

Non-compliance with Residential Care Standards: Towards a Risk-management Framework for Preventing Elder Mistreatment

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As the regulatory authority for promoting standards in residential care facilities in Ireland, the Health Information and Quality Authority (HIQA) is responsible for the regulation of care facilities for older people in Ireland, and has the power to de-register an individual care facility that is in serious or persistent breach of its standards. In such an event, HIQA issues a report detailing the transgressions of standards that it found on initial and subsequent inspections. Such inspection reports provide a transparent account of the evidence for the HIQA decision to cancel the registration of a nursing home. In their totality, the HIQA inspection reports also present a dataset with which to examine common themes that suggest patterns and trends in the way that nursing homes fail to meet their statutory obligations to provide safe care environments and good standards of care to their residents.

This review examined a sample of such reports and, in addition to identifying common themes, also identified practices that might represent instances of potential mistreatment and neglect of residents. The themes that emerged from the sample of reports were: environmental

factors (the physical care environment), institutional factors (reporting procedures, use of restraints and staffing concerns), practice factors (poor care practices, poor safeguarding of residents' finances and possessions and rigid routines) and resident factors (poor resident communication, limited opportunity for meaningful engagement, and lack of respect and dignity of residents).

Based on our analysis of the selected HIQA inspection reports of residential care homes that were in breach of the HIQA standards, there is evidence to suggest that risk of mistreatment of residents occurs at four levels, namely the environment of care, the institutional practices, daily care practices and the individual resident. These four levels of risk can, in turn, provide the basis for risk analysis and the development of a risk management plan aimed at reducing elder mistreatment in residential care homes for older people. The transgression of good standards at any one of these levels is in itself unacceptable and can adversely influence the quality of life of the individual resident and increase the risk of elder mistreatment occurring.

1. Background

This report presents findings from an analysis of a selected sample of Health Information and Quality Authority (HIQA) inspection reports into older people's residential care homes that were non-compliant with HIQA standards and regulations. The analysis focuses on violations of regulations that predominantly relate to the poor safeguarding of residents from elder mistreatment and the emerging themes can be used to develop a risk management framework for the prevention of mistreatment in residential care settings for older people. The report identifies common challenges to achieving appropriate care for older people in residential care, which is a significant issue of public interest (Phelan 2009).

In Ireland, approximately six per cent of the population age 65 years and older are in receipt of residential care (McGill 2010, CSO 2012). Over two thirds (68%) of residential care centres available to older people are provided by the private sector, 11 per cent are provided by a voluntary organisation and 21 per cent are provided by the Health Service Executive (HIQA 2012). While the majority of older people living in residential care homes receive high quality care, there is evidence to suggest that mistreatment does occur and that there are shortcomings in the quality of care provided to residents (Drennan *et al.* 2012; Department of Health and Children 2009). Elder mistreatment can take several forms including physical, sexual, psychological, financial or material, neglect or discriminatory abuse and is defined as:

A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights (Working Group on Elder Abuse 2002, p. 25).

The report *Abuse, Neglect and Mistreatment of Older People: An Exploratory Study* (O'Loughlin and Duggan 1998) was among the first studies to raise awareness of elder mistreatment in Ireland. This study provided the catalyst for the establishment of a working group, which was established to address how best to respond to the issue of elder mistreatment. The group published a seminal policy document entitled *Protecting Our Future*, which made 29 recommendations categorised under: policy, legislation, research, training and education, carers, advocacy, staffing structures and the reporting of

abuse (Working Group on Elder Abuse 2002). The document also specifically referred to the quality of care in residential care facilities and indicated that establishing and maintaining good practice are key to the prevention of elder mistreatment in institutional settings:

Good practice care settings include adherence to the relevant legislation and regulations while also adopting policy and operating procedures for the following: care planning, protection of residents' property and valuables, minimum standards of physical facilities, confidentiality and privacy, nursing procedures, drug administration policies, activation/participant of residents in the community, advocacy, complaints handling, including appeals procedures, and disciplinary procedures (Working Group on Elder Abuse 2002, p. 52).

The policy document also defined institutional abuse as comprising 'poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing, and insufficient knowledge base within the service' (p. 27). A review of *Protecting Our Future*, undertaken some seven years later, emphasised that mistreatment in institutional care settings remains a priority area requiring attention (National Council of Ageing and Older People 2009).

The quality of care of older people living in residential care received significant national attention and notoriety in 2005 following revelations of elder mistreatment in a Dublin residential care home. The revelations were contained in a TV broadcast by the Irish national broadcaster, Raidió Teilifís Éireann (RTE), which contained undercover footage of work and care practices in the residential care home. Footage included nursing and care staff asleep while on night duty, staff teasing residents and ignoring their calls for assistance and the inappropriate use of restraints. The TV broadcast was a media event that attracted much public commentary that reflected public, political and professional concerns and resulted in the institution of two official enquiries. Both inquiries concluded that unacceptable care practices had occurred at the residential care home (O'Neill 2006; Department of Health and Children 2009). Instituted by the Department of Health, a Commission of Inquiry into the case reported that the poor standards of care were attributable to the significant increase in the number of

frail, high dependency residents with high dependency levels as well as insufficient numbers of registered nurses (Department of Health and Children 2009). It also identified that health care attendants lacked appropriate training to deliver adequate care. In the Leas Cross Review, it was argued that the case in question was unlikely to be an isolated one and suggested that the standard of care in nursing homes most likely varied and was dependent on several factors, including weak policy, legislation and regulation and 'the speed of growth in the private sector and capacity of the regulatory bodies to keep pace' (O'Neill 2006).

2. The Health Information and Quality Authority (HIQA)

2.1 The Health Information and Quality Authority

The policy document *Protecting Our Future* (Working Group on Elder Abuse 2002) together with widely publicised cases of mistreatment in residential care homes culminated in the establishment of an independent regulatory authority, the Health Information and Quality Authority (HIQA), with the remit to regulate providers of residential care and other care services. Set up in response to the concerns about the quality of care provided to residents in residential care settings, HIQA was charged with responsibility for setting standards for good quality care and ensuring that these were adhered to in residential care settings. The Authority was established in May 2007 under the Health Act 2007 and its remit was set out in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the Health Act 2007 (Registration of Designated Centre for Older People) Regulations 2009. In addition to other mandated functions, HIQA set standards to promote quality and safety in Ireland's health and social care services and, since July 2009, it also assumed responsibility for undertaking independent registration and inspection of public, private and voluntary residential care services for older people. Prior to this, it had been recognised that regulation and inspection of nursing homes was inadequate (Phelan 2009).

The Authority recognises the need to protect the rights of older residents in residential care homes and the need to support service providers in delivering quality care. Consequently, each residential care facility for older people is statutorily obligated to register with HIQA, which, in turn, verifies, through regular inspections, that the residential care facility is 'fit' to operate. The registration process involves an in-depth examination of all aspects of a centre's operations:

The purpose of regulating designated centres for older and vulnerable people is to ensure that people in these centres receive safe, good quality care and a good quality of life within safe and suitable surroundings in centres that are run and managed by people who are fit to do so (HIQA 2012, p. 9).

The HIQA Standards were developed by a Working Group based on legislation, consultations with key stakeholders, including service providers, healthcare professionals, older people's advocacy groups, the Department of Health and Children and the Health

Service Executive, and research. The resultant *National Quality Standards for Residential Care Settings for Older People in Ireland* outlined 32 quality standards, which provide a framework for the provision of high quality care for older residents in nursing homes.

Under the Health Act 2007, HIQA is authorised to seek legal enforcement for non-compliance of its standards, which provide the basis for assessing whether an appropriate standard of care is being delivered in the residential care facility. In meeting its regulatory function, HIQA undertakes scheduled and unscheduled visits to residential care facilities for older people and publishes inspection reports. The reports identify where the standards are being met, where improvements are necessary and clearly state any required actions that the residential care facility needs to undertake in order to meet the HIQA standards. Inspection reports on residential care facilities that have been subjected to legal or enforcement activities only become publicly available once the case has been resolved. HIQA is mandated with the responsibility to ensure that the required changes are made, assessing whether the necessary actions have been completed, changing the operational conditions of the residential care home, prosecuting service providers for failing to comply with the registration conditions, and cancelling a residential care home's registration. All actions are taken in the interest of the residents living in the residential care facility. At the time of writing, the *National Quality Standards for Residential Care Settings for Older People in Ireland* were being reviewed.

2.2 The HIQA inspection process

HIQA's current Standards relate to the following seven key areas: rights, protection, health and social care needs, quality of life, staffing, the care environment, governance and management. Nursing homes are inspected on an ongoing basis and are re-registered every three years to ensure that they continue to comply with the Standards. Inspections are carried out using the following six domains of inquiry: governance, quality of the service, health care needs, premises and equipment, communication and staffing. This regulatory framework highlights good practices, identifies breaches of the HIQA Standards and provides the nursing home's response to the action plan proposed by the inspectors.

HIQA conducts several types of inspections, including the 'scheduled inspection', the most common type, and a

'registration inspection', which is part of the registration process and is also required when there is a change in ownership of a nursing home. 'Monitoring inspections' are generally one-day inspections conducted when a nursing home has not been inspected within a certain timeframe and these tend to focus on specific regulations. 'Triggered inspections' are prompted by notification of concerns for the safety and wellbeing of residents. This type of inspection accounted for 9 per cent of all inspections in the first 15-month period of HIQA inspections (HIQA 2012).

Each initial report of an inspection outlines a plan and the actions required to ensure that the standards are met. Follow-up reports provide details on how the recommended actions from the initial reports have been adhered to (HIQA 2012). Each HIQA inspector summarises his/her visit findings into the following three categories: 'evidence of good practice', 'some improvements required' and 'significant improvements required'. Should a care home continue to breach the standards, HIQA inspectors arrange a meeting with the person-in-charge or proprietor to discuss the issues. Closing a nursing home is always a last resort and occurs in circumstances where there are considerable concerns about the continued violation of standards (HIQA 2012).

2.3 HIQA standards and the protection of residents from mistreatment

In a report of its first 15 months of initial and follow-up inspections (1 June 2009 to 30 September 2010) HIQA reported that among other breaches, the regulations relating to general welfare and protection, training and staff development, residents' rights, and assessment and care plans were frequently breached (HIQA 2012). The most frequently breached regulation related to the general welfare and protection of residents, and was breached by a quarter of nursing homes; many offered inadequate provisions for the prevention of abuse or the risk of abuse (HIQA 2012; The Wolfe Group 2013). In its report, HIQA remarked: 'considering the high profile of prevention of elder abuse, it is worrying that a quarter of centres recorded a breach in relation to this regulation' (HIQA 2012, p. 27). An analysis of follow-up inspection reports related to the breaches found that just over half of the required actions had been implemented, which HIQA considered less than satisfactory (HIQA 2012).

While all 32 HIQA Standards pertain to the welfare and

wellbeing of residents, Standards 8 and 9 have particular direct relevance to the protection of residents from mistreatment. Standard 8 states that 'each resident is protected from all forms of abuse' (HIQA 2009, p. 21) and stipulates that each residential care facility should comply with certain criteria for ensuring residents' protection. Firstly, the care facility must have a policy on the prevention, detection and response to abuse, which clearly sets out the procedures for preventing abuse, responding to suspected, alleged or evidence of elder abuse and neglect, and reporting suspected or alleged abuse to the Health Service Executive, An Garda Síochána and the Chief Inspector (HIQA 2009). All procedures should be informed by best practice and implementation of the policy should be reviewed annually. Standard 8 also requires that:

The person in charge takes steps to ensure that the resident is safe from physical or sexual abuse, psychological abuse, financial or material abuse, neglect or acts of omission, or discriminatory abuse, through deliberate intent, negligence or ignorance by others within the residential care setting. All allegations of any such incidents are fully and promptly investigated in accordance with the policies and procedures (HIQA 2009, p. 21)

Standard 8 also requires that each residential care facility has a policy on whistleblowing, which outlines the procedures for protected disclosure and requires that each staff member is aware of the nominated person to whom they can report without negative repercussions. Finally, each staff member should also be trained in the prevention, protection, identification and the reporting procedures for abuse, especially for vulnerable residents (HIQA 2009, p. 21).

Standard 9 relates to the protection of residents from financial abuse and requires the nursing home to ensure that 'each resident's finances are safeguarded' (HIQA 2009, p. 22). This standard stipulates that the nursing home should have a clear policy and clear procedures on the management of residents' personal monies and possessions. This includes the requirement that staff should maintain signed records of any handling of residents' monies and, in the absence of another suitable person, the service provider should maintain all records and inform the Chief HIQA inspector and the Department of Social and Family Affairs. Moreover, the provision of secure facilities for the safe-keeping of money and valuables should be available to all residents.

3.1 Prevalence of elder mistreatment in residential care

The protection of older people from mistreatment in residential care settings remains largely understudied. A small number of studies have reported the prevalence of conflict within nursing homes based on staff self-reports about abusive behaviours that they may have engaged in and/or observed. Seminal work undertaken by Pillemer and Moore surveyed 577 staff in nursing homes in the US in the late 1980s and found that the most commonly perpetrated form of abuse by staff was psychological abuse. Study findings showed that 40 per cent of respondents reported that they engaged in shouting, insulting or swearing at a resident in the previous year. Furthermore, a tenth of staff admitted to engaging in one or more acts of physical abuse in the previous twelve months, which related to excessive use of restraints, pushing, grabbing and pinching residents or hitting or slapping a resident (Pillemer and Moore 1989).

In Germany, Goergen (2004) used a multi-method approach, including interviews with staff and residents, surveys and analysis of cases of elder abuse, to examine mistreatment of older people in care homes. This study found that neglect and psychological abuse were the most frequent forms of abuse reported. Almost three quarters of nurses interviewed had engaged in at least one incident of neglect or abuse in their work with older people. The reported prevalence of elder abuse perpetrated by staff in other studies varies. For example, a Swedish survey of 600 nursing home staff found that 2 per cent reported that they had abused an older person in the previous year (Saveman *et al.* 1999), while a survey of residential care staff in Israel found that over half reported that they had engaged in more than one type of 'maltreatment' in the previous year (Natan *et al.* 2010). Another study in the Czech Republic found that almost half of the staff reported perpetrating psychological abuse and 12 per cent reported perpetrating physical abuse (Buzgova and Ivanova 2011).

In Ireland, Drennan *et al.* (2012) undertook a survey of over 1,300 registered nurses and healthcare assistants from 64 nursing homes to examine staff-resident interactions in residential care settings. The authors reported that the vast majority of staff working in care settings experienced conflict with residents. Over half of staff reported that they had observed one or more neglectful acts and just over a quarter reported that they

had been involved in at least one neglectful act within the preceding year. In addition, approximately 12 per cent of staff reported that they had observed another member of staff physically abuse a resident in the preceding year, with restraining a resident beyond what was needed and pushing, grabbing, shoving or pinching a resident being the most frequently observed forms of physical abuse. Three per cent of staff reported that they themselves had committed one or more acts of physical abuse on a resident. Approximately a quarter (27%) of respondents had observed another member of staff psychologically abuse a resident, while 8 per cent of staff reported that they themselves had engaged in psychological abuse. Drennan *et al.* (2012) reported that low levels of job satisfaction, staff experiencing emotional exhaustion and burnout, poor staff commitment to their organisation and experiences of stress in the organisation were factors associated with the risk of neglect and abusive behaviours in residential care settings for older people. Another Irish study based on data from general practitioners, found that almost a third had witnessed substandard care in a nursing home and one in four reported that they had failed to report this to the relevant authority (Gleeson *et al.* 2014). Poor care in residential care homes can lead to neglect and, if ignored, can lead to serious risk of harm or mistreatment (National Association of State Units on Aging 2005).

The inappropriate use of restraints has also been identified as a form of elder physical mistreatment and has been associated with the development of pressure sores, incontinence and physical and emotional distress (Gallinagh *et al.* 2001). Restraints have been reportedly used more frequently with people with dementia and agitation (Pillemer and Moore 1989; Buzgova and Ivanova 2009). Goergen (2004) found that approximately one in ten staff reported using physical restraints such as lap belts, bed rails and table trays, and 7 per cent reported using chemical restraints. In 2012, the Irish Department of Health published *Towards a Restraint Free Environment in Nursing Homes*. This policy statement declared that the inappropriate use of restraints, including environmental restraints that deliberately restrict an individual's movement, such as locking doors or placement of furniture to restrict mobility, represented an infringement on a person's rights and dignity. The policy document aimed to ensure that the use of restraints should be a last resort in care work and should only be used in accordance with the law and best professional practice.

3.2 Poor care practices

Some institutional practices have been deemed abusive. Clough (1999) highlighted the importance of recognising the ways that structural, environmental, individual and worker style factors contribute to poor practice and mistreatment in residential care settings.

Structural factors include a culture in which the mistreatment of residents is tolerated and care settings in which older people are disrespected and devalued and where there is little concern for their health, safety or welfare. Environmental factors relate to the settings in which the residents live and which can lead to abuse, and include the condition of the building, available facilities and staff. Clough also suggests that individual characteristics such as personality types and past experiences may lead staff to engage in abusive behaviours towards residents. Finally, work style relates to staffing and poor management styles and lack of awareness of staff and their behaviours (Clough 1999; Bennett *et al.* 1997). Mistreatment can also be the result of the interplay between the different factors (Clough 1999). Other factors may include failing to take account of previous complaints; ignoring the fact that the establishment appears run down; staffing issues like high turnover, sickness and little supervision; absent, uninterested or preoccupied senior staff; residents with few visitors or few outings and who are regarded as problematic; uncertainty surrounding the future of the residential care home; staff attitudes and treatment of residents; and discord among the staff (Clough 1999).

Studies have found that the characteristics of the nursing home facility, such as size, type and whether it is a for-profit home, may be associated with resident mistreatment (Pillemer and Bachman-Prehn 1991; Jogerst *et al.* 2006). Based on the findings of a postal survey among 409 nursing homes in Iowa, Jogerst *et al.* (2006) reported that nursing facility abuse rates were associated with a metropolitan area, ownership, occupancy rate, and number of residents and certified beds. High levels of staff stress, poor physical environments and a weak management culture have also been found to be associated with elder mistreatment in nursing homes (US National Centre on Elder Abuse 2005; Shinan-Altman and Cohen 2009).

Researchers have examined ways of improving standards of care and reducing the prevalence of mistreatment in

residential care homes for older people by ascertaining the views and experiences of residents, staff and managers (Plunkett and Brainerd 2002; DeHart *et al.* 2009; Drennan *et al.* 2012). An alternative means of identifying ways of promoting good quality care and resident safety is to examine published reports and case reviews undertaken by safeguarding staff, and by retrospectively visiting cases involving serious incidents in care homes to examine lessons learnt (Kitson 2009; Manthorpe and Martineau 2011); this approach can help to guide policy and interventions and provide a better understanding of factors that may lead to abuse (Phillips and Guo 2011).

4. Aim and objectives

The aim of this review was to examine publicly available reports of residential care home inspections, which contain evidence of poor standards and poor care practices that may represent a potential or actual risk of elder mistreatment.

The objectives were to:

- Examine HIQA inspection reports to identify common themes, patterns and trends in the way that residential care homes fail to meet their statutory obligations to provide safe care environments and good standards of care to their residents.
- Identify factors that can be used to inform the development of a framework in which risk of elder mistreatment in residential care settings for older people can be assessed.

5.1 Research design

This review involved a documentary analysis of HIQA inspection reports in which the main outcome was deregulation or closure. Inspection reports were analysed for evidence of failure to comply with regulations that enforced the protection of residents from mistreatment.

5.2 Selection process and data collection

Purposive sampling was used to select HIQA inspection reports for residential care settings that were in breach of the HIQA standards and whose final inspection indicated deregulation or closure during the period 2010 to 2012. Work undertaken by the Wolfe Group (2013) found that eleven nursing homes were de-registered following a breach in standards and subsequent to several HIQA inspection visits within the two year period.

Despite ample timeframes, some nursing homes' registrations were cancelled as a result of repeated failure to address the requirements stipulated by the HIQA inspectors and thus failed to comply with the regulations and standards. Each of the residential care facilities received several inspection visits from HIQA and was provided with considerable time to address the standards before their registration was cancelled.

Data collection involved collating HIQA inspection reports, available from the online HIQA database, including initial inspection reports, action plans and follow-up reports from nursing care homes whose registration was cancelled and subsequently closed down. A total of eleven residential care homes were included in the sample. Inspection reports were imported into NVivo 9 software to support data management.

5.3 Documentary analysis

Selected HIQA inspection reports were subjected to thematic content analysis in order to identify common emerging themes from the data. Extractions were coded using nodes. Reports were read through and re-read for passages that indicated poor care practices in which residents were considered unprotected and vulnerable to mistreatment. Themes were further grouped into categories. Thematic analysis provided a flexible method for identifying, analysing and reporting patterns or themes within the data (Braun and Clarke 2006). Themes and codes were cross-examined by a second researcher in order to enhance trustfulness, consistency and transferability (Slevin and Sines 2000). Information about resident-to-resident or resident-to-staff problems were not recorded in HIQA inspection reports and were therefore not included in the analysis. Data analysis continued until data saturation was achieved, whereby no new themes emerged from the data (Pope *et al.* 2000).

6.1 Introduction

Several themes pertaining to the protection of residents from elder mistreatment in residential care emerged from the analysis of selected HIQA inspection reports. The themes, as outlined in Figure 6.1, constituted broad categories of predisposing factors that resulted in a failure to protect older residents from the risk of mistreatment. The themes were: environmental factors (the physical care environment), institutional factors (reporting procedures, use of restraints and staffing concerns), practice factors (poor care practices, poor safeguarding of residents' finances and possessions and rigid routines) and resident factors (poor resident communication, limited opportunity for meaningful engagement, and lack of respect and dignity of residents).

6.2 Environmental Factors

The environmental factor that emerged from the data related to the physical environment of the nursing home, which in turn, impacted on the physical safety and wellbeing of residents. The condition of a nursing home, its accessibility and the general environment, such as its design, decoration, and the presence of residents' personal belongings can influence residents' experience and safety within a nursing home. HIQA Standards 25 and 26 relate to the physical environment. Standard 25 states that 'the location, design and layout of the residential care setting are suitable for its stated purpose [and] it is accessible, safe, hygienic, spacious and well

maintained and meet residents' individual and collective needs in a comfortable and homely way' (p. 43). Standard 26 requires that 'the health and safety of the resident, staff and visitor to the residential care setting is promoted and protected' (p. 54). In the published reports that were reviewed, several nursing homes failed to meet these two standards.

6.2.1 Physical care environment

A dilapidated nursing home provides a poor physical environment within which good quality care can be provided to residents. A common theme that emerged from the HIQA inspection reports was residents' exposure to such an environment. The reports commented on the rundown and unsafe physical condition of the buildings, the decrepit furnishings and the inaccessibility of some areas of the nursing homes to residents. For example, one inspection report described the rundown and unkempt outdoor area of the nursing home, which was deemed unsuitable and hazardous for residents to use at their leisure:

The garden was cluttered with debris and miscellaneous items. The plants around the perimeter were overgrown and protruding into the walking area. There were no grip rails provided in the garden. Consequently, the walking conditions were unsafe (Glenbervie, 30.09.2009).

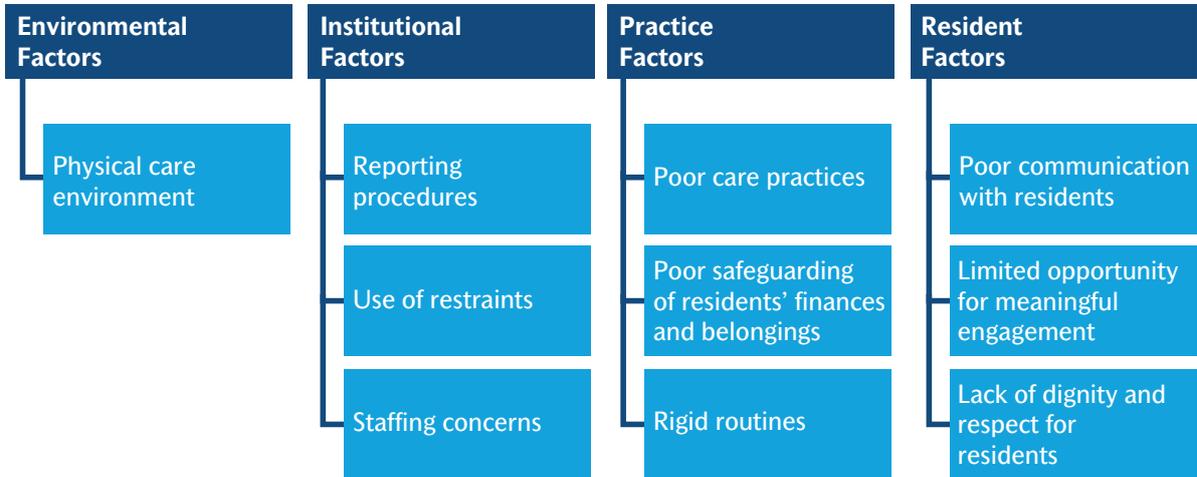


Figure 6.1 Factors in protecting residents from the risk of elder mistreatment in residential care

Another inspection report noted that the outdoor area of the nursing home was unsafe and inaccessible to residents with mobility problems:

Inspectors observed that residents had limited access to the outside as the surface area to the side and back of the building was rough, stony, and uneven making it hazardous for residents to use safely. No outdoor seating was available for residents ... the exit doors in the conservatory are ramped but there is no railing for residents' safety. Steps lead to the front door, which had no ramped area for wheelchair users (Woodside, 23.09.2009).

In some nursing homes, the mobility of residents was severely restricted to certain areas of the home:

There was no lift as required by law. As a consequence, residents could not easily go to bedrooms or the toilet on the first or second floor. Residents in bedrooms on the first or second floor could not easily reach the ground floor (St Anne's, 23.02.2010).

Fire escape routes were sometimes reported as being inaccessible to residents, which could have detrimental consequences for their safety in the event of a fire and an emergency evacuation of the building, as the following inspection report extract illustrates:

Many of the fire escape routes included steps. The provider, person in charge or staff had no individual evacuation plans in place for the highly dependent and immobile residents to ensure they could be quickly and effectively moved to a safe area (Glenbervie, 05.03.2010).

Other inspection reports commented on 'water damaged ceilings' and the 'dampness on walls and ceilings' (Owen-Riff, 14.03.2012). Inspectors wrote about the general appearance of the nursing home, stating that the dining areas were somewhat functional in appearance and would benefit from decoration; many of the chairs in the lounge areas were in a state of poor repair and required refurbishment (Upton House, 8.09.2009) and a number of care facilities needed repainting (Woodside, 23.11.2010). Poorly kept décor and furnishings appeared to be common across many of the nursing homes:

Some floor covering was cracked and broken, did not have a safety finish and was seen reported to be slippery when wet. Some bedrails were seen to be loose and poorly fitted, bed-table frames were rusted and corroded and residual divan type beds with porous finishes were in use (Suirmount, 7.04.2011).

Furnishings and fittings in poor condition are not conducive to effective cleaning and infection prevention and fail to promote the welfare and safety of the residents. Inspectors also commented on the condition of residents' rooms; reports indicated that many were 'in need of considerable refurbishment' (Upton, 06.05.10). One inspection report noted that 'the atmosphere in some bedrooms was malodorous, oppressive and offensive' (Woodside, 23.11.2010). Bedrooms sometimes were not only in need of cleaning and updating, but few personal items or artefacts or residents' personal belongings were visible:

Residents' bedrooms were sparsely decorated, with many having no pictures, photographs or personal mementos (Owen-Riff, 21.04.2012).

The following report excerpt demonstrates how the room temperature impacted on a resident's decision whether or not to get out of bed:

One resident's bedroom was notably very cold. The resident stated he felt cold and did not want to get up as a result (Owen-Riff, 21.04.2012).

A rundown nursing home in poor physical condition promotes a care environment that lacks vitality and energy. An environment that is considered dull, unstimulating and oppressive can affect residents' behaviours and negatively impact on their quality of life. This, in turn, may create the circumstances for mistreatment to occur, as Clough (1999) observed: 'Signs of a run-down nursing home may be one of several 'alarm bells' that may heighten the likelihood of elder mistreatment occurring' (p. 25).

6.3 Institutional Factors

Several institutional factors emerged from the data, which relate to the day-to-day running of the nursing home. These included the established rules and regulations of the nursing home, as well as policies and staffing.

6.3.1 Reporting procedures

Standard 8 of the HIQA standards states that 'each resident is protected from all forms of abuse' (p.15) and that there should be 'a policy on the prevention, detection and response to abuse within the residential care setting'. However, not all the nursing homes met this standard and some of their elder abuse policies were outdated or incomplete, as evident in this extract:

Inspectors reviewed the policy on preventing, detecting and managing allegations of abuse, it was dated 2006 and was not specific to the centre. The policy did not detail what to do in the event of an allegation of abuse (Glenbervie, 30.09.2009).

The policy for this same nursing home was evidently not sufficient to guide practice and the report noted that the home would 'develop local procedures', but failed to specify what should happen in the event of an allegation of abuse, for example, to whom the incident should be reported and the actions that would be taken (Glenbervie, 16.01.2010). The inspection report went on to highlight the shortcomings in staff's understanding of what constituted abuse, as many did not recognise verbal abuse of residents as a risk to resident safety and wellbeing and therefore indicated that this form of behaviour by staff would not be reported.

In another nursing home, an allegation of abuse had been made and, while the incident had been recorded on a complaint form, the document lacked important details. The complaint had not been communicated to the person-in-charge and, as a consequence, no follow-up investigation had taken place:

The inspector noted that this allegation of abuse had been recorded on a complaint form maintained in the complaints folder. The person-in-charge stated that she was not aware of this incident which had occurred on 31 August 2012 and did not know what member of staff the

allegation had been made against. The inspector read that 'pending' had been recorded under the 'immediate action taken' section of the form but there had been no investigation carried out into this allegation (Owen-Riff, 25.09.2012).

Furthermore, it was evident that the staff in this same nursing home had received inadequate training on elder abuse, as many were unaware of and lacked knowledge about reporting procedures:

Staff spoken with were familiar with the different types of abuse, some were not clear on how to respond to suspicions of abuse. Some staff members stated that the decision to report the alleged abuse depended on how serious they thought it was. These staff members had not received adequate education on the prevention, detection and response to elder abuse (Owen-Riff, 25.09.2012).

While there was a policy on elder abuse in most nursing homes, there was no indication that staff had undergone any elder abuse training and staff were also unaware of the existing HSE elder abuse services:

There was a policy in place on detecting and reporting elder abuse. However there was no evidence of staff training on the protection of vulnerable adults. Staff were not familiar with the Health Service Executive (HSE) 'Trust in Care' policy on the protection of vulnerable older people. Neither the provider nor the person-in-charge were aware of the existence of HSE specially trained caseworkers on elder abuse (Rostrevor, 28.04.2012).

Clear up-to-date policies, guidelines, reporting procedures and training on elder abuse are vital for the protection of residents from mistreatment. The absence of such policies and procedures and training creates confusion as to what is deemed acceptable and unacceptable staff behaviour. In addition, failure to act in response to alleged incidents of abuse promotes a culture which suggests that the mistreatment of residents can be tolerated. Failing to follow up on allegations of abuse could mean that potentially harmful behaviours could deteriorate into more serious cases of elder abuse (Beach *et al.* 2005).

6.3.2 Use of restraints

Standard 21 of the HIQA standards refers to resident behaviours that are considered challenging; it states that challenging behaviours should be assessed using a standardised assessment tool and that the risks and benefits of using a physical restraint in relation to the level of distress or potential harm should be evaluated. However, as the following case example illustrates no such assessments had taken place and ongoing records of the duration or the frequency with which the restraints were used were not maintained:

There was no restraint assessment in place for some residents who had lap belts and bedrails prescribed. The care plans said “restraints whenever necessary”. There was no record of when the restraints were to be put in place or for how long they were to be used. This posed a risk to residents’ safety and wellbeing. There were two residents observed to be in restraint on the day of the inspection. One of these residents was in his bedroom and was not supervised on an ongoing basis (Glenbervie, 16.01.2010).

One inspector reported observing a resident in the main day room of the care facility lying and sitting in a specially tilted-back chair and was informed that this form of restraint was being used to prevent falls (Avondale, 23.09.2009). Another example of inappropriate use of restraint was that of a resident who had been sitting in the day room restrained in a chair by a lap belt and after a review of the resident’s care plan, the inspectors reported the following:

There was no specific medical symptom that required the use of physical restraint and no identification of alternative measures to the use of restraint. Inspectors noted that the documentation relating to the duration of the restraint periods was not always complete (Upton House, 06.05.2010).

Restraints used in nursing homes did not only consist of physical restraints, but in some cases, chemical restraints were used without the required assessment or appropriate documentation:

Inspectors found he received chemical restraint on 18 occasions over 11 days without an

appropriate record being maintained. The daily nursing notes reviewed by the inspectors stated the resident was calm and settled and did not identify incidents where additional medication was required. There were no records of agitated or aggressive behaviour yet the chemical restraint (a sedative) was administered on 18 occasions (Glenbervie, 25.11.2009).

As the following extracts from inspection reports show, other more obscure forms of resident restraint were actively used in some of the nursing homes:

There were two residents who told inspectors that they were restricted from going outside. Inspectors reviewed one of these residents’ files and found no assessment or care plan regarding the restrictions in place for this resident (Glenbervie, 16.01.2010).

Inspectors were concerned that all exit doors were locked and residents had no easy access to the garden without staff assistance. Some residents stated that going outside was not encouraged by the staff (Woodside, 23.09.2009).

The use of restraints was frequently not used in line with best practice and regulations. In some nursing homes, bedrails were used for a quarter of the residents; however the duration for which the restraint was used was not recorded and restraint assessments were often absent or incomplete. In most cases, there was no evidence that alternatives to bedrails were considered. In one case, nursing staff had documented that bedrails were applied at the request of the family, and not based on a clear and justifiable clinical rationale (Woodside House, 23.11.2010). Practice in relation to the use of restraints was the same with residents who were agitated and were prescribed chemical restraint and, again, alternatives were not tried prior to the restraint being used (Owen Riff, 21.04.2012).

6.3.3 Staffing concerns

Section 5 of the HIQA standards relates to staffing. Standard 22 states that ‘staff are recruited in accordance with best human resource management practices’ (p. 32); Standard 23 states that ‘there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the

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needs of the residents' (p. 33) and Standard 24 states that 'staff receive induction and continued professional development and appropriate supervision' (p. 34). Several staffing concerns were documented during the HIQA inspections and breaches of these standards were reported. These included recruitment procedures, vetting, staff skill mix and adequately trained staff.

Staff recruitment practices

Despite the fact that the HIQA standards stipulate that staff should be recruited in accordance with best practices, it was evident from the inspection reports that nursing homes did not always adhere to this standard. All nursing homes are required to maintain the relevant documentation for each staff member, including recruitment information, references, police vetting documents and so forth. The following excerpt indicates that this was not always the case:

There were no policies available for the recruitment, selection and vetting of staff. The person in charge advised inspectors that no staff records, including personnel files, were maintained in the centre (Glenbervie, 30.09.2009).

Follow-up inspection visits to the same nursing home in the following months revealed that the issue was still not being addressed by the provider/person-in-charge:

All documents pertaining to staff were maintained in a single envelope and there was no separate file for any staff member. There were no staff records maintained for at least two staff members (Glenbervie, 16.01.2010) ... Inspectors reviewed the file of a staff nurse employed who told inspectors she had started orientation in December 2009. There was no record of the recruitment interview for this staff nurse. There was no evidence verification of references, induction or orientation to the centre. There was no evidence of application for Garda Síochána vetting (Glenbervie, 5.03.2010).

One kitchen assistant was working as a care assistant and the staff member in question had no previous experience in care work and had not received any training for the role, such as instruction in safe manual handling. This posed a risk to both staff and residents (Glenbervie, 30.09.2009).

Insufficient information about staff was also common in other nursing homes, as the following extracts indicate: 'personnel files seen by inspectors did not contain the required information such as three references and Garda Síochána vetting' (Rostrevor, 28.04.2010), 'three written references, and evidence of mental and physical fitness were not in all files reviewed and four staff did not have files' (Upton House, 06.05.10) and 'there was no policy in place relating to the recruitment, selection or vetting of staff' (Woodside, 23.09.2009). In one nursing home, testimonials were provided on employees' work in the nursing homes, by individuals who had no function in the home (Woodside House, 09.04.2010). Some files did not maintain photo identification records. Not all nursing staff had provided evidence of up-to-date registration with their professional regulatory body (Owen Riff, 14.03.2012). The recruitment procedures of one staff member were reviewed by inspectors and showed that employment was offered and undertaken without evidence of either full employment history, proof of Garda Síochána vetting, three written references or evidence of verification of information given to the provider by the staff member (Woodside, 23.11.2010).

Inadequate staff training and supervision

It is not only important to have nursing and care staff who have been appropriately recruited and vetted, but it is also necessary to have staff who have received the appropriate training to be able to address the needs of nursing home residents. Standard 23 relates to staffing levels and staff qualifications. The following passage demonstrates the importance of having appropriately skilled staff employed to care for the range of needs of residents:

Inspectors found that the mixture of residents in the centre included people under 65 with alcohol problems and social problems. There were also residents over 65 with dementia and other complex needs which staff struggled to meet (Glenbervie, 16.01.2010).

Standard 24 relates to staff training and supervision. The Standard states that staff members should receive 'induction and continued professional development and appropriate supervision' (p.34). However, some nursing homes did not have a programme for new staff: 'The person in charge told inspectors that there was no staff induction programme in place' (Glenbervie, 30.09.2009).

The HIQA inspection reports revealed gaps in staff training, particularly in staff training on elder abuse:

There had been no training for staff on preventing elder abuse. This posed a risk to residents as staff members were not fully informed in up-to-date practice in this area. There had been no review of operating policies in line with the new Regulations and Standards and staff did not demonstrate an adequate understanding of the new legislative framework (Rostrevor, 28.04.2010).

Elements of elder abuse staff training were evident in other nursing home inspection reports; however the training provided was inadequate. In some instances, the person in charge reported that he/she took on the responsibility of educating staff about the indicators of abuse and reporting procedures; however this did not include the DVD on elder abuse, which is a compulsory component of the elder abuse training (Upton House, 06.05.2010). Other inspection reports also highlighted inadequate staff training in this area. One nursing home had an adult protection policy, but it did not include the referral process to the HSE caseworkers for elder abuse when required and it was clear that not all staff had received the appropriate training in elder abuse:

One staff member employed for some time told the inspector that she had not watched it (the training DVD) yet, and other staff did not articulate sufficient learning or clearly demonstrate that they understood the importance of their own role in the protection of residents. There were no elder abuse training records for staff available to inspectors (Woodside House, 23.11.2010).

Staff members did not always receive adequate education on the prevention, detection and response to elder abuse in nursing homes and relied on their own discretion as to whether they should report an incident or suspicion.

6.4 Practice Factors

Practice factors relate to aspects of the day-to-day practices in a nursing home and the care work engaged in by staff. These include the quality of the care provided, the protection of residents on a daily basis and established routines.

6.4.1 Evidence of poor care practices

Throughout the inspection reports reviewed, there was evidence of poor care practices and a failure to meet the care needs of residents. In the majority of the reports, the type of care delivered was not recorded on resident care plans and was not person-centred. It was evident that the residents did not receive the appropriate care and attention from staff.

Inadequate care plan records

Resident care plans were frequently absent or incomplete and did not always address the residents' needs or provide evidence that the care required was delivered. An example reported by an inspector was that of a resident who was on continuous ambulatory peritoneal dialysis, but there were no records in the resident's care plan of how best to support this resident (Owen-Riff, 03.06.2010). Another example was that of a resident who was prescribed antibiotics for a chest infection, but who had not been receiving his regular prescribed nebulizer for over two weeks and the inspectors observed that this omission could have serious consequences for the resident and could result in prolonged illness (Glenberrie, 05.03.2010). Similarly, a resident who was reviewed by a dietician and whose swallowing reflex was poor had no mention of it in the care plan and therefore no care guidelines were in place (Glenberrie, 25.11.2009). Care plans that were not sufficiently detailed failed to indicate the care required:

Some care plans were not detailed enough. For example a care plan on catheter care did not state the type of catheter in use, the size, when it was inserted and how often it should be changed (Owen Riff, 3.06.2010).

In residential care settings, it is also important to record any changes in residents and their health, to monitor changes and to respond to any significant changes so that the appropriate care can be provided. One inspector observed that a resident's weight had decreased by 16.2kg in a 4-month period; however the information recorded had never been evaluated to determine the cause or consequences of the rapid loss in weight (Glenberrie, 25.11.2009). This problem was commonly reported in several nursing homes, as this example shows:

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Nursing records reviewed demonstrated that two residents had documented weight loss, one of which was a significant loss; however there was no evidence of appropriate commentary, intervention, monitoring, investigation, rationale or plan of care (Woodside, 18.04.2011).

In some cases, residents were not able to have their weights recorded as they were unable to stand and alternative weighting scales were not provided by the nursing home (Glenbervie, 05.03.2010).

Lack of resident supervision

Residents who require greater nursing support than others need more supervision; however appropriate supervision was not always provided by the nursing and care staff, which placed some residents at risk. The importance of adequate supervision was evident from the following inspection report:

Inspectors noted one resident at a dining room table with a cup of tea mid-morning. There was no staff member in the area to supervise. The resident had fallen asleep while holding the cup and as a result spilt the tea on himself. The tea was not hot, but the potential for serious injury was evident (Owen-Riff, 14.03.2012).

Similarly, inspectors found that a resident who had sustained a fractured hip following a fall had been in the bathroom unsupervised, despite her care plan indicating that she should be supervised in the bathroom (Glenbervie, 05.03.2010).

In some cases, staff neglected to attend to the essential care needs of some residents. For example, several inspection reports documented that water and drinks were not freely available or easily accessible to residents throughout the day (Owen Riff, 21.04.2012). Additionally, inspectors frequently observed residents being propped up with the use of pillows and being in the same seating position or location throughout the day, which was considered poor practice as it posed a risk of pressure sore development in the residents (Woodside, 23.09.2009). A resident in a nursing home was assessed and was found to be at high risk of developing pressure sores and had a pressure alleviating mattress; however he was left sitting in a chair in his bedroom for long periods without a pressure relieving cushion despite complaining

of being sore from sitting (Glenbervie, 05.03.2010).

Another resident who was also assessed as being at high risk of developing pressure sores was not being provided with any pressure relieving equipment as a preventative intervention (Woodside, 23.11.2010).

Inspection reports included mention of a definitive absence of pressure relieving seating and equipment in nursing homes and residents were seated on pillows and household cushions. One inspection report spoke of the lack of therapeutic benefit to residents of such devices and of how these were not in line with best practice in infection prevention (Woodside, 23.11.2010).

The poor quality of care provided in some nursing homes left residents at risk. For example, inspectors had observed a nurse administering eye drops, but had not adhered to the guidelines for administration, as she failed to wash her hands or draw the lower eye lid down as required (Glenbervie, 05.03.2010). Inspectors also observed nursing care staff engaging in unsafe manual handling practices:

Two staff members, a care assistant and the personal assistant to the provider were seen to carry out a full underarm lift with a resident from a wheelchair to a chair in the day room. The staff nurse was then observed bringing in this resident's Zimmer frame after the lift was completed (Owen-Riff, 21.04.2012).

In some cases, contradictory information about care practices within the nursing home was supplied. This was evident in the following extract in which a resident's care plan stated that passive limb exercises was a necessary intervention to prevent the resident's limbs from becoming contracted:

The staff nurse told inspectors that care staff carried out the exercises when they assisted the resident to and from bed. The two care staff who attended the lady in question told inspectors they had never carried out passive limb exercises and they had not received any instructions to do so (Glenbervie, 05.03.2010).

6.4.2 Poor safeguarding of residents' finances and belongings

Standard 9 of the HIQA standards states that each resident's finances should be safeguarded. However, there was evidence in some reports that nursing homes did not comply with this standard. A common theme across the inspection reports was the inadequate arrangements for safeguarding residents' cash and valuables (Upton House, 06.05.2010). For example, an inspector compiled a list of all the residents for whom the provider collected their state pension. The initial number given to the inspector was five, but at a later inspection, it transpired that the number was in fact nine (Glenbervie, 5.03.2010).

Several nursing homes failed to provide a safe and transparent means of managing or protecting residents' finances or their personal belongings. One nursing home had no policy or system in place for managing residents' finances and valuables:

The provider informed the inspectors that he managed the finances of several of the residents. He stated that he used the residents' money to buy cigarettes and alcohol for them. Details of income and expenditure, purchases made and balance of money were not recorded and there was no staff signature (Glenbervie, 30.09.2009).

Similarly, another nursing home report stated that 'the system in place for the management of residents' finances was not robust' (Rostrevor, 28.04.2010). In another report, the inspector referred to the lack of a formal arrangement for safeguarding residents' finances:

The inspector was concerned that the provider did not manage residents' finances and did not have formal arrangements in place to protect the interests of residents (Owen-Riff, 25.09.2012).

In one case, residents expressed dissatisfaction to the inspector about having no lockable area for their valuables (Glenbervie, 30.09.2009). Efforts to address this problem were evident in later inspection reports; however the system was unsuitable for some of the residents:

The provider provided combination locks on some residents' wardrobes. Residents spoken to said they were not happy with the combination locks

as they could not remember the numbers (Glenbervie, 16.01.2010).

Some months later, an inspection report for the same nursing home provided a resident's view of having no access to his finances: 'one resident told inspectors he did not have any money and was unhappy that he had to ask the provider for money when he was going out' (Glenbervie, 5.03.2010). Inspectors discovered that a notebook for this same resident's finances was not maintained.

There also appeared to be little protection for residents' personal belongings: 'very few personal belongings were visible in the residents' bedrooms' (Woodlock, 18.05.2010). Inspectors reported that residents' clothes were also poorly cared for as they were frequently unlabelled, which meant that clothing was often mixed up and even went missing (Glenbervie, 16.01.2010). In some cases, staff relied on their memory to identify residents' items (Rostrevor, 28.04.2010). In one instance, residents and staff told inspectors that clothing regularly went missing and they frequently saw residents wearing each other's clothes (Glenbervie, 5.03.2010). This practice of communal clothing was reported in another nursing home:

The inspector noted a container of socks and a container of sponges in the linen room. The person in charge stated that the socks were 'house socks' and used communally for all residents. She also stated that the centre had 'house pyjamas' used communally for all residents (Upton House, 24.07.2012).

6.4.3 Rigid routines

Standard 18 of the HIQA standards states that 'each resident has a lifestyle in the residential care setting that is consistent with his/her previous routines, expectations and preferences, and satisfies his/her social, cultural, language, religious, and recreational interests and needs' (HIQA 2012, p. 26). Daily routine in the case reports reviewed did not appear to promote residents' choice and autonomy. The HIQA inspections examined the established routines within nursing homes and discovered that a number of homes had a culture of rigidly-set routines and practices. In the case of one nursing home, some residents indicated that they were happy to fit in with the routine of the nursing home and indicated that they had become used to the schedule;

however some residents indicated that they would prefer to have the option of 'lying in for a while longer' and a few residents commented that breakfast was a 'bit early' (Rostrevor, 28.04.10). According to one resident, the routine on any given day was dependent on the particular staff member on duty, as one resident remarked: "It depends who was on if you got a lie in or not" (Rostrevor, 28.04.10). The same inspection report also referred to the residents' experiences of the routine of early breakfast: 'breakfasts were given by night-time staff and although some residents said that they liked an early breakfast, others stated that they would sometimes like to lie on in the mornings and have breakfast later' (Rostrevor, 28.04.10). Some inspection reports highlighted the fact that mealtimes were hurried and residents did not always get the opportunity to enjoy their food in a relaxed environment:

Inspectors observed that residents' lunch was a rushed affair and noted that the dinner trolley arrived to the dining/sitting room at 12:50hrs and was returned to the kitchen 20 minutes later at 13:10hrs even though some residents had not finished their meal (Upton House, 18.01.2013).

The routine in this nursing home appeared to be task-orientated rather than based on the individual resident's needs or wishes and appeared to discourage residents' independence rather than encourage it. One nursing home report observed that the nursing home was task-focused, rather than resident orientated or designed to encourage residents' independence. Residents were not always offered a choice in relation to aspects of the daily experience, such as timing of breakfast and other meals or the timing of retiring to bed and rising in the morning.

Another example of rigid routines was set shower days, which did not provide a flexible approach to personal care (Rostrevor, 28.04.10). In another nursing home, six residents were returned to bed before staff went off duty at 16.00hrs and, according to the staff, this practice was in place to accommodate the staff shifts, not residents' needs or wishes (Upton House, 18.01.12).

6.5 Resident Factors

6.5.1 Poor communication with residents

HIQA Standard 2 relates to consultation and participation and states that each resident has the right 'to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices' (HIQA 2012, p. 9). A common theme in the HIQA inspection reports was the absence of consultation with residents about their care plans, the running of the nursing home, and about their interests and preferences. The reports indicated that resident care plans frequently omitted social and recreational assessments. For example, one inspector noted that: 'two residents said that they would like the opportunity to start knitting again and another resident described the grand piano in the day room as "neglected" and would like to hear it played more often' (Rostrevor, 31.08.2010); however this information was absent from the residents' care plans and there was no evidence that these wishes and interests were being addressed.

Continued non-compliance of HIQA standards can lead to substandard care and reduced quality of life for residents. Few nursing homes indicated a system that reviewed and improved the quality of care and the quality of life for residents:

There was no formal mechanism in place or evidence to substantiate that the residents were consulted or informed as to the organisation of the centre, that their views were sought either collectively or individually and used to influence and improve upon the delivery of services (Woodside House, 23.11.2010).

In addition, it was evident from nursing home inspection reports that few residents were involved in planning their care or the running schedule of the nursing home:

There was little evidence that the concept of residents as active participants in their own care or in the organisation of the centre and services provided to them had been embraced ... There was no evidence that the views, wishes and preferences of the residents informed the organisation of the service and the delivery of services (Woodside House, 18.04.2011).

Residents indicated that they were offered very little choice in the nursing home. One resident stated that 'he just ate whatever he was given and that a menu with choice was not normally available to them' (Woodside House, 23.11.2010). One inspection report stated:

Inspectors viewed the menu which was in the form of a book and available in the dining room. There was a three-week menu cycle. It was not displayed in an easily readable, legible format and was not clearly visible to residents. On the day of inspection, a choice of meals was not offered and residents told inspectors that they did not know what they were having for dinner until it was served (Glenbervie, 30.09.2009).

Another inspection report indicated that, while residents were offered a choice of meals, the methods used to communicate the meal choices to residents were inadequate:

Although residents were offered a choice of food for lunch on a day-to-day basis, some residents were not able to remember what they had chosen and staff did not remind them of their choices as they served their meals. The menu was located behind the door of the dining room and there was no alternative menu for people who may have benefited from the use of graphics to communicate the available choices (Rostrevor, 27.04.2010).

Overall, the methods of communication used by staff with residents were reported to be very poor, and there was evidence of very little effort to enhance communication with people with dementia. Residents were not always facilitated in communicating their needs, especially those with hearing difficulties and visual impairments and assessments were not undertaken to explore how the communication needs could be enhanced (Rostrevor, 27.04.2010).

Opportunities for residents to voice their interests, needs or complaints were not always available:

Some residents stated that they had no involvement in organising the social and leisure aspects of their daily lives. There was no residents' committee or advocacy group in place to allow residents an opportunity to share their views and

feedback with the provider or the person in charge (Glenbervie, 30.09.2009).

Residents appeared to have little confidence in staff addressing any of their concerns or complaints. For example, many residents said that their clothes were missing and that they did not report this as "nothing will be done" (Glenbervie, 16.01.2010). On follow-up visits to nursing homes, it was evident that some had made no attempt to facilitate better communication with residents, as recommend by a previous visit:

There had not been any development of communication methods, such as advocacy, life stories, or reminiscence therapy, as ways to facilitate communication and engagement with cognitively impaired residents (Upton House, 30.03.2011).

Another nursing home similarly failed to use various means of enhancing communication with residents:

There was little evidence of enhanced communication and orientation cues such as talking mats, pictorial signage or orientation/whiteboards (Woodside House, 18.04.2011).

Poor communication from staff went beyond residents and extended to family members. One relative reported that staff were not forthcoming with information and that in order to find out about his/her relative's health care needs: "you have to be proactive ... seek out the nurse or phone the GP if you have a concern" (Owen-Riff, 3.06.2010).

6.5.2 Limited opportunity for meaningful engagement

The dearth of available opportunities for meaningful engagement for residents was evident throughout most of the inspection reports. Few activities were organised on a daily basis for residents and most of the HIQA inspectors observed residents remaining in the same chair for long periods without any form of stimulation or entertainment other than television. Even then, it was noted that some of the television programmes being shown were not ageappropriate for the residents (Owen-Riff, 14.03.2012). Inspectors observed the same music programmes being repeated on the TV and in-house sound system, and residents expressed a dislike for the music programmes available. Inspectors

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highlighted the fact that staff appeared to be unaware of residents' needs for stimulation:

Inspectors noted from observations and interviews with residents and relatives that residents were unfulfilled in many areas of their lives. There was no access to exercise, mental stimulation and emotional needs were not met by staff (Glenbervie, 16.01.2010).

Residents were observed to spend prolonged periods with little to occupy them, stimulate them or engage them in a way that was meaningful and psychosocially beneficial to them ... One resident told the inspector that she just "sits and sleeps" while another said that she found the days very long and looked forward to her daughter calling to take her for a walk (Woodside House, 23.11.2010).

HIQA inspectors often reported that the activity programmes within the nursing homes and outside involvement with the community were inadequate. One inspection report stated:

With the exception of an annual visit by local schoolchildren at Christmas, there was no evidence of the involvement of the wider community in the centre and residents said that they did not go out on any trips or outings (Upton House, 06.05.10).

Some of the residents, particularly the younger residents, made comments to inspectors such as "I'm sitting here with nothing to do – I'm frustrated" (Glenbervie, 30.09.2009). Inspection reports quoted residents stating that 'from time to time, they are bored' (Rostrevor, 27.04.2010). Activities that were planned by the nursing home were often not resident-centred or appropriate to their needs, interests and capabilities. Residents' interests were not always documented and did not contribute to the planned activities of the care home. This was particularly true for residents with higher dependency needs and greater cognitive impairment (Owen Riff, 09.08.2011):

The amount and variety of activity was limited, did not include appropriate therapies for activity focused care for those with dementia, and care plans did not detail activities and meaningful

occupation that suited residents' individual needs and preferences (Upton House, 30.03.2011).

One nursing home resident suggested that the "music could be more often" and stated he would "like more people to talk to" (Owen-Riff, 03.06.2010). Other residents commented that the mornings were long and "a bit dead" (Owen-Riff, 09.08.2011).

Standard 17 of the HIQA standards states that 'each resident can exercise choice and control over his/her life and is encouraged and enabled to maximise independence in accordance with his/her wishes' (HIQA 2012, p. 25). Meeting this standard requires staff to encourage residents to engage in activities and provide opportunities to engage in social activities, so that resident independence and autonomy can be promoted. Nursing home residents who spoke to HIQA inspectors expressed their dissatisfaction about not being consulted and this hindered their independence:

Several residents explained that the provider managed their finances and bought cigarettes, tobacco and alcohol for them to consume in the centre. These residents stated that they have lost their independence and they could not make choices about going out or shopping because they have no money. A resident stated that he had to get permission to go out and another said that he missed his freedom (Glenbervie, 30.09.2009).

Several nursing homes had no activities planned on inspection days (Glenbervie, 16.01.2010). One relative commented that 'her mother spends most of the time in the dayroom and that the layout of it could be improved to encourage socialising' (Rostrevor, 27.04.2010). The HIQA inspector went on to state that 'there were insufficient opportunities for residents with dementia to engage in meaningful activities' (Rostrevor, 31.08.10). Another nursing home inspection report spoke of similar absence of activities:

There were not sufficient opportunities for residents to participate and engage in meaningful activities that suited individual needs and preferences as outlined in their care plans (Upton House, 06.05.10).

Inspection reports referred to poor opportunities for social activity with many residents isolated in their bedrooms and with no interaction or conversation for very long periods of time during the day. The nursing home staff did not always encourage residents to participate in the social programme, where one existed: 'one resident, who required help in attending mass, informed inspectors that she would love to go, but had not been informed by staff. Following this, she was assisted to the living room where mass took place' (Woodside House, 09.04.2010). Another nursing home had a weekly schedule of social activities; however in reality staff had little time to engage with the residents or the activities: 'Although a weekly schedule of recreational events was in place which included bingo, music, singing and one weekly exercise session, inspectors observed that these activities did not always take place ... only one activity was observed to take place' (Creevelea, 31.03.2010). This resulted in residents sitting around for long periods.

6.5.3 Lack of dignity and respect for residents

HIQA Standard 4 states that 'each resident's right to dignity and privacy is respected (HIQA 2012, p. 17). Respect should apply to the language used by staff towards residents, the care provided to residents and the treatment of personal resident information and personal belongings. According to the HIQA inspection reports reviewed, some nursing home practices were institutional in their practices and transgressed residents' rights to dignity. During inspection visits, inspectors witnessed inappropriate use of language by some staff members and observed staff addressing female residents using language such as "good girl" (Glenbervie, 30.09.2009). It was noted that this form of address was not conducive to maintaining the dignity of residents.

Inspectors also reported practices that transgressed individual resident's personal dignity, such as at mealtimes. Some residents were observed wearing bibs long before mealtimes had commenced and in some cases a towel rather than a bib was used. While staff assistance was available, some staff remained standing over the residents while assisting them with their meal (Woodside House, 23.11.2010). One inspector observed paediatric drinking beakers with nursery themed imagery being used as a modified utensil, which was originally designed to promote residents' independence (Woodside

House, 18.04.2011). Staff were observed leaving used incontinence wear in residents' bedrooms (Woodside House, 18.04.2011) and communal creams were reported to be in use (Owen-Riff, 21.04.2012).

Inspectors spoke to residents about their clothing and laundry and many residents said that their clothes were missing (Glenbervie, 16.01.2010). Clothing was not consistently labelled and there was a lack of clean underwear available for residents. In discussions with staff, inspectors found 'an institutional approach to residents' clothing such as the sharing of clothes and underwear' (Glenbervie, 05.03.2010). An inspection report for one nursing home noted the use of 'house socks' and 'house pyjamas' for communal use by residents and indicated that washing sponges were also used communally (Upton House, 24.07.2012). In addition, inspectors observed personal information relating to individual residents displayed in a prominent location, which did not respect residents' privacy or dignity. For example, a report stated that 'there was a shower list displayed at the nurses' station specifying the days of the week on which residents had showers' (Rostrevor 27.04.2010).

The HIQA inspection reports also highlighted instances in which residents' right to privacy were infringed. Some practices did not safeguard residents' privacy. For example, residents did not always have access to lockable storage space in their rooms (Rostrevor 27.04.2010) and 'bedroom doors, bathroom doors and toilet doors could not be locked to promote and protect the privacy and dignity of the occupant' (Woodside House, 18.04.2011). Inspectors also observed bedroom doors propped open with residents lying on their beds uncovered while waiting for assistance (Owen-Riff, 14.03.2012) and observed residents through an open door using the toilet in an assisted bathroom adjacent to reception (Avondale, 23.09.2009). In one nursing home, a common complaint by residents was the difficulty with meeting visitors in private and the lack of privacy in the case of shared bedrooms (Woodside, 23.09.2009). There was also no separate designated room for residents to have clinical examinations, consultations or therapies if required (Woodside House, 23.11.2010). An inspection of this same nursing home almost two years later found that maintaining residents' privacy remained problematic.

7.1 Introduction

As the regulatory authority for promoting standards in residential care facilities in Ireland, the Health Information and Quality Authority (HIQA) has the responsibility to cancel the registration of individual care facilities that are in serious or persistent breach of its standards. In the event of de-registration, HIQA issues a report detailing the transgressions of standards that it found on initial and subsequent inspections. Such inspection reports provide a transparent account of the evidence for the HIQA decision to cancel a nursing home's registration. In their totality, the HIQA inspection reports also present a dataset with which to examine common themes that suggest patterns and trends in the way that nursing homes fail to meet their statutory obligations to provide safe care environments and good standards of care to their residents. This review examined a sample of such reports and, in addition to identifying common themes, also identified practices that might represent instances of potential mistreatment and neglect of residents. The themes were: environmental factors (the physical care environment), institutional factors (reporting procedures, use of restraints and staffing concerns), practice factors (poor care practices, poor safeguarding of residents' finances and possessions and rigid routines) and resident factors (poor resident communication, limited opportunity for meaningful engagement, and lack of respect and dignity of residents).

7.2 Risk of elder mistreatment

There have been several calls for information on the risks to resident safety and wellbeing, which are not 'specific incidents', in order to enhance understanding of the factors that are associated with mistreatment in residential care (Commission for Healthcare Audit and Inspection 2007; Hyde *et al.* 2014). Based on our analysis of the selected HIQA inspection reports of residential care homes that were in breach of the HIQA standards, there is evidence to suggest that risk to residents occurs at four levels, namely the environment of care, the institutional practices, daily care practices and the individual resident. These four levels of risk can, in turn, provide the basis for risk assessment and risk management that residential care homes might adopt.

The transgression of good standards at any one of these levels is in itself not acceptable and can adversely

influence the quality of life of the individual resident. Continued transgression of the standards at any or at all four levels may lead to serious neglect and mistreatment of residents. A tolerance of poor institutional and care practices creates the conditions in which poor individualised care, neglect and mistreatment of residents become normative practice. In its *National Quality Standards for Residential Care Settings for Older People in Ireland*, HIQA (2012, p. 27) states that 'all reasonable measures are required to be taken to protect each resident from all forms of abuse, including policies and procedures, recording and training for staff for the prevention, detection and response to abuse'. This requires that those in charge of residential care facilities must recognise the factors that exist in their facilities that can lead to abuse, which includes a tolerance of systems and practices that fail to take account of the individual needs and wishes of each resident. HIQA (2012, p. 27) also declares that care should be suitable and sufficient 'to maintain the resident's welfare and well-being, having regard to the nature and extent of the resident's dependency and needs'.

7.3 Environment and institutional practices

A dilapidated environment can affect the safety and wellbeing of residents and increase their vulnerability to mistreatment, and can therefore be considered an important contributor to circumstances of mistreatment (Hyde *et al.* 2014). A poor environment can also infringe on a resident's right to maintain a high degree of independence within the nursing home facility. Grzywacz and Fuqua (2000) emphasise the importance of having a strong and healthy environment for those who may display challenging behaviours, which are related to and reinforced by the individual resident's physical and social surroundings.

The institutional factors that relate to the day-to-day running of a nursing home include policies and practices in the way the facility is managed and include the extent to which it is resident or staff oriented. In addition, the content and quality of staff training also give rise to the type of institutional practices that prevail in a nursing home. Institutional practices give rise to the risk of neglect and mistreatment and, hence, appropriate staff training in the prevention, management and reporting of

elder abuse is fundamental to ensuring that nursing home residents are safe and protected from elder abuse (Hawes and Kimbell 2009; Phillips and Guo 2011). Nursing home staff need to be afforded protected time so that they can become familiar with elder abuse policies and guidelines and a particular emphasis needs to be placed on the prevention of mistreatment. Dehart *et al.* (2009) noted that in many cases, mistreatment by direct care staff in nursing homes results from misunderstandings, thoughtlessness, heavy workloads, and a lack of skills and knowledge and understanding of what constitutes mistreatment.

In a study that evaluated elder abuse training in Ireland, Fealy *et al.* (2014) reported that nursing students 'had difficulty in recognising and differentiating situations and circumstances that may render older people as vulnerable to abuse and neglect' (p. 76). The authors reported that trainees had relatively low levels of knowledge concerning the complexities of managing and responding to elder abuse, such as ritualistic abuse within care settings as well as reporting and responding to abuse. Another Irish study reported older people's perceptions of elder mistreatment and indicated that older people believed that staff should be competently trained, have police clearance and be supervised; however, they believed that this was not the case (O'Brien *et al.* 2011). Thus, greater emphasis needs to be placed on recruiting appropriately vetted and suitably trained staff who are familiar with what is deemed acceptable and unacceptable practice in the care of older nursing home residents.

Clough (1999) highlights the importance of transparency in the care of older people in residential care homes and emphasises the inherent power of staff who work directly with residents, and notes that a vital element in reducing potential abuse is to create a culture that encourages openness, in which staff can talk candidly about their concerns or uncertainties in practice. The culture of an institution can also heavily influence the inappropriate use of restraints (Goergen 2004). Despite the view that restraints are 'inhuman and degrading' (European Convention on Human Rights), there is evidence that there is excessive use of restraints in nursing homes (Pillemer and Moore 1989; Hawes and Kimbell 2009; Drennan *et al.* 2012), which are sometimes used to compensate for staff shortages.

7.4 Care practices and engagement with residents

Practices related to the day-to-day running of a nursing home and the care work provided by staff are important in determining risk of neglect and mistreatment of older residents, since elder abuse must be considered with reference to 'the nature of direct care and the acts of intimate caring of others' (Clough 1999, p. 13). Poor care practices, rigid routines and poor regard for the safeguarding of residents and their belongings contribute to abusive practices (Clough 1999). Payne and Gainey (2006) note that for some nursing home residents, their lifestyle or 'routine inactivity' may make them vulnerable targets for both personal and property crime. Poor care of residents' personal belongings conveys a message that residents and their possessions are unimportant. The Working Group on Elder Abuse (2002) recommended that each nursing home should establish an advocacy service to enable residents to protect their assets and possessions. Treating residents' material possessions with disregard may also represent an ageist attitude, which can be a prelude to elder mistreatment.

Our analyse of the HIQA inspection reports showed that essential care practices were not being recorded on resident care plans and were not person-centred; poor record keeping can lead to a poor standard of evidence-based care and may be attributable to high staff turnovers, which, in turn, may contribute to poor staff-resident relationships and a breakdown in staff-resident communication. Poor communication with residents can be further compounded if residents have behaviours that challenge or have communication difficulties. Nursing and care staff consider challenging behaviours and communication problems to be one of the most stressful aspects of caring for older people (Drennan *et al.* 2012; Natan *et al.* 2010; Benjamin and Spector 1990). Empirical evidence suggests that care staff interact significantly less with people with cognitive impairment when compared to people who can communicate cogently (Charlesworth *et al.* 2007). Subsequently, poor communication can lead to residents' needs being unmet and greater opportunities for incidents of mistreatment and neglect to occur. Therefore, staff's verbal and nonverbal communication strategies need to be enhanced in order to build rapport with nursing home residents (Dehart *et al.* 2009).

Nursing home residents have a right to dignity and respect. Studies have shown that staff who hold poor attitudes towards older people are more likely to engage in practices that threaten the welfare of those in their care. Drennan *et al.* (2012) found that one in ten nursing and care staff who provided care to older people in Irish nursing homes agreed with the statement 'residents in nursing homes and residential care settings are like children, they need discipline from time to time'. Previous studies have also found a correlation between poor attitudes towards older people and tolerance of abuse and neglect (Pillemer and Moore 1989; Goergen 2004; Shinan-Altman and Cohen 2009).

The literature draws attention to the importance of meaningful engagement and participation in social activities as well as being listened to; these contribute to residents' psychological wellbeing and have been found to be associated with improved quality of life (Marshall and Hutchinson 2001; Jonas-Simpson *et al.* 2006; Krueger *et al.* 2009). Nevertheless, as evident from the resident-related factors identified in this report, staff appeared to fail to recognise the importance of this aspect of a resident's life. Moyle *et al.* (2011) reported evidence that the social and intellectual stimulation needs of nursing home residents with dementia are being ignored, with staff mostly concentrated on their physical needs. Accordingly, staff in residential care settings need to identify ways in which residents can participate and engage in meaningful activities and, where possible, make a valued contribution to the nursing home.

7.5 Towards a framework for the prevention of elder mistreatment

The findings from the analysis of inspection reports of eleven residential care homes that failed to comply with national quality standards showed that risk factors for elder mistreatment resided at four levels, namely environment of care, the institutional practices, daily care practices, and at the level of the individual resident. These factors provide a basis for the development of a risk management framework for the prevention of elder mistreatment within residential care settings for older people. Owners and managers of residential care homes, in assessing the quality of care for residents, could use the factors identified at each of the four levels, as the basis for risk analysis and a risk management plan aimed at reducing the risk of elder mistreatment.

The care environment

The environment in which care is provided has been recognised as a possible contributor to creating circumstances of mistreatment (Hyde *et al.* 2014). Studies have found that the mistreatment of older people is more likely to occur in residential settings which are rundown and cramped (Hawes 2003); therefore, those responsible for the management of residential care homes should ensure that the physical care environment is maintained to a standard that promotes safety, independence, stimulation and comfort for all residents. For example, the residential facility should have all areas accessible to residents by installing lifts and mounting hand rails and ramps where necessary. Additionally, fire escapes should be accessible to all residents, uneven surfaces should be levelled out so as to prevent falls and the care facility should maintain a comfortable temperature for residents. Moreover, garden areas should be accessible and well maintained for residents to enjoy at their leisure and the interior décor and furnishings should be assessed by owners and managers periodically to determine whether they are of an acceptable standard.

Policies and staffing

Several factors associated with the risk of elder mistreatment were identified at institutional level; these mainly related to policies and staffing. A common factor identified by the analysis was inadequate recruitment and training procedures. All residential care centre employers and managers need to ensure that the required documentation for staff, such as previous employment references, and evidence of police vetting, are maintained and up to date. Furthermore, all staff involved in the direct care of residents need to be appropriately trained, particularly in the policies and practices aimed at protecting residents from mistreatment, as studies have shown that staff training is key in the prevention of elder mistreatment in residential care homes (Joshi and Flaherty 2005). It has been recommended that training should be frequent and not a 'one-off' and trainers themselves must be well educated and provide consistent information (National Centre on Elder Abuse 2005). By addressing these factors, staff will be familiar with what constitutes acceptable and unacceptable behaviour, which, in turn, will contribute towards a culture that prevents elder mistreatment from occurring and makes its early detection more likely.

Care practices and routines

The risk of elder mistreatment in residential care centres can also be reduced by addressing poor care practices. Practices can be improved by applying and maintaining comprehensive and up-to-date person-centred care plans, which provide detail of residents' physical, social and nursing care needs. In addition, daily care practices must ensure residents' safety and staff should be mindful of the fact that the more frail among their residents require greater supervision at mealtimes, shower times and when engaging in activities, so as to prevent falls and spillages. Good quality care practices also include the protection of residents' personal belongings and possessions (Clough 1999). The risk for elder mistreatment can be reduced by providing clear guidelines around the storage and handling of residents' personal belongings, such as maintaining a log of their possessions and finances, labelling clothing and belongings, and providing suitable secure storage for their valuables.

Another factor identified as a contributor to the increased risk of elder mistreatment was daily routines within the residential care home. Residential care facility owners and managers should examine daily practices for evidence of routines, which have been developed for staff and organisational convenience rather than for the residents' needs, comfort or preferences. Simple but effective changes might include individualised morning wake-up calls, staggered mealtimes and resident choices regarding time to retire to bed. Daily rituals and routines of the type identified in the HIQA reports act as a barrier to resident autonomy and independence and therefore impact on residents' quality of life.

Resident factors

The risk for elder mistreatment can occur at resident level. Frequently, emphasis is placed on the physical and medical care needs of residents and less on their psychosocial needs and quality of life (Kane 2003; Forbes-Thompson and Gessert 2006). Residential care home managers need to recognise that, in addition to ensuring the best possible care outcomes, it is important that their residents have meaningful lives and a good quality of life while in residential care. For example, enhanced staff-resident communication can improve quality of life for residents and some authors suggest that building relationships with residents should be a priority for direct

care staff (DeHart *et al.* 2009, p. 376). This means talking and consulting with residents, listening to their preferences and hearing their views and wishes.

Furthermore, innovative and effective means of enhancing communication with residents who have difficulties communicating or who have challenging behaviours could be explored; this might include simple methods like pictorial signage, story boards, advocacy and reminisce therapies. Therapeutic verbal and non-verbal communication techniques, such as open-ended questions, positive statements, eye contact, affective touching and smiling, have been shown to benefit staff and improve the quality of life of older people with cognitive impairment (Levy-Storms 2008). These approaches require adequate staffing levels, so that staff can devote sufficient time to engage with residents so that their needs and wishes can be heard and fulfilled.

In accordance with each resident's individual care plan, activities should be organised for and with the resident and their families; residents should not find themselves sitting for long periods of time without stimulation or the option of engaging in meaningful activities. Basic activities that can promote engagement can range from age-appropriate television programmes, movies, music, singing, card/board games and walks, to community involvement such as working with youth groups and attending religious services. By not providing rich stimulating activities and supporting residents to engage with these types of social activities, this important aspect of residents' lives is at risk of being neglected.

Those charged with the responsibility of managing a residential care centre should ensure that the dignity and respect for residents is maintained. For example, when speaking with residents, the language used by staff should be age-appropriate and respectful and if the use of bibs and beakers is required, these should be used at mealtimes appropriately and discreetly. In addition, doors should never be left lying open when residents are changing or using bathroom facilities and residents' clothing should be labelled and not be assumed to be for communal use.

7.6 Limitations

This analysis of published HIQA inspection reports has a number of limitations. Firstly, undertaking secondary data analysis has inherent reliability and validity limitations, since the data on which the reports were based were collected, collated and presented by a third party and may therefore be subject to reporting bias (Phillips and Guo 2011). Secondly, the HIQA reports do not contain information detailing actual incidents of mistreatment or abuse, such as the time that incidents occurred or the staff involved, and therefore do not represent the true extent to which residents experienced mistreatment in the nursing homes in question. Thirdly, the sampled reports were those concerning nursing homes that were in serious and/or persistent breach of HIQA standards and, as such, may not represent the majority of residential care facilities and, hence, the findings may not be representative of other residential care settings for older people in Ireland.

7.7 Conclusions

Recognising the factors that predispose residents of residential care homes to risk of elder mistreatment helps to improve awareness and provide a better understanding of what is required to achieve good quality care practices. This can, in turn, help to identify weaknesses and areas for improvement, ensure that standards are being complied with and thereby contribute towards an environment and care practices that make mistreatment of residents less likely to occur and its early detection more certain.

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