximum dependency in all of these nursing homes.

Introduction

Aging at all stages of development brings with it both growth and loss. The losses of old age, in particular those brought about by age-related disease give rise to increasing levels of disability in later life. At a certain level, the ability for an individual to live independently in his or her own home becomes compromised. This trend appears to have been attenuated in recent decades, with a reduction in the amount of disability within older population in the developed world. Manton et al, showed an acceleration of decline in chronic disability prevalence from 1994 to 1999 in the United States compared with the period from 1989 to 1994. In addition they found a large relative and absolute drop in institutional use between 1982 to 1999, despite a more than 30% increase in the over 65 population in the US. [2]. A similar trend has been noted in Ireland, with no increase in the absolute number of publicly funded nursing home places between 2000 and 2004, despite the increase in the numbers of older people (Table 1).

	Total Subvented beds	Basic subvention	Enhanced subvention	Contract	Public	**Total**
2001	6837	4785	2052	1422	8296	15,133
2002	6752	3813	2939	1717	8550	15,302
2003	6847	3597	3250	1573	8525	15,372
2004	7501	3421	4080	1339	7580	15,081

Table 1: Publicly funded nursing home places in Ireland 2000-2004 (Source, Department of Health and Children)

Despite these encouraging developments, age- related disability continues to be one of the commonest factors precipitating admission into nursing homes. Those needing long term care tend to be very frail and vulnerable group: in one Irish study almost a quarter of those requiring long term care died in hospital while waiting placement. [3]. Studies in the UK have shown that about 75% of residents in Nursing Homes are moderately to severely disabled [4 5]. Medical morbidity and associated disability rather than non-specific frailty and social needs were the main factors implicated for

admission in over 90% of older people to Nursing Homes in the UK. More than 50% of these residents had dementia, stroke or another neurodegenerative disease.

Bowman et al in a survey of dependency and clinical diagnoses of residents in 244 care homes across the UK found a very high level of disability: nearly half the residents were immobile, and a further 32% could only walk with assistance [6]. Nearly two thirds were classified as being confused or forgetful, which is likely to indicate the presence of dementia. Over a quarter had three disabilities simultaneously, suffering from confusion, immobility and incontinence.

A major concern that has emerged in the international literature is that the health care needs of older people in long term care may not be given due recognition. International studies have clearly shown a failure for identification and pro-active management of the complex morbidity of older people in nursing homes [7]. This has been recognized by the Institute of Medicine of the US National Academy of Sciences, whose seminal and influential (in the US at least) 1986 report on poor standards in nursing homes lead to the development of the formalized mandatory review of standards in US nursing homes [8], and in particular the Minimum Data Set Instrument through the OBRA 87 law. In common with other experts, in subsequent reports, the Institute of Medicine noted that deficiencies in the adequacy of nursing staff is a key factor in poor quality care in nursing homes and that adequate minimum staffing levels need to be implemented [9]. There was also a failure to address chronic disease management and appropriate prescribing [10].

Concerns over failure to recognize these complex care needs have been recognized by professional and advocacy groups such as the Irish Society of Physicians in Geriatric Medicine [11], the National Council on Ageing and Older People and the Commission on Nursing, but public policy statements from the Department of Health and the Health Boards have been conspicuous in their silence on this issue, with the exception of one review of services for older people carried out in 2001 [12].

A second concern identified in many countries has been the need for adequate standards for regulation, in particular in the face of a growing trend towards privatization of the residential care sector. The increasing privatization of residential care has been a marked feature of residential care in the Dublin area: nationally there

has been a shift from 55% public and 45% private to 45% public and 55% private long-stay beds in just 4 years from 2000 to 2004; however, in North Dublin, there are about 1400 private beds and 480 public beds, a ratio of 75% private to 25% public. This shift from the public to the private sector has occurred without any public debate, and may have important consequences for the health of older people in residential care. For example, the US government agency for quality in health care has funded research showing that the for-profit nursing homes have lower operating costs [13] but higher hospitalization rates than nonprofits [14]. This trend has also been noticed in the private sector in Northern Ireland [15 16]. In general, the quality of care in not-for profit (Voluntary and public) homes in the US is higher than in for-profit (private) homes [17]. A forthcoming study from the NCAOP demonstrates that within the private sector, the ratio of registered nurses to care assistants is significantly lower than that in the public sector. In addition, the survey found that the ratio of registered nurses to residents was significantly lower in the private sector than in the public sector. While dependency levels in public geriatric hospitals were highest, this alone could not account for the variance in staffing levels [18].

Several markers have suggested that the private sector as structured in Ireland is unable to manage all dependencies of care. The first was a tendency of nursing homes to refuse up to three quarters of patients referred to them from general hospitals [19]: this concern was recognized by ERHA in its review of services for older people in 2001 [12], and by the Minister of State with responsibility for older people in 2000[1]., who reiterated the need to maintain an adequate number of public beds. Secondly ERHA in effect recognized that nursing homes were no longer routinely able to cater for patients with high dependency by tendering specifically for high dependency beds at a different rate to the standard subvention[2]. While this was a positive move, it raised issues about the adequacy of funding and service provision for patients with high levels of dependency in nursing homes without this revenue stream.

[1] Dáil debate, 26/10/2000
[2] Minister of State S Power, written reply to Dáil question, 10/2/2005

Specialist nursing for older people - gerontological nursing

One of the key requirements of the nursing home regulations is the twin goals of suitable and sufficient care (5a), a high standard of nursing care (5b) and a sufficient number of competent staff on duty at all times (10d). Although the general public may not be aware of scientific developments in care for older people, it has now been recognized for some considerable time that outcomes of care improve when older patients are cared for by nurses with demonstrated competence in gerontological nursing and in environments that structure nursing care around the needs of older adults. Kindness, while an important aspect of care, is not a substitute for for this type of competence, and the general public would not be impressed if care in a surgical unit, coronary care unit or special care baby unit was at an inadequate level of competence but delivered with kindness.

Today, the day-to-day practice of most nurses involves caring for older patients. Yet it is likely that too few nurses have been exposed to specialized knowledge about care of older adults, either in their educational programs or in the work setting. This is of particular concern given that it has been shown that outcomes of care improve when older patients are cared for by nurses with demonstrated competence in gerontological knowledge and skills.

The history of geriatric nursing in the United States is notable for the scope of its response to the burgeoning demands of older adults and their families. The American Nurses Association (ANA) convened its first focus group on gerontological nursing in 1962; the first gerontological practice group convened in 1966. In 1968, the Geriatric Division of the ANA published the first geriatric nursing standards, followed shortly by ANA certification of the first gerontological nurses. This flurry of activity coincides with the attention generated by Titles 18 and 19 of the Social Security Act, which established Medicare and Medicaid.

Since then, the increased number of older adults, the changing face of American health care, and substantial shifts in health policy and funding have helped to shape geriatric nursing education, research, and practice. In the USA, philanthropic foundation commitment and support nationally has substantially shaped the recent history of gerontological nursing. In 1981, the Robert Wood Johnson Foundation

supported the Teaching Nursing Home to demonstrate patient and educational outcomes related to collaborations between academic nursing and nursing homes [20]. The Kellogg Foundation funded a national project to develop geriatric curriculum for associate degree nursing programs, with an emphasis on long-term care. During the past 25 years, the John A. Hartford Foundation has supported the academic preparation, practice, and research capacity of geriatric medicine. Beginning in 1990, the Hartford Foundation began to invest in geriatric nursing. Foundation funding for 2001 represents a $35 million investment in geriatric nursing (http://www.gerontologicalnursing.info/). This commitment, which represents the largest funding commitment of any foundation in nursing, has served to stimulate curriculum reform, the development of academic centers of excellence, and pre- and postdoctoral scholarships, thus positioning geriatrics as a substantial area of future research and practice within nursing [21].

In England and Ireland there has been a rapid expansion in the number of courses run for postgraduate training in the care of older people, and such courses are available at five universities in the Republic of Ireland. The Commission on Nursing specifically noted in 1998 that: "The setting up of post-registration nurse education programmes in care of the elderly is a welcome development. These courses vary in their academic award up to masters in gerontological nursing. The advancement of post-registration education to this level is important in relation to the development of clinical career pathways of clinical nurse specialist and advanced nurse practitioner in care of the elderly. Unfortunately, both the number of courses and their participants are small when compared with the number and educational needs of nurses working in care of the elderly. The Commission recommends that centres of nursing education, in conjunction with third-level institutes, develop nurse education programmes to meet the needs of nurses working in care of the elderly, which would facilitate greater integration among the disciplines of nursing."

Given the international disquiet about care standards in nursing home, the complexity of care required by vulnerable older people, it would seem very important that these recommendations would have been implemented and extended to nurses in nursing homes. The Irish Society of Physicians in Geriatric Medicine have recommended in 2001 that there should be adequate training for the nurses in long term care and where

possible this should include a Higher Diploma in Specialist Care of Older People [11].

Leas Cross Nursing Home

Leas Cross was a large nursing home by Irish standards, registered for 111 beds (the median number of nursing home beds was 45 in ERHA in 2004). It had very complex case-mix where the majority of patients had high dependency levels. At a once-off assessment in early 2005 the dependencies were:

Light/minimal dependency	8 (9%)
Medium dependency	31 (33%)
Heavy dependency	42 (45%)
Maximum dependency	12 (13%)

Table 2: Dependency levels in Leas Cross Nursing Home in 2005

The median number of identified diagnoses in those whose notes were reviewed was 5, and nearly all were on multiple medications. Over half were identified in the case notes as suffering from dementia: as it recognized that care staff in nursing homes do not detect dementia in a significant number of cases, the prevalence of dementia was probably higher than this, a fact supported by an estimate of 80% in HSE correspondence.

Identification of deaths

A total of 105 deaths were detected between 2002 and 2004. The register was poorly maintained with no stated destination or death declaration for 439 out of a total of 690 entries (64%). Although some of these could be identified as repeated short stays, (presumably to provide respite for those caring for the patients at home), and others were individual short stays, in at least three cases, the death of the patient was not mentioned on the register, two of these occurring after discharge to Beaumont.

Cross checking was done with a sample of the deaths with the Registrar of deaths, and this produced one further unrecorded death.

In general, the column for indicating the (statutory) obligation to report deaths to the Health Board was left vacant. For 40 admissions (6%), the rubric for next-of-kin was blank: the Nursing Home Regulations require this information

There are discrepancies between the number of admissions in the register and the returns made to the health board for the annual report on long term care by the Department of Health and Children in 3 of the 4 four years when returns were made: no returns were made for three of the seven years involved.

Pattern of the deaths

It is a matter of both common sense and scientific fact that the morbidity associated with nursing home entry is such that one is more likely to die in a nursing home than in the community -- the standardized mortality ratio is greater than six times higher in a nursing home than in the community [22]. However, some scrutiny of death rates in nursing homes is helpful, as it may be useful in detecting one of two main concerns: an unduly heavy and complex case-mix of patients, or else deficiencies in care. Observation of these trends is clearly an important (but neglected) public health aspiration: observation of undue mortality should trigger a review of case-mix, care and staffing, whereas very low mortality should prompt a review of undue discharge to die in hospital or else inappropriately low dependency. This is standard practice for one large chain of nursing homes in the UK, and it is a source of concern that no government or health agency knows the death rates in Irish nursing homes.

I could only detect one published Irish study of time to death in transfers (from St James's Hospital) to nursing homes, as yet in abstract form[323]. The median duration of survival, between the years 1997 to 2000, varied from 17 to 44 months. Less than half the cohort had died for 2001to 2003 and it was not therefore possible to calculate median survival times. In Leas Cross, the median time to death of those who died was 221.5 (7.3 months) days from all hospitals, but only 77 days (2.5 months) for the St Ita's patients. This was a particular cause of concern and mirrors concern was expressed in strong terms by the consultant psychiatrists in St Ita's Hospital to both the NAHB and the Director of St Ita's Hospital.

Another perspective is to look at one year mortality. In a US study of 45,000 nursing homes residents this was 35% [24] and this was matched closely by a New York study, suggesting one year mortality rates between 32-34% [25]. No corresponding figures exist for Ireland. In Leas Cross, there was a steady rise in one-year mortality from 1998 to 2000, and thereafter remained steady at 38-39%.

Year	Deaths/Residents	One year mortality
1998	2/14	14
1999	5/21	24
2000	6/19	32
2001	7/16	44
2002	5/38	39
2003	30/76	39
2004	14/37	38

Table 3: 1 year mortality for patients dying before, or living after one year at Leas Cross Nursing Home

There is also evidence of increasingly short lengths of stay for those died over the course of the years, although this is a less reliable measure.

Year admitted	1998	1999	2000	2001	2002	2003	2004	2005
Average length of stay (days)	2026	1822	866	672	398	240	121	41

Table 4: Length of stay of those who died while resident at Leas Cross Nursing Home by year of admission

As will be discussed later, there is an almost complete absence of systematic monitoring of deaths in Irish nursing homes, but the above indicators would be sufficient to cause the type of in-depth review mentioned by Bowman et al in 2004.

[3] I was unable to gain access to the first draft of the paper, but when published this should be a valuable resource

Deaths notified to the HB/HSE and the Coroner's Office

Deaths reported to the HB/HSE

There is a statutory obligation to report deaths in nursing homes to the Health Board/HSE. Only 31 of 60 notifiable deaths were notified to the health board, of which 16 were received on foot of a telephone request from the senior Area Medical Officer. While the Health Board was concerned that deaths of residents in hospital were not being reported, legal advice to the Health Board at this time indicated that the nursing home was not obliged to report deaths of residents who died in hospital. A significant number of other nursing homes in the NAHB/HSE (NA) did not fulfil their statutory obligation to report deaths, with 33 unreported deaths in eight other nursing homes 2004 and to June 2005: following this audit, the HSE (NA) wrote to all nursing homes reminding them of this statutory obligation. Three nursing homes reported all deaths.

Deaths notified to the coroner

The deaths occurring in those resident in Leas Cross fell under the jurisdiction of two coroners. Those who died in Beaumont Hospital were under the jurisdiction of the Dublin City Coroner, and those who died in Leas Cross or James Connolly Memorial Hospital under that of the Dublin County Coroner.

Since February 2004, there has been a recommendation by the Coroners that deaths in residents of nursing homes should be referred to the Coroner's office, and while not legally binding, represents not only best practice but also a strong moral imperative. A letter from the Manager of the Nursing Home Section to the chairman of the Federation of Irish Nursing Homes (19/4/2004) makes it clear that the NAHB consider it best practice and that deaths in nursing homes must be reported to the Coroner.

Of those who died in Leas Cross from July 2004, 8 were referred to the Coroner and 8 were not, a compliance rate of 50%

Of those who died in Beaumont from July 2004, 6 were referred to the coroner and 10 were not, a compliance rate of 38%

All three who died in other hospitals were referred to the Coroner.

The Coroner's reporting system is an important mechanism for detecting concerns over any issues that might arise from deaths of nursing home residents. In the case of the Dublin City Coroner, an officer of the coroner's court contacts the next of kin to enquire about the circumstances of the death and to elicit any concerns that might arise. The system also allows concerned health care professionals to express their worries over adequacy of care.

Where the coroner decides to investigate the death more fully, the investigation is thorough and in the case of one death in Leas Cross provided an insight into poor quality of care which resulted in a verdict of death by medical misadventure. The transcripts and verdict of the case of the one case in the public domain represent a telling indictment of the standards of care which are mirrored in the absence of adequate and satisfactory documentation of appropriate nursing care.

The inclusion of a mandatory responsibility to report deaths of residents in nursing homes in forthcoming legislation is to be welcomed, and should be extended to include the deaths in hospital of those who were resident in a nursing home prior to admission to hospital, but this does not free nursing homes or hospitals from the responsibility under best practice of reporting such deaths to the Coroner.

Review of nursing home case notes

The case notes consisted of nursing and medical notes, with associated correspondence from visits from the Old Age Psychiatry services and hospital referrals. Where the resident came from a general hospital, there was in all cases a medical and nursing referral letter, usually comprehensive and of a high standard, and often there were accompanying letters from therapists, particularly speech and language therapy and clinical nutrition. When the resident came from home, there was usually a brief referral from their family doctor. In no set of notes could I find the person's medical records from their former GP, and I could find no request for their medical records, nor any evidence of such a policy.

The nursing notes generally consist of a number of sheets, including:
An **information sheet** with demographic details, next of kin, GP, general medical history, medications, physical observations on admission, problems and hobbies/interests. It is not stated who should fill this out, and there is no place for a signature.
An **Enquiry Sheet**, to be filled in by Matron or Staff Nurse only, with demographic and contact details, and space for Diagnosis, Medical History, Psychiatric History, Mobility, Eating, Continence, Allergies, Particular Likes and Dislikes, Medical Card, Type of Stay (Long, Short or Respite) and a place for a signature and date.
A **Profile Sheet**, again with demographic and contact details, Smoking, Drinking, Personality, Physical Illness/Operations, Psychiatric History, Medication, History of Present Condition, Values, Beliefs, Likes, Dislikes, Assessment by other doctor, Any Other Information. It is not stated who should fill this out, and although there is an instruction for signature and date, there is no place for a signature or date.
An **Admission Form**, with demographic details and administrative and financial sections.
Daily Report sheets, with usually day and night staff reports

A small number of case notes had a more complete assessment, modelled on the Roper-Logan-Tierney model of care, covering areas of care and offering the potential for more detailed nursing care. These were invariably filled in a different hand to that of the Enquiry Sheet, and often proposed a very limited repertoire of actions, with the proposed review dates rarely achieved or with any consistency.

In general, the filling and maintenance of the forms of the case notes was deficient in many respects. Not only were important basic data missing, but the structure of the notes was counterproductive to care planning for this patient group, and there was little evidence of any structured care planning, nor in turn was there any evidence of a systematic review of care planning. There also seemed to an unfortunate mixing of nursing and administrative functions, with financial details of weekly payment recorded on a number of Enquiry Sheets in the same hand as one of the nurses filling out the sheet.

Weight: Only 11/107 (10%) had a weight recorded on admission. This is important at three levels: a) because malnutrition is a common and serious problem in nursing homes and good nursing care requires a baseline weight as an important component of planning care, b) it is a marker of the standard of nursing care, and c) it is required by the NH regulations.

Skin condition: Only 15/107 (14%) had skin condition recorded on admission: within this group, some of the descriptors were conversational in tone rather than reflecting the nursing practice, ie, 'weak and pale'. This is again important at several levels. Given the high prevalence of disability in LC, many would be at risk of developing pressure sores [26], and adequate planning of pressure sore prevention requires assessment and monitoring of skin condition: indeed it is one of the key pillars of quality assurance in residential care in the UK NHS [27].. A failure to record skin condition is also a marker of the standard of nursing care. More worryingly, none of the residents had a formal pressure score annotated as a part of their routine nursing assessment or nursing notes.

In 5 case notes the enquiry sheet missing. Of the rest, there were further major failings in filling out of the relatively modest range of rubrics:

- Diagnosis: 46/100 had a primary diagnosis registered
- 87/100 had Medical history registered
- 86/100 continence (15 ticked)
- 17/100 eating not registered
- 7/100 mobility not registered

There is a very marked degree of difference between the quality and quantity of the nursing notes of those patients who were admitted before 2001. The daily notes tended from 2003 onwards often consist of rather telegraphic annotations such as 'all care and needs attended', yet these care needs were not characterized in writing.

In particular, there were deficiencies noted in pressure sore prevention and care, assessment and management of swallow disorders, and in documenting the use and appropriateness of restraints which were indicative of a failure to adequately understand and progress care for these vulnerable people.

The following anonymized sample exemplifies the gap between the recommended treatment from the referring hospital and the written record:

	Referral recommendation	Leas Cross Response
Dysphagia	Clear speech and language therapy recommendation for soft food, thin fluids, supervision when eating and drinking, slow feeding – making sure each mouthful is swallowed before giving the next, encourage patient to clear residue after swallowing, pt to remain upright for 20 minutes after eating or drinking, pt requires additional care with oral/dental hygiene. Offered review	Enquiry Sheet, (unsigned and undated): feeding required, requires soft diet. No mention of specific provisions in Daily Notes. Choking noted with no reference to dysphagia or action
Pressure sore prevention/care	Sacrum red but intact – Airworks mattress	Skin 'dry and flaky' noted on admission: 4 weeks later, first mention of skin – 'sore noted on back'.

		Pressure mattress was removed as 'not working'. 1 day later, Special pressure mattress placed and turned on. Seated on Buxton chair all day long, granuflex, mention of pressure sores from weeks 8-10 and again no further mention of pressure care until sacral sore again noted week 48.

Pressure sore prevention and care

Pressure sore care is key indicator of quality of care for vulnerable older people in residential care [26]. Pressure sore prevention and care has been selected as one the eight core areas of quality assurance by the UK Department of Health [27 28]. Pressure sores are a preventable occurrence and standard pressure sore relieving strategies can reduce the incidence of pressure sores [29]. In some jurisdictions severe lapses of pressure sore care leading to death have successfully been pursued by government agencies as homicide, most notably in Hawaii [30].

The care in Leas Cross raised grave concerns in the case notes reviewed. Pressure sores were documented at one stage or other in 33 of 100 available notes, in each case a Grade II or greater. It is likely that the pressure sore rate was higher if Grade I pressure sores were included. A national survey of nursing homes in Germany, the prevalence of pressure sores of Grade II or higher was 11.5% [31].

The inadequate documentation and lack of clear care routines for pressure sores are notable in one the cases which entered the public domain [32]: in her case the coroner entered a verdict of death by medical misadventure. A review of the nursing andmedical case notes was consistent with this [33]. In at least one other case, following a complaint by family, a pattern of very poor care documentation is noted, with no

weight recorded on admission, extended periods of inadequate note-keeping, failure to track the development of serious pressure sores, and failure to detail treatment.

Restraints

An alarming number of the residents were being noted as being nursed in Buxton chairs, and although there was a written policy on restraints, there is only evidence of one relatively cursory attempt at surveying restraints and consent. The documentation as supplied gives no sense of the application of an informed policy on restraints which reflects the reality that restraints pose a very great hazard to frail older people in nursing homes [34]. Nursing homes with a high use of restraints are associated with low performance on a number of quality of care indices [35]. There is almost no documentation on the use of bed-rails.

Medical Cover

Medical cover was almost exclusively provided by a single medical officer at any one time, with one providing it to the end of 2002, and the other from early 2003. No documents were offered to this review outlining training for the post, policies for medical cover, or other medical policies, such as immunization, infection control, and medication review. Any medical referral letters from Leas Cross gave no contact details for the medical officer other than those of Leas Cross Nursing Home, although they were not based in the nursing home full time.

The Nursing Home Inspection team made a particular note of requesting clarification from the nursing home proprietor as to whether a single GP could provide a level of input adequate to the needs of - potentially -111 patients. They were given an undertaking by the proprietor that he would provide this information in two weeks, but this was not provided in any documentation.

The case in the public domain through the Coroner's court [33] raised serious issues over the role of the medical practitioner in pressure sore care, and in only a very small number of the 33 cases with pressure sores was there a medical note observing the pressure sores.

In two instances the nursing notes note difficulty in contacting a doctor, in one case extending for three days. While any notes review must try to take into account differences in clinical practice and care, some concerns arise out of the deferring assessment to the next day for one patient who had a very high sodium and urea, and who was subsequently transferred to hospital and died shortly thereafter.

There was no evidence of a policy on dysphagia (difficulty with swallowing) in the documentation supplied, although a significant minority of those who died in Beaumont were detected as having this significant disorder, a number of those referred to the nursing home had the disorder, and a high number of older people in residential care have swallow disorders [36].

Prescriptions

The prescription forms were in a Kardex style, with the medications and signatures in differing handwriting in most cases. The forms did not allow for clear notification of failure to prescribe, or the reasons why this might be so. When prescriptions were re-written, there were a small number of patients who seemed to have two (and occasionally three Kardexes) at one time.

Regular medication review is a standard part of the care of older people, but in Leas Cross, nearly all prescriptions were written in a different handwriting to that of the doctor's signature, including virtually all rewriting/recharting of medications. There was no indication that medications were removed at the re-writing of the drug Kardexes. No written policy was offered to support regular medication review.

Influenza vaccine was not indicated on the prescribing forms and was episodically mentioned in the medical notes. No written policy was offered for vaccination schedules, and no pneumococcal vaccine was prescribed on the Kardexes, despite a significant number of patients with cardiorespiratory disorders.

Nursing Staffing

The staffing and qualifications as documented at Leas Cross were clearly deficient in terms of specialist expertise, nursing numbers and nursing infrastructure. This is perhaps the single most grievous area of concern of practice within the nursing home,

and it is not unreasonable to infer that many of the other problems arise from this fact. While individual nurses may behaved in a professional and appropriate manner, the ensemble of nursing care as documented left much to be desired. Qualified nursing time is not surprisingly associated with better care and outcomes [37] and there is no documentary evidence that this was appreciated at any level in Leas Cross.

There is no documentary evidence that the proprietor sought senior staff with experience of specialist nursing of older people. At a senior level, neither of the directors of nursing had any experience of specialist nursing care of older people, neither had any formal specialist qualifications in the nursing of older people. Other than when prompted by the Nursing Home Inspection Team, neither is noted in any documentation as expressing concern over the lack of nursing staff or over the lack of a senior nursing infrastructure. In terms of training, some effort was made by the second Director of Nursing to hold team meetings and some educational groups, but the apparent failure of this programme to have substance and depth can be seen by the decision of the Director of Nursing to cancel the programme due to poor attendance and participation in May 2005.

Finally, there is no evidence that the Nursing Home Inspection Team or HSE had expectations of experience with specialist nursing of older people as a prerequisite of approving Directors of Nursing of residential care for older people.

The lack of Assistant Directors of Nursing, apart from a late temporary promotion of a member of staff, meant that it appears that nursing staff and care assistants had to relate directly to the Director of Nursing for any substantive decision.

In the documentation supplied, there was no evidence of other programmes of training, and no aspiration or requirement for higher training in gerontological nursing for nursing staff. There was no evidence of specific acculturation programme for nurses from foreign countries, a cause for significant concern given not only the demographic and cultural differences in their training (if any) in the care of older people [38] but also any potential communication barriers, which in turn may be exacerbated by the high prevalence of dementia among the residents [39].

There was no evidence of the use of any recognized measure [40] for the calculation of required numbers of qualified nursing staff proportional to the numbers of residents and their dependency. Using any of these ratings would have given a significantly higher level of qualified nursing staff, and this was also the finding of the nursing home inspection team.

Perhaps the most telling estimate of the deficit is a memo of a meeting on 8/6/2005 between the Chief Officer of the HSE (NA) and the proprietor of Leas Cross, a senior officer of the HSE (NA) and the senior nurse seconded to Leas Cross which advised that in excess of 20 additional nurses (including middle and senior nurse management) would be required to provide an appropriate standard of care. This is also perhaps a marker of the importance of ensuring that there is a senior nurse with experience in senior management of a residential facility on the nursing home inspection team. The HSE (NA) in a memo of the 9th of June 2005 are recorded as advising that in the event that Leas Cross did increase the level of staffing and were in a position to provide quality care to high dependent patients, that HSE (NA) would fund accordingly

Care Assistant Staffing

Care assistants play an important role in the complex and sophisticated care of older people. However, care assistants also require formal training, as recognized by the Department of Health and Children in promoting FETAC training for care assistants in the public health system. There was no evidence of any vocational training for any of the care assistant staff in Leas Cross, and no policy proffered for ensuring such training. Equally, there is no evidence of specific acculturation for non-nationals who worked in the service. This represents a major concern for the maintenance of care standards.

Therapist staffing

Among the striking findings on reviewing the case notes of those who died at Leas Cross was the virtual complete absence of documentation of formal input by physiotherapists & occupational therapists. It is clear that this frail group of older people will not only require physiotherapy but also occupational therapy, clinical nutrition and speech and language therapy (given the high prevalence of swallow

disorders in extended care [36]). The Nursing Home Regulations put the onus for the provision of these services on the proprietor or by arrangement with the health board (30 c). The HSE needs to clarify whether therapy services are provided by the private sector as part of the package or whether older people should receive these therapy services from the HSE as required. The provision of dysphagia and clinical nutrition services is a particular incidence in point which often requires videofluroscopy, geriatrician, ENT or gastroenterology support. It is likely that the HSE needs to consider actively the provision of outreach teams to provide joined up multi-disciplinary support to older people in both private and public nursing homes rather than looking at once-off contracting in of independent contractors who may not have the opportunity to meet up with each other or whose funding arrangements do not permit for the holding of an inter-disciplinary case conference.

Specialist Medical Input

The provision of services by old age psychiatrists and geriatricians was an important part of both support to the older people in the nursing home, but also played an important role in bringing cases of poor quality care to the attention of the health services and the coroner. Both services have documented the fact their resources were very stretched by trying to support the large group of frail people in nursing homes, and adequate resourcing of both specialties is an important component of supporting high quality care in nursing homes. Adequate and timely access to specialist beds is equally important, and it is of some concern that the geriatricians in Beaumont wrote in the following terms to the CEO of Beaumont in 2005:

"..it is virtually impossible for us to admit patients electively or semi-electively for geriatric assessment. This flies in the face of standard and acceptable practice for our specialty...." and the old age psychiatry service also requested (but unclear as to whether they received) increased resources to support older people with complex illness in nursing homes.

Hospital notes

The hospital or A/E records of 46 of those who died in Beaumont were examined by me in the course of the review. Eight were brought in with cardio-respiratory arrest, and are recorded as dying in A/E, although the precise time of death cannot be established with certainty.

Of the remaining 38, of the 24 who had renal profiles available for inspection, 20 had renal failure, often at very elevated levels, for which dehydration was likely be a contributory factor, particularly given the lack of routine use of fluid charts in Leas Cross.

Pressure sores were noted in 12 patients and red skin (possible Grade I pressure sores) in 4, giving a total of somewhere between 32-42% prevalence of pressure sores. Six of thirty-eight were noted to have swallow disorders. Two patients, both fallers, were noted to have rib fractures on chest X-rays.

Procedures/guidelines and other documentation offered for review by Leas Cross

Two sets of protocols/guidelines were offered for review by Leas Cross, the first set was of varying quality, and the second set a version of nursing guidelines developed in the Midland Health Board. There was little evidence of systematic application of the guidelines. A pressure relieving prevention policy which is dated to be effective from 2nd May 2005 would seem to be of a normal level of competence expected, but there is no relationship of assessment for risk of pressure sores found in the vast majority of the notes reviewed by me. Seven pressure relieving lesion reporting forms are presented all dating from after1st May 2005 - three of which relate to the same patient. Three forms of a different format and two more of a yet a further different format are also noted from about this time. Although there is documentation in this folder related to a course in continence promotion there is no documentation offered to me of a policy for Leas Cross Nursing Home on continence management and incontinence prevention.

The policy on restraints again no shows little evidence of systematic implementation. Document GN008 on restraint notes that 'responsibility lies with all staff and that chemical or physical restraint should only be taken when all other methods of management have failed. The definition includes chemical restraint and other physical restrains including safety belts, chairs – such as buxton chairs. It also

mentions that if physical restraint is to be used it should not be implemented without the agreement of two registered nurses who should record their decision on the nursing report. It further states that in the case of an emergency, physical restraint may be used without the prior consent of the next of kin, but they must be informed of the action taken and the reasons why the physical restraint was used.' The documentation also included physical restraint forms. These all dated from 19th November 2004. The restraint forms recognise 31 patients and in total involve 25 with cot sides, 16 with wheelchair (uncertain as to whether or not it involves other restraints), 3 with a wheelchair and strap, 7 with a Buxton chair (uncertain whether strap or other restraint included) and 1 with Buxton chair and strap.

Equally, document GN007 on death of a resident states that responsibility lies with all staff and person-in-charge and that a cause of death certificate will be requested from the GP. It also states that the proprietor/person-in-charge must ensure that a cause of death certificate is received from the GP and the health board notified and the coroner notified. This clearly was not followed in at least half of the deaths.

Minutes were available of meetings held with staff covering issues such as rosters, roles and responsibilities, laundry, teamwork, training, wages and other business. These are dated as occurring 7th January 2005 and at two week intervals up to mid May 2005. A number of issues were brought up around appropriate behaviour to residents. There was evidence of concerns also over staff speaking Filipino among each other and also of staff refusing to work in certain areas or to work with other staff members. In terms of philosophy of care very basic instructions are being generated through these meetings, including instructions to clean Buxton chairs and wheelchairs prior to sitting people in them. In terms of residents, an instruction was noted that residents were not to be issued with remote controls for TV's. From these meetings issues of concern around staff training and morale are clear, particularly as evidenced by instructions asking staff 'not to be hanging around the nurses stations', long delays in answering bells and concerns over the development of pressure sores were raised in the middle of May. Meetings were terminated in mid-May 2005 as the Director of Nursing felt that only a few staff contributed to the meeting and there was no interaction with anyone else.

A further collection of documentation included a number of testimonials from relatives supportive of the care of residents of Leas Cross dated 12th July, 1st June 2005.

There are certificates from the Centre of Nurse Education of the Northern Area to certify that the incoming Director of Nursing and a senior nurse have attended five days of training in February on current best practice in Psychiatric Nursing as well as an invoice for dementia training session from the Dementia Services Information and Development Centre. A Dementia Care Policy is included in the documentation but there is no evidence of any particular plan or format for implementing this document.

A Plan of Action dated 29 March 2005 with the Director of Nursing nominated as the head lists the following actions:-

1. To increase staff nurse ratio and has agreed with one RGN per month
2. To introduce a nursing management structure and to have 2 CNM II's and 2-3 CNM I's.
3. Care Plan Development and is annotated as Director of Nursing and Staff Nurses and Director of Nursing research ongoing.
4. Dementia Policy/Alzheimer Policy and to take action on this in terms of research policy development.
5. Restraint Policy which states that it exists but it needs to be updated and covers a number of areas of concern.
6. Continence Promotion Policy, Pressure Area Care Policy, Wound Management, Documentation of Legal issues and Training Programme are all mentioned. The ongoing action shows a sessional training programme divided among staff on areas such as emergency situations, skin care, manual handling, fire safety, MRSA infection control, wound care, continence promotion, hand-washing, pressure area care, care of persons with dementia, basic life support, documentation and accountability, mouth care, nutrition of the elderly, nutrition and dysphagia. However, a significant number of these are marked down as continous, ongoing or date to be confirmed.

A document entitled *Independent Inspection Report on the Closure of Leas Cross Nursing Home*, commissioned by the registered proprietor, and written by Rita Craig of Elderly Care Consultancy Services (Dr Jonathan Levy and Ms Rita Craig, Elstree, UK) seems quite qualitative and individual in its judgements, for example at the points where it describes the quality of the environment. There are a significant number of qualitative statements around staffs' understanding of care practices that do not seem to be backed up by any data, evidence or quantitative material: for example, it refers to criteria in place for selection and recruitment of staff, but these were not available to the reviewer. The reviewer states that the 'the majority of the residents pointed out that they had no complaints with the home's standards of care and were all very happy' is not backed up by a clarification of methodology or of any data. This is accompanied by a report entitled *Independent Report* from Dr Johnathan Levy, which appeared largely conjectural, and in particular refers to the "dumping" of pre-terminal and terminal patients in Leas Cross, as if there was no sense of the nursing home having a contract with the HSE, or insight into their professional responsibilities. Dr. Levy also talks of Leas Cross being underinformed of the medical state of the patients arriving from hospital, when in fact the quality of transfer information was almost uniformly high.

Rosters offered for March 2005 showed generally 3 staff nurses on during the day and 9 care attendants for the full 12 hours shift with another nine for the 8-2.30 shift. At night it was 2 staff nurses and 6 care attendants doing the 12 hour shift with the support of 2 on the evening shift. On the day roster at times there would be 2 nurses on duty between the hours 6-8pm. In January 2005 a pattern of at times having only two nurses in the afternoon was seen as well.

There is an undated description of activity therapy occurring daily cared out by two individuals and of a physiotherapist attending twice weekly. The Fit for Life group have invoiced for activities approximately twice per week.

Internal Funding

It is not clear to the reviewer as to what was the managerial philosophy to Leas Cross in terms of any budgetary pressures, and as to whether or not they may have been a factor in terms of what appeared to be inadequate levels of staff trained in the care of

older people in the nursing home. No written documentation was offered of any communications between the proprietor and the directors of nursing on this topic.

Official Oversight of Leas Cross

The Nursing Home Act and Regulations unequivocally state that responsibility of the Minister for ensuring standards of care in nursing homes rests with the health boards. Although the Nursing Home Inspection Team is the main form of official oversight of the quality of nursing home care, other sources of oversight include ERHA's assessment of nursing homes tendering for heavy dependency care beds, statistics provided for the Department of Health and Children's annual report on long term care, as well as reporting of deaths in nursing homes to the Health Boards/HSE. The Coroner's system is a point of reference outside of the health system. There seems to be little evidence of coordination between these systems.

Overview of Nursing Home Inspection Team

Background

Prior to October 2004 there was no designated team assigned specifically to inspection of private nursing homes in the Northern Area Health Board. Inspections were conducted at an area level by Directors/Assistant Director of Public Health Nursing and the Area Medical Officer or GP. Following a change in October 2004 a designated team was set up consisting of a Director of Nursing, Assistant Director of Nursing and a sessional General Practitioner. The unit was located at St. Mary's Hospital and a further Assistant Director of Public Health Nursing was assigned from Community Care area 7 to the team. A full time administration officer also joined the team. In January 2005 a structured pre-planned inspection process was put in place. Nursing Homes were scheduled for inspection and agreement was reached that each nursing home would be visited and notification issued to the proprietor of the date that the inspection was to take place. This was to ensure that they were available to meet the inspectorate team.

A new process was instituted to meet with the proprietor and Director of Nursing to outline the new inspectorate team, to outline the change in emphasis of the inspection process from infrastructure to care, and the need to work in a climate of partnership to ensure that best practice was adhered to at all times in the provision of care to the residents and to raise the standards of care required.

The initial visit was to be on a once-off basis and future inspections were to be unannounced. This process is reported as receiving positive support from the private providers' perspective. By June 2005 all nursing homes in the Northern Area Health Board had had at least one inspection visit with a number receiving a number of follow-up inspection visits. There are a number of recommendations arising out of this report which include developing qualitative and quantitative standards to be reviewed specifically for each standard, involvement of residents in the inspection process, scrutiny of written policies, procedures and records, observation of daily life in the home and improving capacity for inspectorate teams to access multidisciplinary experts.

Team composition

The NAHB/HSE (NA)'s resource intentions in setting up the Inspection Team is not at all clear, in particular, it is uncertain whether team members had their other duties entirely provided for by new appointments or whether other services were reduced to provide for the team's time input into the inspection process. The Inspection Team in their 2005 report call for more access to multi-disciplinary experts, ie, geriatricians, old age psychiatrists, practice development, occupational therapy, physiotherapy, dietetics, speech and language therapy [41]. At a meeting of 5/7/2005 with the Assistant CEO of the HSE (NA), they expressed their concerns over adequate resourcing of the Nursing Home Inspection Team, and in particular medical input, given the reduction in public health doctors from 10 WTE to 1.5 WTE between 1999 and 2005.

Reports of visits

The sequence of visits portrays a consistent pattern of deficits in care. Prior to the new format of inspection, the reports for Leas Cross were relatively brief with a significant focus on physical surroundings.

The first break with this was an individual report (22/1/2004) following the death of a patient which outlined a complete lack of formal assessment procedures or protocols for pressure sores, as well as scanty and poor documentation with no evidence of appropriate care, inadequate staffing and skill mix. These issues would become a recurrent refrain over the next eighteen months, and the report concludes with the

perception that Leas Cross was working with the NAHB to correct these deficits, again a recurrent refrain.

This was followed by a report on the nursing home after a complaint about a patient who was subsequently transferred elsewhere. This report of 13/7/2004 outlines severe deficiencies in staffing, skill mix, senior nursing structure, health and safety, Bord Altranais medication regulations, nursing care standards, and access to the doctor. Yet again it was noted that the Director of Nursing and Leas Cross seemed to be interested in working with the NAHB on improving all these deficits.

Yet another report arose from a family's concerns over the care of their relative prior to transfer and death in Beaumont Hospital. This report of 12 Jan 2005 concluded that: 'the major deficits noted in reviewing this case is the lack of documented care plans, weights, clear nursing notes describing care given, no ongoing assessments / updates of functional status (mobility, continence, fluid charts, etc.). Given the very poor documentation in this case it is difficult to satisfy ourselves as to whether (the resident) received adequate nursing care as directed by the Care and Welfare Act 1993.'

Arising from these very significant complaints around individual patients, as well as the concerns of the consultants in old age psychiatry and geriatric medicine, a report of 10 March 2005 details concerns over skill mix and staffing, in which the Nursing Home Inspection Team focussed on a number of care areas that needed improvement, including: management of resident dependency levels, effective care planning and documentation and development and initiation of specific care policies.

The inspection of 7/8 April 2005 highlights deficits in:

- Staffing
- Communication and continuity of care
- Adequacy of records of care provided: in particular fluid balance charts, wound and pressure sore prevention and treatment, and documentation of residents' nutritional status including weight.
- Adequacy of drug administration records

- Notification of deaths to the Health Board
- and requested clarification of the adequacy of the medical care provided.

The report mentions that while they had provided a dependency tool previously, the dependency calculations were performed by the Director of Nursing on the 8th of April, ie, the second day of the inspection.

The pattern of the reporting of the subsequent inspections, with one exception, show ongoing concerns over the standard of care. The (unannounced) inspections of May detail a perception of progress in terms of structure (by way of an internal promotion), and the employment of extra nursing staff. Although work in progress was reported on procedures and documentation, there was no improvement apparent in any of the case notes reviewed by me after this date. The team noted that there were 4 complaints investigated in the previous 12 months at Leas Cross and there was an ongoing independent inquiry being conducted on behalf of the HSE.

The Nursing Home Inspectorate Team proposed a possible model for matching dependency, a dependency classification adapted from one based on medical and surgical ward models. Although the formula used gives a multiplier for increasing levels of dependency it does not translate this into number of staff required on the ground or indeed have any comment about their training requirements or needs.

On a return visit the following was noted: that new Director of Nursing's C.V. had been forwarded to the Director of Public Health Nursing and had been cleared; that one of the staff nurses had been promoted to Acting Assistant Director (presented as an interim arrangement until Leas Cross recruited an Assistant Director and a C.N.M. II) and that of the 3 R.G.N.'s, 2 of the 3 were in place and a third was due to take up post shortly. Medical care was noted as provided in the main by 1 G.P. visiting 5 days a week for 1-3 hours and providing 7 day emergency medical cover. The doctor on the inspection team is noted as accepting the GP's invitation to meet regarding medical care cover. A review of medical and nursing records such as documentation, care plans and core care policies was reported as being in progress and to be reviewed in 3-4 weeks time.

A further unannounced visit to Leas Cross occurred on 30th May at 2pm. Staffing arrangements were noted and the fact that the GP had seen 8 residents on that day. All patients were out of bed and 5 patients with pressure sores and their condition were discussed with the Acting Assistant Director of Nursing. A sixth resident with pressure sores had been admitted to hospital. The only nursing issue identified by Acting Assistant Director of Nursing was as to who would assist or relieve her when she would be deputising for the Director of Nursing on leave. The presence of the activity co-ordinator in Leas Cross doing an exercise programme was noted. Surprisingly, there was no comment in this letter on the standard or quality of care.

A letter of 23rd June 2005 details the results of a further unannounced inspection, including breaches of good nursing practice, professional guidelines and the Misuse of Drug Acts and regulations. They also noted that no record was kept of residents who refused to take medication at the time prescribed. A further letter describes breaches of the Nursing Homes Regulations around:

- maintenance of the register
- copies of nursing registration
- laundry
- inadequate staffing to support good safe practice in the delivery of care given the number and dependency levels of the residents
- failure to comply with good practice in relation to the receipt, storage and administration and recording of drugs
- lack of clarity in relation to care plans
- lack of evidence that current nursing care practice was informed by the care plans
- non-availability of consent forms for restraints currently in use
- no evidence that a highly dependent resident who had a fluid balance chart had any fluid intake since 4 p.m. (five hours later on a very warm day)
- concern that highly dependent residents were accommodated on the first floor remote from the nurses station which would present difficulty in terms of emergency or evacuation
-

At this stage the Nursing Home Inspection Team declared that on the basis of their findings that the current staffing and skill mix did not support good, safe practice in the delivery of care, given the number and dependency levels of the patients.

What might be termed as the final inspection report was written by the senior nursing officer seconded by the HSE N/A to Leas Cross, and her team, following the putting in place of a team from the HSE to try to run the nursing home. This is a devastating amplification and clarification of the many concerns of the Nursing Home Inspection Team dating back to the April visit, as well as the addition of a number of features. These are so comprehensive that I have added them as an appendix to this report (Appendix 1). The report is also a testament to the key role that nursing staff engaged in the senior management of residential facilities can play in identifying threats to appropriate patients care.

A reply by the proprietor to this report (27/7/2005) is inconsistent with the ensemble of other documentary sources. Much of points seem to relate to changes that were about to happen or were being considered in late spring/early summer 2005 and do not relate to the main body of care of those whose deaths are reviewed in this review. For example, no patient who died was admitted after the date where he stated that changes had been made in admission practices such as the use of the Waterlow score for pressure sore risk assessment (2/5/2005): also, no significant change was noted in the Daily Notes of the notes reviewed, or in the prescribing patterns. A reference to continence training must be considered in the light of the Director of Nursing's decision to stop the staff meetings in May 2005 as she felt that only a few staff contributed to the meeting and there was no interaction with anyone else. There is no documentary evidence of three care teams functioning from February as described by the proprietor. There was also no evidence of an Infection Control policy. The description of the recording of restraints is at variance with the rest of the documentary material. The defence of transcribing prescriptions by staff other than doctors, even when counter-signed raises concern. The delegation of medication administration, and no documentation of those who self-prescribe also raises concerns.

Outside review of the Nursing Home Inspection Team: Mr Martin Hynes and ERHA Heavy Dependency/Intermediate Care Beds Tender Process

In a separate review of the death of a resident prior in 2001, Mr Martin Hynes noted that there had not been any huge disparity in the number of complaints received regarding Leas Cross compared with other Nursing Homes in the area at the time when it had 38 residents. Mr. Hynes also notes that the Inspection Team reports do not state what criteria is used for reaching the conclusion that patients appeared to be well cared for. Mr. Hynes comments on the review process, but did not seem to be aware of the changes in the nursing homes inspection process in the Northern Area Health Board at the time, but does make the point that inspections should focus more on the quality of care and the resources that underpin this. Mr. Hynes in May 2005 recommends a high level inspection of Leas Cross by a team independent to those involved in previous inspections of Leas Cross, but events clearly overtook this recommendation.

As a result of a different inspection process by ERHA for High Dependency nursing home beds, the assessors were concerned at what they had found. Although Leas Cross had on paper seemed suitable for short listing for the tender for such beds in February 2005, on an assessment visit of 15/3/2005 it failed on the areas of quality of premises, acceptability to users and referrers and 'versatility, including ability to adapt to different patient/client needs on a patient centred way'. On this basis it failed for the tender for Intermediate Care and the tender for Heavy Dependency Care was not pursued. This was followed by a letter from the acting CEO of ERHA/HSE (ER) (4/4/2005) requesting clarification from the Assistant CEO of the HSE (NA) as to the standards of care. This again should have been taken as a warning signal of the gravest import.

In his reply to the Acting CEO of ERHA of 13th April 2005, presumably drawing on the visit of 7/8 April, the Assistant CEO of the HSE (NA) expresses concerns over care in Leas Cross. His concerns included: a) adequacy of medical care (and how the inspection team were relying on the proprietor ascertaining from the GP if, in the GP's opinion, the time spent in the nursing home was sufficient to provide the appropriate care required); b) skill mix, mentioning the large number of non-nationals and his belief that Leas Cross were to increase staff numbers and introduce more

supervisory staff. At this point the Assistant CEO of the HSE (NA) mentions that he is in the process of auditing the death rate generally within the 30 nursing homes in the areas, but was not at that time in a position to say if the death rate was higher in Leas Cross than any other nursing homes. He notes however that 80% of the current residents to population had dementia of varying degree and the same percentage had incontinence problems. He notes that he has been advised that there is willingness by the Leas Cross Management to engage constructively and that they were due to meet with the inspection team in four weeks time. From the limited review of the medical and nursing notes in 7/8 April the team concluded that there was no immediate danger to the current residents. He also notes that the HSE (NA) did not have data on deaths and death rates in the thirty nursing homes in the area.

Communications to the Nursing Home Inspection Team

Perhaps the most worrying aspect of the documentary review of the Nursing Home Inspection Team process (including senior management) was the apparent absence of any documentation to counter the perception that they failed to address the very serious concerns raised by various inputs other than the routine inspection process and to incorporate these into executive decisions on nursing homes. These include:

- Serious complaints by relatives about deficiencies in care
- Oral and written communications from mental health professionals at around the time of the transfer of patients from St Ita's Hospital

It is not immediately apparent that the HSE or the Inspection Team understood the significance of such communications given that a) it is difficult for relatives to make such complaints as they often feel that the resident is vulnerable should a complaint be made and b) oral and written complaints from senior health professionals are relatively unusual and need to be taken as a grave warning. It also seems that the written communications with senior health professionals are almost entirely one-way, with no evidence in writing of responses back to the senior clinicians of the NAHB/HSE (NA)'s satisfaction (or otherwise) with the standards of care.

My overall impression is that the concerns raised in the complaints to the HSE were very serious in nature and do not seem to have triggered an appropriate response. In particular, there seems to have been a marked failure to recognize the gravity of

negligence in pressure sore care. In the case of one patient with grave pressure sores, a Senior Area Medical Officer who was enjoined to review the medical care commented that 'the general care of the lady did seem adequate with the exception of the pressure sores': given that the pressure sores were the in large part the cause of her death, this does not seem to represent an appropriate response, but is also a reflection that the team did not use specialist medical assessment. Indeed, it seems unreasonable to ask for an assessment of quality of care from a doctor who is not clinically involved in the care of older people. A letter from a senior HSE (NA) manager to the family does not seem to recognize that the care in the case represented a catastrophic lapse of service provision that was unlikely to represent an isolated incident, or one would that would represent a culture of poor care that would be very resistant to change.

Most of the other complaints from family members are consistent with the poor standards of care reflected in the notes and in the nursing home inspection reports and should have triggered a more prompt and muscular response. In the interests of patient and family confidentiality I do not consider it helpful to further dwell on individual cases in this review, but in virtually all cases, the documentation of needs and care processes was inadequate: all those who have expressed concerns over care to the NAHB/HSE (NA) should have access to a debriefing of the case notes with a relevant professional, and their concerns should be considered by the Institutional Review Group announced by the HSE (NA) on 31/5/05 to review all areas of concern in line with the Department of Health and Children document 'Trust in Care'.

There are a small number of testimonials from families of residents expressing satisfaction with the care of their relative in Leas Cross.

Sequence of Communications from Mental Health Services for the Elderly re Leas Cross.

As this sequence of communications was comprehensive and well-documented, it will be outlined in some detail. It began in October 2003 with concerns raised by a consultant in old age psychiatry (Consultant A) over the need for follow-up of the patients transferred from St. Ita's Hospital to nursing homes and the requirement for an increase or reassignment of staff to follow up these patients. A letter within two weeks to the Director of Nursing, St. Ita's Hospital, clearly outlines the concerns of

two consultants in old age psychiatry (Consultants A and B) about the follow up of patients from St. Ita's Hospital, pointing out that many of these had been in the service for years. They particularly raised attention to the fact that 3 of the initial group of 14 patients discharged to Leas Cross Nursing Home had been referred to Beaumont Hospital and all had been quite seriously ill. They noted that nursing care appears to have been the issue in all of these – the last 2 patients had arrived with bronchial pneumonia, presumed to be secondary to aspiration, and one with dehydration. They specifically request that a named person from the hospital staff be in charge of following up nursing care issues in nursing homes during the transition period of at least two months. This is in contrast to the ongoing psychiatric illness issues which would be followed up by their own team but the consultants point out that the long-term nursing care issue needs to be addressed separately.

These concerns were amplified in the letter to the Director of the Nursing Home Inspectorate Team on 9th January 2004. They pointed out that 7 deaths had occurred since the transfer in September, 3 of which occurred over the Christmas period. Consultant A points out that the Consultant Geriatrician in Beaumont Hospital, spoke to the coroner regarding one of these deaths as there was a question of decubitus ulcers and where they were acquired. Consultant A was clearly sufficiently concerned to telephone the coroner's office to let them know of the death of a second patient. This letter was circulated widely, including to the clinical manager of St. Ita's Hospital, Director of Nursing, St. Ita's Hospital and the Area Manager, St. Ita's Hospital.

In a letter of 19th April Consultant A points out an issue that two of the nursing homes used by St. Ita's Hospital on the discharge initiative have had complaints issued about the care and are under review. She also points out that if nursing homes are left being short of money as a result of the new system of enhanced subvention rather than of contract beds than this cannot be good for patient care. This letter to the Chief Executive Officer of the NAIIB clearly outlines the inequities within the current system but also concerns that the process of enhanced subvention leaves patients vulnerable in the case of price rises.

In a letter 27th April 2004 to a senior officer of the NAHB (circulated to the CEO and ACEO of the Northern Area Health Board), Consultant A again points out that she has significant concerns over the discharge initiative and particularly the deaths occurring in one nursing home -- Leas Cross. She also expressed concern about the nursing home regulations in terms of inspection, process and powers of inspectors, staff levels and skill mix of staff, in particular the number of qualified staff nurses and staff training. In this Consultant A clearly states the willingness for herself and the Assistant Director of Nursing, St. Ita's to be involved in a review group of nursing homes in the area.

In a letter of 30th April 2004 to the Assistant Chief Executive for the Northern Area Health Board, Consultant A points out the concerns that the Northern Area Health Board were considering changing its policy towards funding beds in Highfield Alzheimer's Care Centre which were considered by the Consultants to be of high quality of care. Consultant A in this widely circulated letter clearly states concerns by both herself and the consultant geriatrician at Beaumont Hospital, of care in private nursing homes. This letter neatly summarises the concerns that in the absence of adequate public extended care facilities, that the private sectors as currently configured in nursing homes cannot deal adequately with end-stage dementia or patients with behavioural disturbance and that financial or other possible constraints may be limiting the health board from contracting to more expensive, but what are perceived to be better care, beds for this group of patients in a particular institution.

A memo of meetings between Psychiatry of Old Age and the Nursing Home Inspectorate documented as occurring on 26th May, 23rd Septembers and 5th November 2004 show the willingness of the Psychiatrists to get involved with the issues involved.

A memo exists of a letter which was not sent, but of issues discussed with the Director of Nursing of Leas Cross following a visit to Leas Cross Nursing Home in July 2004. Consultant A highlights that the main problem encountered on review visits was lack of qualified staff and auxiliary staff and basic nursing care to meet her patients' needs. She also notes a lack of stimulation, occupational therapy and supervision.

Of some concern were her findings from interviewing patients who were residents. A percentage of patients complained of inappropriate use of incontinence pads. An ambulant patient's shoes were missing for two days and relatives who were visiting at the time expressed their concerns to Consultant A. Four of the former St. Ita's patients were sitting in wheelchairs and others in old Buxton chairs. General personal hygiene was poor, clothes were grubby in appearance and a few patients had a strong odour of incontinence. Heating in the sitting room of the older part of building was stifling with an extremely hot large radiator. The staffing appeared inadequate with only one qualified staff nurse and 9 care staff caring for 65 residents in one area and one qualified staff nurses and 4 attendants for approximately 40 residents in another area. These concerns were also discussed with the Director of Nursing of St. Ita's.

A further matter of significant concern raised by the Consultant Psychiatrists was that the group with dementia as a primary diagnosis had a high mortality rate in Leas Cross. The admissions that were transferred to hospital were characterized by dehydration, aspiration pneumonia and skin care problems, raising concerns over adequacy of care. They note that staffing levels, skill mix, policies and procedures, staff training for nursing and non-nursing grades are pertinent areas of enquiry and state that the scope of the nursing home regulations and the remit of the current inspectorate need reviewing. These issues were discussed as with both the Director of Nursing and St. Ita's Hospital and with the Director of Public Health Nursing following a meeting in Leas Cross.

On 4th August 2004 the Assistant Director of Nursing in St. Ita's Hospital signalled the setting up of an ongoing review clinic for residents in Leas Cross on a monthly-six weekly basis by nursing staff and six monthly medical review of medication.

In a further letter to the Medical Superintendent, St. Ita's Hospital, Portrane, Co. Dublin on 7th October 2004, Consultants A and B point out that no patient had been transferred against the wishes of him/herself or his/her family in the discharge to nursing home process. Consultants A and B again pointed out that difficulties with respect to the care of the patients raised in relation to the numbers of qualified nursing staff – they point out that in some cases the nursing ratios are very low with just one

nurse and a number of care attendants looking after perhaps 40 or 50 patients. This can only be noted as a very serious indicator of concern on behalf of the Consultant of Old Age Psychiatry about the adequacy of care in the nursing homes.

Consultants A and B clearly point out the problems encountered with previous discharge initiatives to nursing homes, in a further letter of 2nd April 2005 to the Director of Public Health Nursing, Area 8, re long-term beds in nursing homes.

Following this a letter of 6th April 2005 from a senior officer of the HSE (NA) noted the request of the Psychiatry of Old Age Team to cancel six beds in Leas Cross Nursing Home and move them to other nursing homes. The senior officer supported the request, stating that this was without prejudice to Leas Cross Nursing Home who she noted was currently proactively engaged in a service review with the Northern Area Inspection Team.

A report from the Director of Nursing of St Ita's to the 'Chief Officer' of the HSE (NA) (24/5/2005) on the transfer of patients from St Ita's Hospital to Leas Crossdid not make any reference to the concerns expressed over care in Leas Cross.

Finally, on the 8th June 2005 Consultant A wrote to the Director of Primary Community & Continuing Care correcting a statement by the Director of Primary Community & Continuing Care that staff at St. Ita's who had been conducting clinics at Leas Cross had noticed nothing wrong in the nursing home. She noted that she had repeatedly transmitted concerns by correspondence to various levels of the NAHB/HSE (NA) management regarding issues arising from Leas Cross Nursing Home and in particular the lack of qualified staff on the ground and also commenting that a health board paying as low price as possible for beds may not be giving nursing homes a chance to provide a top quality service. In response to their concerns and complaints received by the nursing home inspectorate group set up a working group involving public health nursing, themselves and the Old Age Psychiatrists to discuss the situation regarding nursing homes and the department of social work in Beaumont Hospital was kept appraised of any current happenings or concerns. This group was independent of the work of the Director of the Nursing Home Inspection Team. She

did point out that she has been more satisfied with the care at Leas Cross in the time preceding June 2005.

Comment

In general, the Nursing Home Inspection Team as constituted by the NAHB/HSE (NA) represented an advance on the lack of a formal organized structure prior to this. However, from the documentation supplied it does not appear that it was set up with adequate and clear instruction from the NAHB/HSE (NA) in terms of staffing, expertise and in particular empowerment to take significant action to protect residents of long term care. The leader of the Inspection Team clarified this to the Department of Health and Children in a report of 2005 as to how ineffective the legislation was.

It must be stated that the reviewer has no documentary evidence of more effective functioning Nursing Home Inspection Teams in any other area of Ireland, particularly prior to the screening of the Prime Time documentary in May 2005.

Of particular concern is the lack of documentation that the NAHB/HSE (NA) management responded to the very serious nature of the written concerns expressed by senior clinicians in Old Age Psychiatry and Geriatric Medicine, of the very poor quality of care detected in the review of complaints by families, of the clear expression of concern by the Dublin City Coroner over the death of one patient which was in the public domain, and of the sustained length of time it took to appreciate that Leas Cross was not going to significantly alter its ways.

Public health oversight of standards, dependency, morbidity and mortality in long term care.

As noted above, there is almost no meaningful data on standards, dependency, morbidity and mortality in long term care reports. There were no meaningful connections between the Nursing Home Inspection Team, the coroner's office, and the obligatory reporting of deaths to the health board was shambolic in execution for many nursing homes in the NAHB/HSE (NA).

The Long Stay Reports of the Department of Health and Children are statistics collected on long stay care since 1997, and it is noteworthy that the returns from EHB/ERHA have been below the average for the whole country each year. While the dip to 1.3% in the 1999 figure relates to the change from the EHB to ERHA, the fact

that up 40-53% of institutions may not reply in other years means that these figures are not likely to be helpful in informing policy or debate on extended care.

	1997	1998	1999	2000	2001	2002	2003	2004
Overall	86.6	77	46.9	68.3	84.9	87.3	87.3	85.4
EHB	82	60	1.3	47.1	68.2	85.4	84.6	79.7

Table 5: Response rate of EHB/ERHA and national long-term care facilities to the Department of Health and Children annual survey of long term care (public and private)

A further weakness is exposed by the discrepancies between the returns to the Health Board/HSE from Leas Cross for this report, and the actual numbers of discharges and admissions from the register.

Year	Number of beds	Number of Patients	Admissions declared	Register admissions	Register discharges
1998	**No Return**				
1999	**No Return**				
2000	**No Return**				
2001	35	-	23	23	23
2002	110	53	37	65	49
2003	111	90	127	130	84
2004			39	139	125

Table 6: Comparison of numbers of admissions from the register and those declared to the annual report on long term care of the Department of Health and Children (Source, Department of Health and Children)

It is absolutely vital that the HSE should have a clear oversight of dependency, standards of care, morbidity and mortality in long term care units, public, private and voluntary, in Ireland. The clear candidate is the immediate implementation of the Minimum Data Set. The Minimum Data Set (MDS) as a part of the Resident Assessment Instrument (RAI) was developed by the Health Care Financing Administration (HCFA) to assist US nursing homes in developing a comprehensive

care plan for each resident, following the realization of scandalously low levels of care by the Institute of Medicine. The Institute of Medicine (IOM) report in 1986 identified uniform resident assessment as essential to improvement in the quality of care delivered to residents and reform of the survey process. When the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) became law in 1987, HCFA began a process of public comment leading to a final rule implementing the law. The process was completed on December 22, 1997 and includes the requirement to electronically encode and transmit all MDSs to the State in which each facility is licensed: the equivalent in Ireland would be the HSE.

The Minimum Data Set is a standardized assessment instrument specified by HCFA and optionally supplemented by States (with approval from HCFA) which collects administrative and clinical information about residents. The MDS is a very complete and well-designed assessment which, when used with the Resident Assessment Protocols and professional judgment, is a comprehensive assessment and care planning tool.

The MDS collects assessment information on each resident's characteristics, activities of daily living (ADLs), medical needs, mental status, therapy use, and other things involved in comprehensive planning for resident care. The MDS is used to assess every resident in state licensed facilities on admission, with a quarterly review and annual re-assessment. Significant change in a resident's condition causes a new comprehensive MDS (including review of the care plan) to be completed to insure the resident receives appropriate care.

The MDS can serve as the primary clinical assessment tool for all residents within nursing facilities, as it is a comprehensive yet reasonably brief assessment. The MDS (with additional triggered assessments) is sufficient for most care setting. Other assessment forms in use in facilities should be examined for overlap with the MDS and duplicative forms eliminated.

In the USA there are also sanctions for intentionally falsifying MDSs: fines of up to $1,000 for each MDS a nurse falsifies, and a fine of up to $5,000 for each MDS that someone causes to be falsified. (Clinical disagreement does not constitute fraud or

falsifying - if it is a legitimate clinical issue.) Accurately portraying the resident is the goal. If reviews by other clinicians identify inaccuracies in an MDS, changing the MDS to reflect the resident accurately is expected. Changes made to secure a higher payment, which are not supported by the registered nurse's assessment, may lead to sanctions.

The MDS can also be used to generate Resource Utilization Groups (RUG-III), effectively a case mix system which sets levels of dependency for a resident based on the functional support requirement and medical needs of each resident. Using the MDS, a computer programme first calculates an ADL score, a depression index, and a cognitive performance score. It then identifies each of the major groupings for which the resident is qualified. The ADL index, depression index and cognitive performance scales are also very useful clinically. They can help identify residents with depression and help guide the care planning to help the resident cope or resolve the depression. The cognitive performance scale can assist during care planning to set realistic goals for residents, as well as to identify changes in cognition that could be reversed or treated.

So the MDS is clinically useful, reasonably brief, computerized, and fulfils four goals: it supports individual care plans, it can help generate dependency levels (through RUGS), it assists regulatory authorities and allows for the collection of meaningful statistics nationwide. Overall, it has been deemed to be successful by both nursing home staff and regulators [42 43] and is now used widely through the developed world [44-48]. It is perhaps unique in its robust ability to support improved standards and research in nursing homes [49], although it will not do so on its own, and needs to be implemented in a context which recognizes the importance of appropriate philosophies of care, staff training and resourcing.

Policy and legislation

Although the official government policy of the Department of Health and Children, as expressed in *The Years Ahead*, is to provide an adequate and supportive environment for extended care, there is scant evidence that the Department has taken cognizance of the huge concerns internationally over the quality of care of older people in long term care, or has shown a sense of urgency about the threat posed to a very vulnerable group of people. Despite having been advised many times of these concerns by their own advisory body on older people, the National Council on Ageing and Older People, as well as by advocacy and professional groups, there is only the briefest mention of the potential of poor care standards in national policy. Twenty-three years after *The Years Ahead* was made official health policy, its recommendation for an independent inspectorate for residential care remains unfulfilled.

The first national health strategy, *Shaping a Healthier Future* (1994), reiterates the aim of *The Years Ahead* to 'provide a high quality of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home', but does not pursue any specific goals in this regard and again seems oblivious to the possibility of poor quality care in Irish nursing homes.

The most recent national health strategy, *Quality and Fairness*, makes reference to standards of care in residential care, and I have received no evidence to suggest that these have been followed up in any significant way prior to the Prime Time programme on Leas Cross.

The relevant features in the 2001 Health Strategy are:

a) improved staffing levels in extended care units (unspecified)
b) the remit of the Social Services Inspectorate to be extended to include residential care for older people
c) national standards for community and long-term residential care of older people to be prepared.

No documentation has been offered to me suggesting movement on these objectives prior to the Leas Cross Prime Time programme, although the National Director of Services for the Elderly has been charged with developing standards of care since the summer of 2005.

The deeply deficient Nursing Home Legislation and Regulations have been tolerated well beyond what the time span of what might be considered to be reasonable, and has been reasonably criticized as prioritizing the property rights of those providing the service ahead of the complex needs of the residents [50]. The lack of standards of care available to residents contrasts pitifully with the standards for residential care for children which are comprehensive and easily understood [51], and it is was with some surprise that the reviewer noted a claim in the OECD overview of long term care that Ireland has put into place national standards of care (page 72) [52].

A Cabinet Member (there is some inconsistency in the title) is documented as being briefed on these deficiencies on 30/5/2005, and the Assistant Secretary of the Department of Health and Children received a comprehensive memo on the grave deficiencies of the current legislation/regulations on 24/5/2005 from the National Director of Services for Older People.

The Government Working Group on Elder Abuse, *Protecting our Future*, also drew attention to the high likelihood of abuse occurring in long-term care: *'institutional abuse can occur which may comprise of poor care standards, lack of a positive response to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service'.' Protecting our Future,* adopted as official health policy in 2002, made a recommendation that existing Government policy — *The Years Ahead*, (as updated by *The Years Ahead — A Review of Implementation of its Recommendations*) and *Quality and Fairness* (which includes *An Action Plan for Dementia*) be urgently and fully implemented. In addition, they agreed with the NCAOP that urgent attention should be given to the provision of a formal framework to ensure quality of care for older people living in both community and institutional settings.

Funding

It is clear from international surveys that adequate funding is a key element of providing satisfactory care for older people in long term care [53]. Worryingly, even in a relatively mature health and social care system such as the UK, there is evidence that there are frequent disparities between the fees that state agencies are willing to pay and the full, reasonable cost of long-term care {Joseph Rowntree Foundation, 1998 #960}. The

Joseph Rowntree Foundation calculated that UK nursing homes were underfunded by £1 billion (€1.6 billion) in 2002, and that the average weekly charge should rise from £385 to £459 (€616 to €734 per week) [54].

Although figures are not available for the financing levels of public and voluntary long-term care, the most recent review of average weekly fees in the annual report of the Irish Nursing Home Organization makes for disturbing reading [55]. As can be seen from table 7, the fees in a country which has one of the highest costs of living in the developed world are worryingly low.

Health Board	Average weekly rate
ERHA	€697
MHB	€464
MWHB	€474
NEHB	€589
NWHB	€479
SEHB	€528
SHB	€575
WHB	€495

Table 7: Average weekly fees by health board in 2004 [55].

It is not surprising that the forthcoming NCAOP study found that the levels of qualified nursing staff in private nursing homes was approximately half that of the public sector, and an urgent review of appropriate funding in the private sector needs to be undertaken in conjunction with an improvement in requirements for staffing, training and record keeping.

Funding and NAHB/HSE (NA)

In the light of the above data, and also in terms of the failure of central government to clearly articulate the complex care needs of older people in nursing homes, it might be expected that this would be reflected in a failure to adequately fund Health Boards/HSE for such care.

The NAHB provider plan for 2003 points out that they started with a deficit of €6.9m

in their allocation of €520m. The funding for the following services was increased (even if modestly) from 2002 to 2003 in Children and Families, Services to Ensure Social Inclusion, Primary Care, Cardiovascular Strategy, Cancer and Palliative Care Services, Environmental Health Services, unstated for other and reduced in Intellectual Disability Services, Physical and Sensory Disability Services, Mental Health Services, Alcohol and Addiction Services and Corporate Services. For Services for Older People, the budget for 2003 (€60.225m) was slightly less than the 2002 budget (€60655m), included some new developments, and states that the Board will endeavour to provide the same service as 2002 subject to financial constraints.

Minutes of a meeting on employment ceilings on 21/5/2003 notes that 30 beds were already closed and 70 more closures were necessary in St Mary's Hospital. The Department of Health were informed in a letter of 28/1/2004 by the Deputy CEO of the NAHB that 62 public long term care beds had been closed due to staff ceiling restrictions and that significant deficits existed in the Board's residential settings and community services.

A memo of a meeting of an Assistant CEO of the NAHB and a number of senior staff on the topic of nursing home inspections (2/9/2004) mentions that the board were falling behind in their inspections, discussed the implications of the Rostrevor case, and mentioned the huge demands on the Community Public Health Nursing Service in the context of ongoing vacancies in the service. This seems to be the meeting that led to the more organized Nursing Home Inspection Team, with the release of a General Manager, and the appointment of an Assistant Director of Public Health Nursing to be freed up for inspections. It is not clear to this reviewer whether or not this took account of the reductions in public health nursing staff associated with the employment ceiling.

A report on public health nursing in Community Care Area 8 (13/12/2005) notes that the ceiling on staffing allows for 78.59 whole-time equivalents in an area where there had been previously 88 whole-time equivalents

Of relevance to the support of Nursing Home Inspection Teams, a memo from an ACEO of the NAHB on 18/6/2004 noted that the Area Medical Officer levels had

dropped by approximately 50%, from 19.8 AMO's to 10.4 AMO's, over a period when the population in the catchment area had grown by 7%. It was pointed out in this memo that the NAHB had fallen behind on nursing home inspections and notes that 'with the size of some nursing homes (over 100 beds) and the huge increase in complaints the work load in this area can only be expected to increase'.

A more generic concern about general funding for HSE (NA) not matching the population growth in the area was expressed by an Assistant CEO of the HSE (NA) in a letter to the Director of the PCCC on 5/4/2005.

Irish Health Services Accreditation Board

Just as the Department of Health and Children policy seems be little influenced by the world-wide developments in response to concerns over the quality in long-term care, the IHSAB document on proposed accreditation of long term care represents a disturbing lack of insight into how under-developed the concept of quality of long-term care is in the Republic of Ireland. Policing standards is clearly essential, but pre-supposes that such standards are in place. They are not! Instead, there is significant under-provision of skilled nursing staff in both public and private healthcare systems; there is no systematic public health overview of morbidity and mortality in nursing homes; there is no common form of record keeping to reflect the sophisticated and complex nature of care required in long-stay units; legislation and regulations in this area are inadequate; and Nursing Home Inspection Teams are poorly resourced. In three of the five programmes for the Diploma in Gerontological Nursing, the candidates are not trained in calculating staff numbers required from the numbers and dependency. Finally, funding for the private sector seems to fall far short of the levels that might be desirable to provide adequate care. In its present configuration, the proposed accreditation schedule looks like a cosmetic and irrelevant exercise which instead of helping quality improvement could divert attention from the real issues.

The accreditation needs to be radically reviewed to allow for specific attention to minimum staffing standards for nursing, doctors and the therapies including social work, as well as the appropriate and realistic use of the Minimum Data Set.

Eastern Health Board/ERHA and other Health Boards

Aside from the one ERHA report which clearly sets out deficiencies in care [12], the Ten Year Plan for the EHB does not seem to recognize the possibility of significant lapses in care in long-term care settings [56].

Within ERHA, there is data which should cause concern from a review of nursing staffing and dependency in public long stay facilities in the former South Western Health Board [57]. This survey of public facilities showed significant discrepancies between the actual and identified registered nursing hours per resident in one large facility. The recommended hours of registered nursing input per patient was identified as 3.8 hours compared to an actual availability of 1.8 hours. This was exacerbated in this case of this institution as it also had the lowest number of care assistant hours available to patients. The RCN assessment tool offers a significant advantage over other tools in addressing the problem of the ambiguity surrounding the care assistant grade as this tool requires the assessor to identify those aspects of care which require the specific intervention of a Registered Nurse at one of four levels of intervention and necessitates that the nurse makes decisions about those levels of care if she feels it can be safely delegated to the care assistants available. In this way it can match the patients' needs to both the required and available competencies. This work highlights the inappropriateness of using non specific staff to patient ratios as a means of determining staff levels but rather the need to determine appropriate staffing complement and skill mix.

In the former Western Health Board, a report in 2005 outlined similar shortcomings in nursing staffing in public long-term care facilities in the HSE Western Area [58]. Using recognized criteria, the author noted that the current nursing staff complements were not sufficient to meet the individualised care requirements that would be identified through the care planning process, particularly in respect of lengthening the resident's day and meeting the social and psychological care need of the residents. The report identified a shortfall of 128 whole time equivalents of staff for five public long term care units in the region. The constraints identified pertaining to staffing resource issues and their impact on the delivery of high quality care to older people point to a

system-wide failure to appropriately support long term care which is not confined to the private nursing-home sector. These constraints include:

- insufficient nursing staff
- less than adequate definition of roles and responsibilities within the nursing and support staff team in respect to healthcare assistants, housekeeping, catering and laundry management
- inefficient deployment of the staff resource in an effective and flexible manner to meet the needs of the service
- insufficient protected management time for Clinical Nurse Managers
- the age profile of the nursing and support staff resource
- the ability of the services to recruit and retain staff
- insufficient Therapies and Recreational Activities

Irish Nursing Home Organisation

The Irish Nursing Homes Organisation in June 2005 issued a position paper on its policy for standards. The Irish Nursing Homes Organisation stated that it was undertaking research into international protocol to determine what the minimum levels of care should be. In the intervening time period the Irish Nursing Homes Organisation recommended a minimum staffing level below which nursing homes should not go, but they do not differentiate between nursing and care assistants, and do not relate these to patient dependency. They quote a level recommended by the Western Health Board which is as follows: - Nursing/Care Assistants minimum staff resident ratio morning shift 8.00 am - 2.00 p.m. one staff to seven residents, afternoon and evening shift 2.00 p.m. – 8.00 p.m. one staff to eight residents, night shift 8.00 p.m. – 8.00 am one staff to fifteen residents.

The Irish Nursing Homes Organisation recommends mandatory levels of training for care staff in both public and private facilities. They state that both nursing care assistants and nursing staff should have a mandatory time requirement of staff training covering issues such as safety and health at work, hygiene, nutrition, palliative care, and communications. The Irish Nursing Homes Organisation recommends that private nursing homes should maintain a register of approved staff training. The Irish Nursing Homes Organisation is particularly concerned that many care assistants have no formal training as a consequence do not even know what best practice is.

Professional bodies

Apart from the Irish Society of Physicians in Geriatric Medicine [11] and the Commission on Nursing, I could not find any specific direction from other professional bodies alerting their members to the special and complex needs of older people in long term care. Given the lead role of nursing in the direction and provision of care in nursing homes, an Bord Altranais might well consider specific guidance to the nursing profession in this area, and more specifically to those considering Director of Nursing posts. This is particularly relevant in the light of the fairly detailed concerns outlined by the Commission on Nursing eight years ago. The Commission on Nursing (1998, section 9.4) stated that it was concerned about the anecdotal information supplied to it in relation to the conditions and staffing levels in care of the elderly and it recommended that the Department of Health and Children examine conditions and staffing levels in care of the elderly services as a matter of urgency. They also stated that apart from the effect on the standards of care, staffing levels impact on the ability of staff to attend educational courses. In section 9.6 of this document they noted that private nursing home bed provision is increasing significantly and the Commission had considered that nurses working in these care of elderly settings should be encouraged and facilitated to update their skills and knowledge. The Commission recommended that application for a renewal of registration of nursing homes should indicate the opportunity for educational update provided to nursing staff.

Conclusions

The principal finding was that the documentary evidence was consistent with the care in Leas Cross being deficient at many levels, and highly suggestive of inadequate numbers of inadequately trained staff, and furthermore no documentary evidence that the management of the nursing home and clinical leadership recognized the ensemble of care provision required to meet the needs of the residents. The overall documentary findings are consistent with a finding of institutional abuse: *'institutional abuse can occur which may comprise of poor care standards, lack of a positive response to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service''*. The documentation was consistent with a deficiency in the regulatory process of the Health Board/HSE (NA) at all levels in its response to the clear deficits uncovered, and in its assessment that the proprietor and senior clinical management at Leas Cross had the insight or capability to effect meaningful change. There is no record of senior management in the HSE (NA) appearing to give due weight to written concerns by senior clinicians about standards of care.

The context within which this was occurred was that of policy, legislation and regulations which have over many years failed to adequately articulate and address the complex needs of this most vulnerable and frail population of older Irish people. The revenue funding associated with long term care is also deficient and contributes to the neglect of this most vulnerable group of older people. With a few honourable exceptions there has been a systematic failure by government, health boards and professional bodies to address the issue of appropriate quality of care for older people with the highest levels of health and social needs in Irish society. Given this lack of engagement by the government and health system with the very real concerns over quality of care in long term care, it would be a very major error to presume that the deficits in care shown in Leas Cross represent an isolated incident. Rather, given the lack of structure, funding, standards, and oversight, they are very likely to be replicated to a greater or lesser extent in institutions throughout the long term care system in the country. This is not to deny the motivation, kindness and dedication of very many who work in nursing homes, but rather represents a failure of government and the health system to address both the context and standards of care in the light of widespread national and international concern over quality of care in nursing homes. Urgent action is needed to remedy this system failure so as to ensure that vulnerable

older Irish people can be confident that they will be cared for a in safe and caring environment with an optimal quality of both life and care.

Recommendations

Primary

1. The Department of Health and Children and the Health Services Executive must in its policy, as a matter of urgency, clearly and formally articulate its recognition of the complex health and social care needs of older Irish people requiring residential long term care.
2. The provision of this care should be clarified formally in terms of adequate numbers of adequately trained nursing and health care assistant staff, with adequate governance structures in terms of senior nursing staff. The minimum numbers of nursing staff should be calculated using a modern instrument such as the RCN Assessment Tool or the Nursing Needs Assessment Tool [1], and at least half of nursing staff these should have the diploma in gerontological nursing. A sufficient number of middle and senior grade nursing staff, relative to the size of the nursing home, will be needed to be added to the calculated total to ensure an adequate care infrastructure. Directors of nursing in all long term care facilities should have the diploma in gerontological nursing or equivalent. All health care assistants should have FETAC training or equivalent. Appropriate acculturation and gerontological training should be provided for all non-national staff.
3. An electronic version of the Minimum Data Set should be made mandatory for all patients in nursing home care to assist in the development of individual care plans, the monitoring of quality and the provision of national statistics on dependency, morbidity and mortality.
4. Funding arrangements for nursing home care should be urgently reviewed by the Department of Health and Children and HSE to ensure that it is matched to the provision of high quality care to older people in long term care
5. The Nursing Home Legislation needs to be urgently updated to put the above provisions into place, to place the older person at the centre of its deliberations, and to adequately guide both provision of quality of care and

quality of life, as well as providing timely and appropriate powers to the Social Services Inspectorate to effect change.

6. Pending the introduction of the Social Services Inspectorate, Nursing Home Inspection teams need to be immediately developed and staffed with relevant expertise to be able to detect poor practice patterns, and vigorously supported by the HSE in their recommendations. All written queries/concerns should have a rapid assessment and written response.
7. The Irish Health Services Accreditation Board process for long term care must be radically reviewed to reflect the realities of long term care in Ireland. This would include the determination of not only training but also appropriate numbers of nursing and health care assistants proportionate to the case-mix of residents, as well as congruity with MDS data from the nursing home.
8. For those who are not looked after by the GP who provided their care while at home, the medical cover must be more clearly and unambiguously specified in terms of relevant training (at least the Diploma in Medicine for the Elderly or equivalent), responsibilities and support from the HSE.
9. Multi-disciplinary team support must be clearly specified in terms of both meeting need but also the facilitation of team work, and requires at a minimum: physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work.
10. Specialist medical support (geriatric medicine and psychiatry of old age) need to be developed to provide formal support to the medical officer, nursing staff and therapists not only in the care of patients but also in the development of appropriate care guidelines and therapeutic milieu. These services need protected access to dedicated specialist in-patient facilities for appropriate assessment and support of those in long term care.
11. Professional bodies with regulatory responsibilities for healthcare workers should clarify the highly specialized needs of older people in residential care in guidance to their members, with particular emphasis on the scope of practice of those who accept senior positions.
12. The public health overview must of residential care must be strengthened. The HSE must coordinate data nationwide, not only on the MDS of all residents of long term care, but also of all deaths of residents, including

those that occur in hospital, and should also ensure seamless communication with coroners throughout the country.

Local recommendations

a) As this review did not replace standard complaints and redress procedures of the NAHB/HSE (NA), the HSE (NA) must ensure that it provides a timely and appropriately supported service to address the concerns of older people and their relatives about the quality of care that they or their loved ones may have received, or are receiving in long term care in the HSE Northern Area.

b) Residents (and their families) of any nursing homes that scored poorly in the ERHA tendering process in 2005 for Heavy Dependency/Intermediate Care Beds should be informed of this as a matter of some urgency, as there is a high likelihood that there are residents with high or maximum dependency in all of these nursing homes.

Acknowledgements

I would like to acknowledge the unconditional cooperation of the former proprietor of Leas Cross, and the two most recent former Directors of Nursing of Leas Cross, in providing documentary evidence for the purposes of this review.

Equally, I would like to acknowledge the unconditional support of senior management in HSE (NA) to support the execution of this review.

The Department of Health and Children, the Eastern Regional Health Authority, Beaumont Hospital, and the Departments of Old Age Psychiatry, St Ita's Hospital and the Department of Geriatric Medicine in Beaumont Hospital, facilitated the provision of documents to be reviewed.

The Dublin City Coroner, Dr Brian Farrell, and the Dublin County Coroner, Dr Ciarán Gallagher, were unstinting in their support for this review.

Special thanks are also due to Mr Charles McGuinness, Registrar for Deaths, for his efficient and pro-active help with extracting copies of the death certificates used in this review.

Finally, I would like to thank Ms Karen Quinn, Loreto Hogan and all their team members at HSE (NA) for the administrative, technical and secretarial support which made this review possible.

References

1. Slater P, McCormack B. Determining older people's needs for care by Registered Nurses: the Nursing Needs Assessment Tool. *J Adv Nurs* 2005;52(6):601-8.
2. Manton KG, Vertrees JC, Wrigley JM. Changes in health service use and mortality among U.S. elderly in 1980-1986. *J Aging Health* 1990;2(2):131-56.
3. Coughlan T, O'Neill D. General hospital resources consumed by an elderly population awaiting long-term care. *Ir Med J* 2001;94(7):206-8.
4. Bajekal M. Health Survey of England 2000: characteristics of Care Homes and their residents. London: Stationary Office, 1999.
5. Challis D, Mozley CG, Sutcliffe C, Bagley H, Price L, Burns A, et al. Dependency in older people recently admitted to care homes. *Age Ageing* 2000;29(3):255-60.
6. Bowman C, Whistler J, Ellerby M. A national census of care home residents. *Age Ageing* 2004;33(6):561-6.
7. Hancock GA, Woods B, Challis D, Orrell M. The needs of older people with dementia in residential care. *Int J Geriatr Psychiatry* 2006;21(1):43-9.
8. Institute of Medicine. *Improving the quality of care in nursing homes*. Washington: National Academy of Science, 1986.
9. Harrington C, Kovner C, Mezey M, Kayser-Jones J, Burger S, Mohler M, et al. Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *Gerontologist* 2000;40(1):5-16.
10. Fahey T, Montgomery AA, Barnes J, Protheroe J. Quality of care for elderly residents in nursing homes and elderly people living at home: controlled observational study. *Bmj* 2003;326(7389):580.
11. O'Neill D, Gibbon J, Mulpeter K. Responding to care needs in long term care. A position paper by the Irish Society of Physicians in Geriatric Medicine. *Ir Med J* 2001;94(3):72.
12. ERHA. *Services for older people: review of the implementation of the Ten Year Action Plan for Services for Older People 1999-2008*. Dublin: ERHA, 2001.
13. Cohen JW, Dubay LC. The effects of medicaid reimbursement method and ownership on nursing home costs, case mix and staffing. *Inquiry* 1990;27:183-200.
14. Freiman MP, Murtaugh CM. The determinants of the hospitalization of nursing home residents. *J Health Econ* 1993;12(3):349-59.
15. Beringer T, Flanagan P. Acute medical bed usage by nursing-home residents. *Age Ageing* 1998;27(5):659.
16. Beringer TR, Flanagan P. Acute medical bed usage by nursing home residents. *Ulster Med J* 1999;68(1):27-9.
17. Spector WD, Selden TM, Cohen JW. The impact of ownership type on nursing home outcomes. *Health Econ* 1998;7(7):639-53.
18. Murphy K, O'Shea E, Cooney A, Shiel A, Hodgins M. IMPROVING QUALITY OF LIFE FOR OLDER PEOPLE IN LONG-STAY SETTINGS IN IRELAND. Dublin: NCAOP, in press.
19. Brennan J, O'Neill D. Contracted beds in private nursing homes: not a solution to long term care needs in Dublin. *Ir Med J* 2001;94(7):218.
20. Aiken LH, Mezey MD, Lynaugh JE, Buck CR, Jr. Teaching nursing homes: prospects for improving long-term care. *J Am Geriatr Soc* 1985;33(3):196-201.
21. Mezey M, Fulmer T. The future history of gerontological nursing. *J Gerontol A Biol Sci Med Sci* 2002;57(7):M438-41.

22. Raines JE, Wight J. The mortality experience of people admitted to nursing homes. *J Public Health Med* 2002;24(3):184-9.
23. Murphy M, Connolly C, Coakley D, Walsh JB, Cunningham C. Median survival of patients admitted to nursing homes from an
acute general hospital. *Ir J Med Sci* 2005;174 (Suppl 2):35.
24. van Dijk PT, Mehr DR, Ooms ME, Madsen R, Petroski G, Frijters DH, et al. Comorbidity and 1-year mortality risks in nursing home residents. *J Am Geriatr Soc* 2005;53(4):660-5.
25. Flacker JM, Kiely DK. Mortality-related factors and 1-year survival in nursing home residents. *J Am Geriatr Soc* 2003;51(2):213-21.
26. Spector WD. Correlates of pressure sores in nursing homes: evidence from the National Medical Expenditure Survey. *J Invest Dermatol* 1994;102(6):42S-45S.
27. Department of Health. Essence of Care. London: Department of Health, 2001.
28. Agency NM. Essence of Care: Patient-focused benchmarks for clinical governance. Leeds: NHS Modernisation Agency, 2003.
29. Abel RL, Warren K, Bean G, Gabbard B, Lyder CH, Bing M, et al. Quality improvement in nursing homes in Texas: results from a pressure ulcer prevention project. *J Am Med Dir Assoc* 2005;6(3):181-8.
30. Di Maio VJ, Di Maio TG. Homicide by decubitus ulcers. *Am J Forensic Med Pathol* 2002;23(1):1-4.
31. Lahmann NA, Halfens RJ, Dassen T. Prevalence of pressure ulcers in Germany. *J Clin Nurs* 2005;14(2):165-72.
32. Kelly O. Alzheimer patient's bed sores extended into bone, inquest told. *Irish Times* 2005(27 January).
33. Newman C. Inquest told of woman's bedsores. *Irish Times* 2005(31 March).
34. O'Keeffe ST. Down with bedrails? *Lancet* 2004;363(9406):343-4.
35. Schnelle JF, Bates-Jensen BM, Levy-Storms L, Grbic V, Yoshii J, Cadogan M, et al. The minimum data set prevalence of restraint quality indicator: does it reflect differences in care? *Gerontologist* 2004;44(2):245-55.
36. Naidoo P. Eating, drinking and swallowing disorders in an extended care facility. *Ir J Med Sci* 2005;174 (Suppl 2):60.
37. Horn SD, Buerhaus P, Bergstrom N, Smout RJ. RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs* 2005;105(11):58-70; quiz 71.
38. Priester R, Reinardy JR. Recruiting immigrants for long-term care nursing positions. *J Aging Soc Policy* 2003;15(4):1-19.
39. Watson R. Practical ethical issues related to the care of elderly people with dementia. *Nurs Ethics* 1994;1(3):151-62.
40. Ford P, McCormack B. Determining older people's need for registered nursing in continuing healthcare: the contribution of the Royal College of Nursing's Older People Assessment Tool. *J Clin Nurs* 1999;8(6):731-42.
41. Nursing Home Inspectorate Team. NAHB Report to the HSE. Dublin: HSE, 2005.
42. Marek KD, Rantz MJ, Fagin CM, Krejci JW. OBRA '87: has it resulted in positive change in nursing homes? *J Gerontol Nurs* 1996;22(12):32-40.
43. Marek KD, Rantz MJ, Fagin CM, Krejci JW. OBRA '87: has it resulted in better quality of care? *J Gerontol Nurs* 1996;22(10):28-36.

44. Jensdottir AB, Rantz M, Hjaltadottir I, Gudmundsdottir H, Rook M, Grando V. International comparison of quality indicators in United States, Icelandic and Canadian nursing facilities. *Int Nurs Rev* 2003;50(2):79-84.
45. Carpenter GI, Hirdes JP, Ribbe MW, Ikegami N, Challis D, Steel K, et al. Targeting and quality of nursing home care. A five-nation study. *Aging (Milano)* 1999;11(2):83-9.
46. Topinkova E, Sgadari A, Haas T. [Urinary incontinence in patients in long-term institutional care. Results of an international study in 8 countries]. *Cas Lek Cesk* 1997;136(18):555-8.
47. Jorgensen LM, el Kholy K, Damkjaer K, Deis A, Schroll M. "RAI"--an international system for assessment of nursing home residents]. *Ugeskr Laeger* 1997;159(43):6371-6.
48. Morris JN, Fries BE, Steel K, Ikegami N, Bernabei R, Carpenter GI, et al. Comprehensive clinical assessment in community setting: applicability of the MDS-HC. *J Am Geriatr Soc* 1997;45(8):1017-24.
49. Mor V. A comprehensive clinical assessment tool to inform policy and practice: applications of the minimum data set. *Med Care* 2004;42(4 Suppl):III50-9.
50. Mangan I. Deficiencies of the law relating to care for older people. In: O'Dell I, editor. *Older people in modern Ireland: essays on law and policy*. Dublin: First Law, 2006:353-371.
51. Department of Health and Children. National Standards for Childrens' Residential Care. Dublin: Stationery Office.
52. The OECD Health Project. Long-term care for older people. Paris: OECD, 2005.
53. Royal College of Nursing. Impact of low fees for care homes in the UK. London: Royal College of Nursing, 2004.
54. Laing W. *Calculating a fair price for care: A toolkit for residential and nursing care costs*. London: The Policy Press, 2002.
55. INHO. Annual Private Nursing Home Survey 2004. Dublin: INHO, 2005.
56. Eastern Health Board. Ten Year Action Plan for Services for Older People. Dublin: Eastern Health Board, 1999.
57. Ni Dhomhnaill E. Review of Staffing Levels in Public Nursing Homes. Naas: SWAHB, 2003.
58. O'Reilly MF. Review of Nursing and Support Staff Team Requirements: A Blueprint for Collaborative Engagement with Stakeholders. Galway: Older People Services, HSE Western Area, 2005.

Appendix 1 Final Report o
Regulation 5(b) of the Nursing Homes (Care and Welfare) Regulations 1993

The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home: (b)a high standard of nursing care:

Care is delivered on a task by task basis and is not directed by a registered nurse. Individual patient needs are not identified so as to highlight the direct care interventions required and to support the appropriate delegation of duties e.g. pressure area management, urinary / faecal incontinence, wound management/skin care, dementia care and general provision of care.

Pressure Area Management-

- It is recognised that patients were assessed using a scoring tool (Waterlow). However the results of this were never utilised as part of any individualised patient care plan.
- There are 30 electric pressure relieving overlay mattresses in use. Of these only one was set at the correct setting. When staff were asked about this care attendants understood the staff nurses set the setting. Staff nurses understood the Director of Nursing set the settings. The Director of Nursing understood the maintenance person set the setting. The maintenance person had no knowledge of this process.
- Some patients who required pressure-relieving mattresses had no pressure relieving cushions to sit on during the day to support pressure area management.
- There were 39 cushions in situ. Of these 13 needed to be replaced due to infection control concerns. These cushions were being used inappropriately as patients who were immobile were not always placed on these cushions and cushions were used more as a comfort aid rather than pressure area management aid.
- There is no record of any training of staff in relation to pressure area management and it would appear staff are unaware of best practice in this regard.
- It was observed that patients are being turned inappropriately and infrequently. Patients' thorax position was being altered while they were not being repositioned into a lateral position thus relieving pressure on the lower extremities. Patents who are immobile are not being stood or hoisted to relieve pressure at regular intervals during the day. There was a lack of knowledge of how to position patients appropriately to relieve pressure.

Best practice requires that:-

- Every patient is assessed and an indication of their level of risk identified using a recognised tool and this should then translate into an individualised care plan which specifies the appropriate management and pressure relieving devices relative to this level of risk.
- Once patient care plans are developed they need to be implemented and evaluated with on-going review. Patients should be turned as appropriate in accordance with the care plan.
- On-going training, education and clinical supervision in pressure area care management / manual handling should be recorded and reviewed regularly.

Urinary / Faecal incontinence -

- There is no evidence of any continence promotion activity or patient assessment for continence.
- The majority of patients are placed on continence pads and changed at set times during the day and night (after breakfast, after lunch, after tea and at bed-time and at

2am and 6am). The process for changing patients after lunch and tea is that patients are placed in a queue along the corridor outside the assisted bathrooms and changed in turn despite the fact that a significant proportion of patients have en-suite facilities in their own rooms.

- o There is a distinct lack of knowledge among staff regarding the management of incontinence and the importance of continence promotion.
- o There is no evidence of staff training in the area of continence promotion.

Best practice requires that:-

- o An awareness and emphasis is placed on the promotion of continence in elderly patients.
- o Patients need to be assessed using appropriate tools and a care plan drawn up identifying their toileting requirements and the appropriate incontinence wear.
- o The care plan needs to be implemented and evaluated with on-going review.
- o Where lack of knowledge is identified, appropriate training should be provided for staff.

Wound Management/Skin Care-

- o There are no individualised patient assessments of any wound or care plans.
- o Dressings are being applied inappropriately.
- o There is a lack of knowledge and awareness among nursing staff in relation to wound assessment and management.
- o Procedures used to carry out wound care are inadequate. There is no evidence of the utilisation of the aseptic technique to carry out wound care.

Best practice requires that:-

- o There is a recognition of a standardised patient assessment of wound care to include an awareness of predisposing risk factors such as medications, relevant medical history, previous wound history etc.
- o Each patient is assessed using a standardised wound assessment chart to include a wound management programme which is implemented, evaluated and reviewed on an on-going basis.
- o Clinical staff should be provided with appropriate training and supervision and be aware of current best practice in wound care management.
- o Clinical staff should be aware of the appropriate primary dressing in relation to the wound assessment.

Caring for Patients with Dementia

- o There is no evidence in practice of either an understanding or ability to manage patients who display challenging or aggressive behaviour.
  For example, one gentleman has a tendency to become aggressive because he feels that his privacy is being invaded when personal care is provided. The management of this gentleman is to approach him with five members of staff, two of whom must be male, in order to provide personal care. On seeking clarification of the role of these five staff it was said that the two men were required for their strength but no other specific role or function was outlined for any of the five staff members.
- o There is no evidence of any written record of the effects of challenging behaviour on patients, staff, residents or others.
- o Another clinical example witnessed, was when a patient was observed to be screaming at the top of her voice until staff produced cigarettes. At no time did the staff engage this person in conversation or dialogue, they simply ran to the press when

they heard the noise and, standing well out of striking range, they threw the cigarettes at the patient. At no time did the staff ask the patient to stop screaming or attempt to calm the situation. The patient proceeded to light her cigarette in the main residential area of the home and staff indicated that they would be afraid to ask her to go to the smoking room as she gets very angry. The staff seemed genuinely afraid of this person and had absolutely no knowledge or skills to deal with the situation.

Best practice requires that:-

- Staff should be trained in the prevention and management of aggressive or violent behaviour. Emphasis should be placed on prevention with known behaviour triggers being identified and avoided where possible.
- Staff should be skilled in de-escalation techniques aimed at calming a situation that has the potential to become aggressive or violent. If and when physical intervention is indicated it should be planned and controlled using agreed evidence based techniques and carried out by a minimum of two staff trained in using such techniques, each staff member should fully understand their role before approaching the patient, one staff member should take the role of co-ordinator and be responsible for conversing with the patient and instructing the team.
- Staff should have effective communication skills in the management of residents with cognitive impairment.

General Provision of Care

- Duties are allocated on a task by task basis and are undertaken with no apparent leadership or supervision.
- No particular system of work i.e. key-worker or team nursing system appears to be in use and therefore it is very difficult to determine who is responsible for which group of residents. The result of this is that nobody takes overall responsibility for any particular person's care.
- The care attendants do not have the knowledge required to identify, at the earliest possible time, when nursing or medical input is required.
- There is no updated nursing assessment of patients care needs or evidence of individualised care plans being implemented.
- No evidence of review and evaluation of residents needs.
- Non -qualified staff do not always seek advice or direction from qualified staff when they are unsure of a particular practice opting for advice from their unqualified peers instead.
- There are large gaps in the provision of care for specific client groups e.g. patients with diabetes, patients with neurological disorders, care of the dying and residents with dysphagia.
- The manual handling of frail disabled residents in the home, as observed, is not in line with best practice.

Best practice requires that:-

- There needs to be clear lines of responsibility for each care attendant which is clearly articulated, delegated and accepted at handover and reviewed on an on-going basis during each shift.
- Non- qualified staff should be aware of whom it is that they are expected to report to and that instructions and direction should come only from that source.
- The review of individualised care must be undertaken on an on-going basis to identify at the earliest possible time additional nursing or medical intervention.
- Best practice requires that a manual handling policy is in place supported by appropriate training

Regulation 5(d)(e) of the Nursing Homes (Care and Welfare) Regulations 1993
The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home:

(d) facilities for the occupation and recreation of persons;

(e) opportunities to participate in activities appropriate to his or her interests and capacities.

- There are inadequate activities in place appropriate to the needs of patients e.g. patients are not brought out to the gardens.
- The seating areas are not conducive to conversation or interactions.
- There is no individual care plan identifying any activities for patients.
- There is no evidence to support a systematic approach to daily recreational activities for each resident.

Best practice requires that:-

- Identify a safe, secure, outdoor area for patient activity
- The seating areas in Leas Cross should be reviewed to facilitate patient interaction in small clusters or groups.
- There should be a designated programme of activities which is planned, structured and individualised for all patients relevant to their level of dependency.

Regulation 29(a) of the Nursing Homes (Care and Welfare) Regulations 1993 *The registered proprietor and the person in charge of the nursing home shall:-*

(a) make adequate arrangements for the recording, safe-keeping, administering and disposal of drugs and medicines.

(b) ensure that the treatment and medication prescribed by the medical practitioner of a dependant person is correctly administered and recorded.

Drug orders

- Nurses have been observed transcribing drug orders which the Doctor then signs. Several prescriptions have been entered with one Doctor's signature to cover all of them.
- It has been noted that nurses have misinterpreted the next due date for depot medication in the medical record which the doctor has utilised without checking the original medical record, e.g. one prescription depicts 'X medication every second Thursday' which was interpreted by some staff to mean that it is given on the second Thursday of the month (i.e once a month), when in actual fact it is prescribed fortnightly on every alternate Thursday.
- Some medications have been omitted through error and subsequently not carried forward in the diary resulting in long periods where prescribed medication was not given, resulting in the patient's deteriorating health.
- Medication orders have been observed to contain illegible and discontinued medications that obscure case of accurate administration.
- There is an uncoordinated approach to the timing of drug orders which the nurses have overcome by either administrating the drug at a later or earlier opportunity than prescribed.

Best practice requires that:-

- The doctor is the only person who should prescribe drug orders and nurses should not transcribe

- Each drug should be signed for separately.
- It is the sole responsibility of the doctor to ensure accuracy of drug orders.
- The drug Kardex should be updated regularly to ensure legibility and completeness.
- The nurses and doctor(s) should ensure that drugs are administered at the appropriate times.

- Some patients on prescription medication which should be given at 8am are woken a

Pharmacy Supplies/Ordering

- Currently the medications are ordered by fax and are delivered by the pharmacy in regular paper shopping bags.
- On arrival the medications have been noted to be deposited at the central concourse station and left unattended. This may be a danger to the residents and visitors who have easy access to this area at all times.
- On arrival of the regular medications in "blister" packs, a care staff, trained by the pharmacy, takes the packs to a room on his own and prepares them for the nurses in the lever arch dispensers.
- On the back of each "blister" pack, each medication is described only by colour, e.g. one such pack was described to contain five white, two brown and one peach tablet.

Best practice requires that:-

- A secure mechanism should be in place for the supply of medications to Leas Cross.
- Medications should be checked/signed for and secured on arrival by a nurse.
- At all times only qualified nurses and doctors should be involved in the preparation, management and storage of medications.
- Due to the current system of tablet colour identification, it is unclear which medication should be removed in the case of discontinuation or in the case of a nurse deciding that a certain medication is contraindicated at any particular time.

Storage and custody of medications

- Medication trolleys have been observed to be open and unattended in unsecured areas and are easily accessible by unauthorised persons.
- Medications i.e. Depixol and Rocephin and dressings are stored in an unlocked filing cabinet in the Matron's office.
- It has been noted that the drug keys are stored with keys that cleaner and ancillary staff have access to at any time.

Best practice requires that:-

- Medication trolleys should never be left unattended when open and drug keys should at all times be kept in the possession of a registered nurse only.
- All medications should be stored in a designated secure area to which only nurses have access.

Administration of medications.

- Medications have been observed to be left unattended at the Patient's bedside as well as at the central concourse.
- Care attendants administer medication by mixing them into a patients' meals, the meals may not then be finished.
- Some patients on prescription medication which should be given at 8am are woken at 6am and the medication is administered then. This is because there are too few nurses available to administer all medications at the appropriate prescribing time.

- Nurses have been observed to record all administration of medications after the complete drug round is over.

Best practice requires that:-

- Medications should only be administered when the patient is immediately available.
- Where a difficulty arises in relation to a patient taking a medication, appropriate alternative methods should be devised and employed to ensure that a prescribed dose is received and this should be overseen by a nurse.
- Appropriate staffing levels should be in place to ensure that patients receive their medications at the prescribed time.
- Contemporaneous recording of medication administration should occur at all times.

Verbal Instruction via telephone.

- It has been noted that nurses have accepted verbal instructions for drug orders over the telephone which are then administered. These drug orders are written up by the doctor the following day or at the next visit.

Best practice requires that:-

- All verbal drug instructions, via the telephone, must only be administered by the nurse on foot of a facsimile of the order sent by the doctor.

Crushing of Medications.

- A large amount of medications are crushed prior to administration. These medications do not form part of any protocol, i.e. doctor's instructions to crush the medication are not evident.

Best practice requires that:-

- Medications become unlicensed once they are crushed. There is need for clearly written doctors instructions and supporting protocols.

Regulation 10.5(d) of the Nursing Homes (Care and Welfare) Regulations 1993

The registered proprietor and the person in charge of the nursing home shall ensure that:-

(d) a sufficient number of competent staff are on duty at all times having regard to the number of persons maintained therein and the nature and extent of their dependency.

Details of total numbers of nursing staff involved in direct clinical care (excluding Director of Nursing and Clinical Nurse Manager) and care attendants and their rosters are as set out below:-

Total Nurses = 11 (including 1 suspended)
Total Care Attendants = 48
Number of Beds = 111

Nursing Staff

Roster	Number of Staff on Duty	Number of Beds	Staff: Patient Ratio
8am- 8 pm	3 RGN's	111	1:37
8pm - 8am	3 RGN's	111	1:37

Care Attendants

Roster	Number of Staff on Duty	Number of Beds	Staff: Patient Ratio
8am- 2.30pm	18	111	1:6
2.30pm- 8pm	9	111	1: 12
8pm - 8am	6	111	1:18.5

- In addition to nursing and care attendants there are ancillary staff.
- There is an inadequate number of clinical nurse managers to direct and supervise clinical nursing care.
- There is no systematic dependency scoring system to identify the level of care each patient requires to determine the number and skill mix of staff required on each shift.
- There appears to be no evidence of an admission policy clearly identifying inclusion and exclusion criteria.
- There is no evidence of care / clinical induction policy for new staff or evidence of a mentoring or clinical supervision policy to support new staff.

Best practice requires that:-

- A patient dependency scoring system must be identified and introduced to indicate the number of staff and level of competency required which will determine the skill mix.
- A specific admission policy needs to be developed with inclusion and exclusion criteria.
- A policy of induction for new staff should be in operation ensuring that all new staff are aware of all policies pertaining to the provision of care. In addition, a period of mentorship or clinical supervision should be provided to new staff.
- An adequate nursing management structure should be in place to direct and supervise clinical nursing care.

Regulation 14(b) and (d) of the Nursing Homes (Care and Welfare) Regulations 1993 *The registered proprietor and the person in charge of the nursing home shall:*

(b) make adequate arrangements for the prevention of infection, infestation, toxic conditions, or spread of infection and infestation at the nursing home.

(d) ensure that a separate well ventilated room is provided for sluicing and for the, storage of dirty linen.

There were inadequate arrangements for the prevention and spread of infection at the nursing home. This was evidenced by:-

- The absence of infection control policies and protocols.
- Lack of essential hand washing facilities and cleansing products. This deficiency was of great concern due to the presence of MRSA in the home.
- No bed pan washers.
- Several sets of dentures discovered together in one bowl.
- Insufficient cleaning equipment i.e. mops.
- In Leas Cross I the sluice room and laundry room are combined i.e. one room.
- No individual basins were available for patients requiring assisted washing at their bedsides.
- There is a lack of awareness among clinical staff of the importance of hand washing and of the infection control procedure.
- The location of the sluice in Leas Cross II is adjoined to the residents' accommodation. There is no adequate ventilation in this area. Access to sinks in the sluice room is hindered because of storage of equipment.

Best practice requires that:-

- Up to date infection control policies and protocols should be devised and implemented.
- Appropriate resources are available e.g. hand towels, soap dispensers / solutions, bins, gloves and patient wipes.
- There should be a bed pan washers installed in the appropriate areas i.e. one in Leas Cross I and one in Leas Cross II.
- Each patient should have their own denture pot which is clearly marked to identify the patients' own dentures.
- Appropriate cleaning equipment should be available throughout the building and dedicated to specific areas as appropriate i.e. sluices, bathrooms, toilets, dining area, hallways and bedrooms, infected Areas.
- The sluicing facilities be reviewed e.g. in Leas Cross I there needs to be a designated sluice room and a designated laundry room. These rooms need to be preserved for their designated purposes and used appropriately.
- Individual basins should be provided for patients who require assisted washing at their bedside.
- There should be on-going educational and training programmes for all staff relating to infection control.

Regulation 14(c) of the Nursing Homes (Care and Welfare) Regulations 1993

The registered proprietor and the person in charge of the nursing home shall:-

(e) maintain a high standard of hygiene in relation to the storage and preparation of food and the disposal of domestic refuse.

- Domestic waste was stored at the front of the building in an open and easily accessible area to the public, residents and passing vermin.

Best practice requires that:-

- Domestic waste should be stored separate to clinical waste and should be held in a secure area away from the public, residents and vermin.

Regulation 15(g) of the Nursing Homes (Care and Welfare) Regulations 1993

The registered proprietor and the person in charge of the nursing home shall ensure that:-

(g) adequate arrangements are made for the proper disposal of swabs, soiled dressings, instruments, disposable syringes and sheets, incontinence pads and other similar substances and materials.

- There is evidence of a policy relating to the disposal of clinical waste, however it is apparent that the staff are not familiar with this policy which is not followed. This is evidenced by the following:-

  There are an inadequate number bins available for the disposal of clinical waste in addition to which there is no formalised method of collection. As a result there are a considerable number of plastic bags containing clinical waste placed out side adjacent to the car park and the domestic waste area.
- Sharp boxes were observed to be overfilled and staff reported that they used a cardboard box until replacement sharps boxes were delivered.

Best practice requires that:-

- The policy on disposal of clinical waste be updated and kept in line with current trends in waste disposal. Adequate resources should be available to support the appropriate disposal and regular collection of waste.

Regulation 11.2(f) of the Nursing Homes (Care and Welfare) Regulations 1993

In every nursing home there shall be provided suitable and sufficient accommodation which meets the minimum standards as follows:-

(f) suitable and sufficient equipment and facilities having regard to the nature and extent of the dependency of the persons maintained in the nursing home.

- Most of the seating in the main foyer at Leas Cross II is unsuitable not only for the moving and handling of patients but also for elderly residents because the seats are very low to the ground.
- There is an inadequate amount of adjustable-height seating.
- There is an absence of footplates on wheelchairs.
- There are no injection trays available for use.

Best practice requires that:-

- Injection trays should be available in clinic rooms.
- Seating with variable heights adjusters should be available which allows ease of access and safe movement and handling of patients. There needs to be an ergonomic assessment of all seating facilities in Leas Cross I & II.
- All wheelchairs should be fitted with footplates for safe movement of patients.

Regulation 11.2(g) of the Nursing Homes (Care and Welfare) Regulations 1993

In every nursing home there shall be provided suitable and sufficient accommodation which meets the minimum standards as follows:-

(g) bed and bedding appropriate to the dependency of each person and suitable and sufficient furniture and other necessary fittings and equipment.

- There is no evidence of an assessment having been undertaken to identify the appropriate bedding requirements for individual clients. Most beds are fixed height; with absence of sufficient high/low beds and beds with back rests. There is also no evidence of the correct hygiene procedures to be used for the treatment of mattresses. Pillows were observed to be hollow fibre for single use, these pillows had been laundered and therefore were no longer fit for use.
- In the absence of sufficient bedding it was noted that extra bed linen was purchased without recourse to the fire safety regulations.
- There is no evidence that furniture and soft furnishings, including curtains and bedding meets with fire safety regulation standards.
- There is no evidence of infected laundering having been managed appropriately.

Best practice requires that:-

- General mattresses should be of a standard that facilitates easy cleaning. Pillows must be of a fire retardant nature and suitable for regular laundering/wipe clean
- All bed linen, soft furnishings, curtains, etc, should meet regulation standards for fire retardancy and be suitable for regular laundering.
- There should be a clear policy for the management of high-risk laundry
- Given the dependency of the patients at Leas Cross (including manual handling, health and safety) all beds should be high/low with adjustable back rests

Regulation 12(a) of the Nursing Homes (Care and Welfare) Regulations 1993

The registered proprietor and the person in charge of the nursing home shall:-

(a) take precautions against the risk of accidents to any dependent person in the nursing home and in the grounds of the nursing home.

- Fire exit doors between Leas Cross I and Leas Cross II are not alarmed and there is no regular supervision within this area.
- On the north wing, a fire exit door is frequently left un alarmed and / or the key is unavailable.
- There is no formal supervision of the designated smoking area which is remote from any active nursing/care supervision.
- Window openings are unrestricted. In the past, residents have got out through the windows in their rooms.
- If a resident is missing, there is no co-ordinated plan in place for search and rescue of that resident.
- There is no evidence of a risk assessment tool in operation particularly in relation to preventing falls.
- There is no evidence of recent fire alarm inspection.

Best practice requires that:-

- All fire exit doors should be appropriately alarmed.
- Designated smoking area should be supervised at all times.
- Window openings should be controlled to a safe point of opening and should not be easily overridden by residents.
- There should be a policy in place for responding to call button/alarm.
- There should be a co-ordinated search and rescue plan/policy in place.
- There should be adequate fencing surrounding the grounds of the nursing home.
- A comprehensive risk assessment in relation to falls should be in place and updated regularly in relation to residents and maintained within their nursing care plans.
- A fire alarm inspection contract should be in place with regular inspections.

Regulation 12(e) of the Nursing Homes (Care and Welfare) Regulations 1993

The registered proprietor and the person in charge of the nursing home shall:-

(e) ensure that safe floor covering is provided.

- There is evidence of cracked floor tiles and uneven surfaces on some tiles. Tiles are also extremely slippery when wet.
- There are large mats at the main entrance for ease of wheelchair use, however these mats are a hazard for patients using walking aids.
- There is no evidence of a change in texture in the floor covering to identify key areas, e.g. doorways at the top and bottom of stairs.

Best practice requires that:-

- There should be a continuous mat from the main entrance throughout hall.
- All flooring should be of a non-slip nature and free from cracks and chipping.
- Steps and difference in floor levels should be avoided where possible and obviously indicated when used.

Regulation 18.1 of the Nursing Homes (Care and Welfare) Regulations 1993

In every nursing home there shall be kept in a safe place a bound register of all dependent persons resident in the home, which shall include the following particulars in respect of each person:

(a) the first name, surname, address, date of birth, marital status and religious denomination of the person;

(b) the name, address and telephone number, if any, of the person's relative or other person nominated to act on the person's behalf as a person to be notified in the event of a change in the person's health or circumstances;

(c) the name, address and telephone number of the person's medical practitioner;

(d) the date on which the person was last admitted to the nursing home;

(e) where the person has left the nursing home, the date on which he or she left and a forwarding address;

(f) where the person is admitted to hospital, the date of and reasons for the admission and the name of the hospital;

(g) where the person dies in the nursing home, the date, time and the certified cause of death.

- Leas Cross Nursing Home does not have a complete patient register with relevant details e.g. address and contact details of next of kin are missing for some patients. Often the only contact details are telephone numbers with no means of knowing whose telephone number it is and the relationship of that person to the patient. In the event of death the cause of death is rarely outlined.

Best practice requires that:-

- Strict compliance with Regulation 18.1 of the Nursing Home (Care and Welfare) Regulations 1993 as outlined above.

Regulation 19.1(d) & (h) of the Nursing Homes (Care and Welfare) Regulations 1993

In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:-

(d) an adequate nursing record of the person's health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty.

- The nursing documentation relating to each patient is minimal. There is a nursing record made at the end of each shift however, they typically read as follows "all needs attended to" or "meds given" or "slept well". Very little detail is given on the care delivered to that particular patient.
- The nursing assessments that are carried out appear to be done on admission and are then filed away in the patients' charts, they do not form the basis of a plan of care and they are not available to unqualified staff who provide the majority of the care interventions. Therefore unqualified staff are not aware of the patient's care needs until they discover this through trial and error.

(h) a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration.

- There are inadequate records on the use of physical and chemical restraint.

Best practice requires that:-

- o There should be a clear policy outlining the principles of good practice with regard to record keeping and documentation such as the An Bord Altranais Guidelines (2003) "Recording Clinical Practice - Guidance to Nurses and midwives, 2002".
- o Staff training in the area of appropriate record keeping should be provided with particular emphasis on the legal aspects of documentation.
- o there is a restraint policy in place supported by adequate documentation and staff training.

Regulation 21(a)(b) of the Nursing Homes (Care and Welfare) Regulations 1993 *In every nursing home there shall be kept in a safe place a record of-*

(a) the name, date of birth and details of position and dates of employment at the nursing home of each member of the nursing and ancillary staff:

(b) details of the qualifications and a copy of the certificate of current registration of each member of the nursing staff employed.

- o Inadequate records were maintained in relation to staff working at the nursing home and this has made it very difficult to authenticate the qualifications of the staff. In addition there is:-
  - o No evidence of current An Bord Altranais registrations for qualified staff
  - o No evidence of Garda clearance for staff
  - o No evidence of references
  - o No evidence of work permits. Individual non national staff contend that they have a work permit for a particular job but in effect are working in a different job. No photograph on staff files.

Best practice requires that:-

- o Strict compliance with Regulation 21 (a) (b) of the Nursing Home (Care and Welfare) Regulations 1993 as outlined above.
- o Compliance with the salient provision of the work permit and working visa/work authorisation programme.

Regulation 27.1(a) of the Nursing Homes (Care and Welfare) Regulations 1993 *The registered proprietor and the person in charge of the nursing home shall:*

(a) take adequate precautions against the risk of fire, including the provision of adequate means of escape in the event of fire and make adequate arrangements for detecting, containing and extinguishing fires, for the giving of warnings and for the evacuation of all persons in the nursing home in the event of fire, and for the maintenance of fire fighting equipment.

- o There is no evidence of a maintenance contract on the fire alarm system e.g. smoke detectors were last tested in 07/04 and prior to that on 12/03.
- o There is an absence of ski evacuation sheets on all beds.
- o Highly dependent residents are residing in upstairs accommodation.
- o Staff appear to be unaware that blocking of fire exits is a serious hazard and impedes the speedy evacuation of residents.

Best practice requires that:-

o There is a maintenance contract on all fire equipment i.e. fire detection system and fire fighting equipment and emergency lighting

- Where residents are cared for on the second floor and there is no other means of escape other than using their mattress, a ski evacuation sheet should be provided.

Regulation 27.1(c) of the Nursing Homes (Care and Welfare) Regulations 1993
The registered proprietor and the person in charge of the nursing home shall:
(c) *take all reasonable measures to ensure that materials contained in bedding and the internal furnishings of the nursing home have adequate fire retardancy properties and have low levels of toxicity when on fire.*

- In the absence of sufficient bedding it has been noted that extra bed linen was purchased without recourse to the fire safety regulations.
- There is no evidence that furniture and soft furnishings including curtains and bedding meet with fire safety regulation standards.

Best practice requires that:-
- All bedding and internal furnishings meet with fire safety regulation standards.

Regulation 28.1 of the Nursing Homes (Care and Welfare) Regulations 1993 *In every nursing home there shall be kept in a safe place a record of-*
(a) all fire practices which take place at the home;
(b) all fire alarm tests carried out at the home together with the result of any such test and the action taken to remedy defects;
(c) *the number, type and maintenance record of fire-fighting equipment.*

- The last evidence of testing the fire alarm system is 07/04. The fire register is not completed.

Best practice requires that:-
- A fire register be maintained on an ongoing basis highlighting and documenting all aspects of fire safety.

Regulation 28.2 of the Nursing Homes (Care and Welfare) Regulations 1993
In every nursing home the procedure to be followed in the event of fire shall be displayed in a prominent place in the nursing home.

- There is no evidence of fire orders in any location. The orders clearly show the procedures to be carried out in the event of a fire.

Best practice requires that:-
- Each location should have an appropriate fire order displayed as per the evacuation procedure for that location.