Examples of Violation of Human Rights in Nursing Homes in Ireland

Right to liberty and security

- Use of restraints including chairs and tables to prevent older person moving
- Decision by nurse and family on do not resuscitate order, without input from GP or geriatrician

Right to respect for private and family life

This right covers privacy, personal choices, relationships, physical and mental well being, access to personal information and participation.

This right is very broad in scope and covers many different situations which relate to the rights of older people. It emphasizes importance of dignity and autonomy

Article 8 relates to the following main interests:

- Privacy – this is defined broadly and relates to all aspects of privacy both in and outside of an individual's private home
- Family life – this covers all close and personal ties of a family kind - not only those of a blood or formalised nature
- Physical, psychological and moral well-being – this covers the right to wellbeing through retaining autonomy, choice and dignity. It requires that there is access to information and participation in decisions that affect an individual's life. Also relates to enabling older people maintain fulfilling and active lives and make own choices

Respect for privacy and dignity

- 3 out of 10 residents with dementia in night attire before 8.30pm- open to visitors in the evening.
- Centres not having suitable equipment to support residents with restricted mobility to bath and shower
- Ignoring requests to go to bathroom
- Soiled sheets left in person's room
- No water
- No food
- Assessed needs not met
- Institutional practices
    - Awakened at 6am for breakfast. Received 2 different types of psychotropic meds. One person had received a dose of 50% more than should have
    - In bed at 6.30pm

- Unsafe medicines management
- Under staffing particularly at night – one nurse for 47 residents half max dependency
- Residents at risk of falls not accommodated in appropriate rooms
- No management of pressure sores

Article 10 - freedom of expression

This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers.

When could this be relevant?

- Lack of clear complaints process
- No record of complaints in nursing home
- Formal consultation processes were not in place in the centre
- Failure to meet the communication needs of residents
- Residents' meetings had yet to commence and consideration was required in relation to how residents' who chose not to participate in such meetings would be consulted with or represented

Everyone has the right to vote

- Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use for older people
- Respecting the right to vote in secret
- Providing support to people to use their right to vote when they wish to

Freedom of assembly

When could this be relevant?

- The right to form a voluntary group or association

10 examples of EA recorded by HIQA [and raised by local and national media]

Examples of EA in specific Nursing Homes:

1. **Dungarvan Community Hospital**

https://www.hiqa.ie/system/files/inspectionreports/594-Dungarvan-Community-Hospital-29.07.2015.pdf

- Overall, the inspectors found that staffing levels in the evening and night time continued to be at the level of major non-compliance and there were no improvements since the last inspection and in fact they had deteriorated as the extra night staff only worked infrequently and not every night as had been in place on the follow up inspection in May 2015.
- Inspectors saw institutional practices that required immediate review and action and an immediate action plan was issued. However on this inspection the exact same practices were in place demonstrating continual non compliance and disregard for person-centered practice: the inspectors visited every unit in the centre at 18.30 hours on a sunny Friday evening and found that the majority of residents in the centre were in bed and curtains were closed.
- The inspectors also expressed concern regarding the lack of ongoing supervision of staff by management in that institutionalized practices have continued despite these practices being identified in previous inspections of the centre. The inspectors found that the centre remained major non compliant.
- Inspectors saw institutional practices in the dementia specific unit in which there were three residents out of the ten residents living there were in night attire before 18.00hrs despite them not retiring to bed until much later in the evening. The nursing staff were not able to give a rational explanation for this practice and it certainly did not fit in with person-centred care nor did it promote the privacy and dignity of the residents on the unit which was open to visitors for the evening. There were three staff on duty until 18.00hrs which reduced to two staff for the remainder of the evening and night and the inspectors formed the opinion that staffing levels contributed to this institutional practice.

Also see:

The Irish Examiner:
http://www.munster-express.ie/front-page-news/general-stories/nursing-home-residents-%E2%80%98up-and-dressed%E2%80%99-by-6am-according-to-hiqa-report/

Below, see RTÉ's coverage [at http://www.rte.ie/news/2016/0109/758836-hiqa-inspection-belmullet-home/] on the following:

2. **Marymount University Hospital and Hospice in Curraheen, Co Cork**

https://www.hiqa.ie/system/files/inspectionreports/582-Marymount-University-Hospital-Hospice-22.10.2015.pdf

- *Allegations of reported abuse were not investigated appropriately; complaints were not recognised as possible allegations of abuse, even though one issue of neglect had been raised by a social worker.*
- *Inspectors found that staff did not have up-to-date training in the protection of vulnerable adults.*
- *The nursing home was also found to have "virtually no care plans" in place to direct or inform the treatment of patients admitted for long-term care or respite care.*

3. **Cahermoyle Nursing Home in Ardagh, Co Limerick**

https://www.hiqa.ie/system/files/inspectionreports/0412-Cahermoyle-House-Nursing-Home-27.10.2015.pdf

- *All reasonable measures were not taken to protect residents from abuse.*
- *It also found that appropriate actions were not been taken following an allegation of abuse to prevent similar incidents happening in the future.*
- *Evidence was found that staff had observed three incidents of potential abuse that had not been reported immediately.*
- *Inspectors said they were not satisfied that the staff understood the nature of the abuse nor were they aware of their responsibilities in preventing, detecting and reporting such behaviour.*
- *Major non-compliance was also found in relation to the safe moving and handling of patients with mobility issues.*
- *HIQA found that the centre did not have suitable equipment to support residents with restricted mobility to bathes and showers.*

4. **Fearna Manor Nursing Home in Castlerea, Roscommon**

https://www.hiqa.ie/system/files/inspectionreports/0339-Fearna-Manor-Nursing-Home-18.08.2015.pdf

- *One nurse that was on duty during the day was to care for 43 residents, most of whom were regarded as high dependency.*
- *On the same week, one care worker worked an "excessive" 101 hours in a fortnight doing a 24-hour shift having just completed a 44-hour week.*
- *Staff told an inspector that long hours were a regular practise at the home.*

5. **The Good Counsel Nursing Home in Kilmallock, Co Limerick**

https://www.hiqa.ie/system/files/inspectionreports/416-Good-Counsel-Nursing-Home-30.09.2015.pdf

- *During an inspection last September, HIQA found that was found to be non-compliant in eight out of 10 areas inspected.*
- *Inspectors said a smell of smoke permeated the centre and burn marks on a bedding indicated that residents were smoking in their rooms.*
- *It said four staff who regularly worked overnight had never been trained in fire safety or taken part in a drill.*
- *Inspectors also found unsafe medicines management including medicines not being administered at the time and frequency required, medicines being kept in an unlocked fridge and no recording of when medicines were opened and if they had expired.*
- *A number of deficiencies were also noted in relation to the use of restraints, the carrying out of assessments and the making of care plans for patients.*
- *In one case records showed that a nurse had made a decision on a Do Not Attempt to Resuscitate (DNAR) order in consultation with the patient's family instead of with a consultant, hospital registrar or GP as guidelines required.*

6. **Tí Aire nursing home, Co Mayo**

https://www.hiqa.ie/system/files/inspectionreports/0401-T%C3%AD-Aire-Nursing-Home-02.10.2015.pdf

- *The night nurse on duty was caring for 47 residents, almost half of whom were of maximum dependency, and two of whom were dying.*
- *The inspection also found insufficient clinical oversight of residents.*
- *The unannounced two-day inspection took place in October following a tip-off to the watchdog.*
- *HIQA said the needs of residents were not adequately met because only one nurse was on duty from 6pm until 8am the following morning. Most of the 47 residents were maximum or highly-dependant.*
- *It said the nurse was responsible for administering a significant amount of medications, supervising care delivery and responding to residents' healthcare needs when required.*

7. **St. Peter's Nursing Home, Co Louth**

https://www.hiqa.ie/system/files/inspectionreports/0122-St.-Peter%27s-Nursing-Home-16.01.2016.pdf

Also see: http://www.northernsound.ie/news/hiqa-criticise-louth-nursing-home-after-allegations-of-abuse/

- Inspectors found major non-compliances in 7 of the 8 criteria they apply.
- Failed to report allegations of abuse, or to investigate them internally.

- A record with details of any plan relating to a resident in respect of specialist health care following assessment and or case reviews was not maintained in the centre to demonstrate involvement, recommendations and or prescription of care plan.
- The record of all incidents in which a resident suffers abuse or harm was not maintained.
- Records were not sufficiently completed to include the nature, date and time of incidents, whether medical treatment was required, considered or offered, the names of the persons who were respectively in charge of the designated centre and supervising the resident, and the names and contact details of any witnesses, the results of any investigation and the actions taken.
- A record of all medication errors had not been recorded and or reported.
- The record of all complaints made by residents or representatives or relatives of residents or by persons working at the designated centre, and the action taken by the registered provider in respect of any such complaint was not consistently maintained.
- Operational procedures described and written policies set out in schedule 5 that included the prevention, detection and response to abuse, management of behaviours that challenged, risk management and the handling and investigation of complaints, had not been sufficiently and or consistently implemented in practice.

8. Talbot Lodge Nursing Home, Malahide, Co. Dublin.

file:///C:/Users/Samobo/Downloads/182-Talbot-Lodge-Nursing-Home-09.07.2015.pdf

- There was no evidence that staff undertook a comprehensive assessment of residents who had behaviours that challenged in order to develop a plan of care.
- A resident who presented a risk to the safety and welfare of other residents and required on-going supervision was unsupervised at times when only two staff were on duty.
- A recent physical assault of one resident by another resident had not been identified as abuse, had not been investigated in line with the policy and was not notified to the Authority as an allegation of abuse.
- Residents at risk of falls were not adequately supervised. Two residents at risk of falls were accommodated in rooms which were over 50 metres from the nearest nurses' station.
- Care plans developed to manage the risk of pressure ulcer development were not being implemented in a consistent manner, -that pressure relieving mattresses were set incorrectly, -residents were not being repositioned at the recommended time intervals -A number of residents were left sitting in transit wheelchairs for considerable periods of time.
- Care plans for some residents at high risk of falls did not reference the level of supervision required or the use of alarm mats.
- The care plans in place to guide the nutritional management of these residents were not sufficiently detailed to effectively manage their needs, and the care plans in place had not been fully implemented.
- Residents' personal hygiene needs were not met to an acceptable standard.
- The personal and social care needs of residents were not comprehensively assessed. There was no evidence that staff undertook a comprehensive nursing assessment in order to develop a care plan to meet the unique personal social and emotional needs of the individual residents.

9. *Waterford Nursing Home, Dunmore Road, Waterford*

https://www.hiqa.ie/system/files/inspectionreports/255-Waterford-Nursing-Home-29.02.2016.pdf

This report sets out the findings of a one day unannounced inspection of Waterford nursing home. The Authority had received two separate concerns in relation to potential issues of safeguarding vulnerable adults in the centre:

• The first concern related to an allegation of institutional practice whereby residents were being washed and dressed before day staff began duty at 08:00. The concern also included information that residents who received night sedation were being woken early in the morning.

• The second concern related to the removal of a call bell from a resident at night. A call bell is an alarm system so that a resident can get immediate attention if needed. The call bell also acts as a way to reassure residents that assistance is always close at hand. The person in charge outlined to inspectors that he had been made aware of a complaint regarding an allegation of neglect of a resident. Inspectors spoke to staff regarding this allegation of neglect. The person in charge said that he was to conduct an investigation into this allegation which he was to forward to the Authority. Of the six outcomes that were reviewed on this inspection, four were at the level of major non-compliance:

- Outcome 7: safeguarding and safety Inspectors found evidence to uphold the first concern relating to institutional practices. After inspectors arrived at the centre, by 06:05 there were two residents awake and dressed and sitting in the dayroom, one resident upstairs and the second resident downstairs. By 06:30 two further residents were dressed and sitting in the dayroom, while a fifth resident was being washed and dressed at that time. Cleaning staff were observed by inspectors at 06.30 to be washing and polishing the floors with a machine. At that time of the morning this machine could be heard throughout the ground floor. Inspectors also saw evidence of the “communication carers books”. These books were used by healthcare assistants to record on a daily basis which residents were washed and dressed by night staff. In relation to the second concern of removing call bells from residents at night inspectors found that investigation process into this allegation was not comprehensive or completed within a reasonable time frame. There was evidence that staff had reported this issue of removal of call bells from residents on 27 August 2015. The person in charge had completed a report of his investigation into the disconnection of call bells. While the substantive issue of unplugging call bells had been addressed by the introduction of a new call bell system, the issue of staff unplugging call bells in an unauthorised manner had not been adequately investigated. Inspectors were given a draft copy of a separate investigation in relation to the unplugging of call bells being undertaken by Mowlam Healthcare as part of a human resource process. The nominee on behalf of Mowlam Healthcare indicated that this process would be completed within four weeks.
- Outcome 8: risk management While this inspection was focused on safeguarding of residents, risk assessments as they related to the safeguarding of residents were

also examined. It was found that improvement was required as to how risk assessments were being undertaken, communicated to staff and followed by staff.

- Outcome 9: medication Inspectors reviewed a sample of prescription and administration records as information received by the Authority indicated that residents who received night sedation were woken early in the mornings. On the morning of 17 November 2015 inspectors observed that four residents who were up in the morning before 06:30hrs had received night sedation the previous night. One resident had received two different types of psychotropic medication the previous night. Inspectors saw that this resident was washed, dressed and sitting in the dayroom at 06:10hrs. Inspectors noted that a medication administration record indicated that a resident received a dose that was 50% higher than the dose clearly prescribed on the medication prescription sheet. Inspectors were not assured that nursing staff were administering medications from the prescription records as this error would not have occurred if nursing staff had administered medication from the prescription which clearly indicated that the medication dose had been altered.
- Outcome 10: notifications of incidents An incident of an allegation, suspected or confirmed of abuse of a resident had Page 5 of 17 occurred on 29 August 2015. Inspectors saw evidence that the incident had been verbally reported by staff to the assistant director of nursing on the morning after the incident. In addition, staff had provided written statements when requested by the assistant director of nursing. However, the Authority had only received a notification from the person in charge on 30 October 2015.
- Outcome 11: Health and Social Care Needs The person in charge outlined to inspectors that he had been made aware of a complaint regarding an allegation of poor wound care regarding a resident. Inspectors reviewed care plans and turning charts for a resident with pressure sores. Inspectors also spoke to staff regarding this allegation of neglect. Based on this initial review of care inspectors were not satisfied that wound care management was in accordance with evidence based practice. Inspectors saw that a referral had been made to a palliative care service which indicated that symptom control was adequate. However, there was no evidence of an integrated multidisciplinary approach to care which would ensure that all complex pathways in relation to physical decline of residents is evident and based on contemporary evidence based practice. The person in charge said that he was to conduct an investigation into this allegation which he was to forward to the Authority. In relation to other non-compliance, during the course of the inspection personal information regarding residents such as personal care needs were left in day rooms which were accessible to all residents and visitors. Inspectors were not assured that staff used discretion when communicating personal care needs either as inspectors saw all this information with residents' names present in communication books used by care staff.
- Overall inspectors concluded that there were shortcomings in clinical leadership as evidenced through the deficits outlined in the report.

The Irish Times coverage of the above:

Vulnerable elderly residents of a Waterford nursing home were being got out of bed, washed and dressed by 6am, the Health Information and Quality Authority (Hiqa) has found.

Some of them had been given sedatives and psychotropic medication the night before and one was observed asleep in a chair in the day room "throughout the morning".

An unannounced inspection of Waterford Nursing Home, Dunmore Road, Waterford, operated privately by Mowlam Healthcare, was conducted on November 17th last year.

The authority had received two separate reports raising concerns about the home, hosting more than 50 residents.

Hiqa found "shortcomings in clinical leadership", and four instances of "major" non-compliance with national standards and two of "moderate" non-compliance.

"After inspectors arrived at the centre, by 06.05 there were two residents awake and dressed and sitting in the day room, one resident upstairs and the second resident downstairs," the report said.

"By 06.30 two further residents were dressed and sitting in the day room, while a fifth resident was being washed and dressed at that time."

Night staff said they had been asked to have residents up and dressed to help the day staff, who started at 8 am.

Four of the residents who had been woken before 6.30am had been give sedatives the night before. "One resident had received two different types of psychotropic medication the previous night," Hiqa said.

This resident was up, washed, dressed and in the day room by 6.10am. Psychotropic medication is used to treat anxiety, depression and insomnia, and can be mind-altering.

Loud machines were being used to polish ground-floor floors soon after 6am, creating noise through the ground-floor area.

Reports that residents' call-bells had been removed or unplugged at night had been made. The issue had been reported also to management and an investigation conducted. Inspectors found a new call-bell system in place.

However "the issue of staff unplugging call bells in an unauthorised manner had not been adequately investigated".

A review of prescription and medication administration records found one resident was given a dose 50 per cent higher than prescribed.

An alleged incident of "suspected or confirmed" abuse of a resident had occurred on August 26th, 2015. It had been verbally reported by staff to the management the following morning, and in writing soon after.

However, Hiqa was not notified until October 30th.

According to Hiqa standards, incidents in nursing homes may be required to be notified to the authority.

Wound care

An allegation of poor wound care amounting to neglect of a resident was made. Management was aware of the complaint. Inspectors spoke to staff and reviewed care plans, but were "not satisfied" wound care management was in accordance with best practice.

Mowlam Healthcare, responding to the report, told Hiqa the residents who were up and dressed early had chosen to get up at that time.

The start time for cleaning staff had been changed to 8am.

All staff were to undergo medication competency assessments. Education on adult protection and on wound management would also be provided to staff. (see the Irish Times: http://www.irishtimes.com/news/health/nursing-home-residents-were-being-wakened-by-6am-hiqa-1.2487170)

10. Conna Nursing Home, Fermoy, Co. Cork

file:///C:/Users/Samobo/Downloads/4447-Conna-Nursing-Home-28.09.2015.pdf

- Inspectors found that notifications had not been submitted to the Authority following two of the incidents reviewed by inspectors: -one incident concerned an issue of alleged abuse -a second concerned a resident who suffered a fall and required hospitalisation. The resident involved had sustained a minor fracture.
- Inspectors noted that the care plan for the infection was generic in nature, was not dated and did not contain details of the antibiotic or any relevant care instructions. In addition, inspectors observed that care plans for those residents with behaviour that challenges were not adequately detailed and did not promote a person centred approach to addressing each resident's needs.

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file:///C:/Users/Samobo/Downloads/4447-Conna-Nursing-Home-23.04.2015.pdf

- Management at a nursing home are moving to address serious concerns raised in an inspection report, including issues around patient money going missing and the use of chemical restraints.
- Two incidents involving money going missing from resident's bedrooms were noted in the complaints log. The centre did not notify the Authority regarding these allegations. There was a record of involvement of the Gardaí in one incident only and the incident remained

unresolved according to records seen. Complaints related to alleged missing money had not been notified to the authority as incidents of alleged financial abuse."

It added that "investigation records into this event were not produced to inspectors" and that "inspectors noted that inappropriate language was used on some occasions when recording details of relatives' complaints".

Elsewhere, the report outlines how the system for safeguarding residents' finances in the centre was "not robust" as all payments into and out of the residents' finances were not documented in a log and were not signed off by two staff members, while inspectors also noted that a notebook set aside for one resident's financial records was blank even though the resident had a large sum of money in safekeeping.

The report noted how "inspectors viewed a sample of complaints recorded which indicated that allegations, which could be construed as allegations of abuse, had been investigated as complaints" and that HIQA "had not been notified of these allegations, within the specified time-frame, as set out in legislation".

"Furthermore, a notification of the absconsion had not been made to the Authority with the required three-day period. This resident had climbed out the window on another occasion and had been prescribed psychotropic medication as a result of the 'behaviour that challenged'. This event had not been notified to the Authority from the point of view of the second absconsion or the use of chemical restraint, both of which are notifiable events (*see http://www.irishexaminer.com/ireland/cork-nursing-home-staff-used-chemical-restraints-378346.html).*

Other relevant media coverage:

The Journal #1

Complaints received by HIQA between 3 November 2015 and 5 March 2016 total at 161.

They cover a broad range of issues people have with elderly services, ranging from complaints to do with understaffing and cleanliness, to more serious allegations of abuse, lack of care and violence.

Furthermore, in one case a person states that they have found their relative sitting in wet underwear on several occasions and that "no dignity or respect is shown" to them.

The person alleges that staff "no longer encourages 'Resident X' to get out of bed" and that the person is "left sitting in wet underwear".

In another instance, a complainant noticed a bad smell in their relative's bedroom at a nursing home and discovered soiled bed linen was left in a bag beside the resident's bed.

Another complaint has to do with a resident "starving to death" while multiple complaints relate to elderly residents becoming dehydrated due to a lack of water.

One heavily redacted complaint alleges sexual assault by members of staff at a nursing home. Who is assaulted or what took place is not clear.

Another person said that the lack of care from staff at a nursing home had increased the health problems of an elderly person who later died. The person said that they had been told by nursing home staff that the residents were "falling deliberately" (see http://www.thejournal.ie/nursing-home-abuse-2705501-Apr2016/).

The Journal #2

THERE WAS ALMOST a 20% rise in the number of reports of abuse in State-monitored nursing homes last year.

In total, the Health Information and Quality Authority (Hiqa), was notified of 424 allegations of "suspected or confirmed abuse of a resident" at nursing homes in Ireland. This is compared to 357 notifications in 2014 – marking a rise of 67.

Under the Health Act 2007, peeople in charge of care centres are required to notify Hiqa of specified events to do with the disruption of the care of residents.

These would include allegations of abuse, loss of power, unexpected deaths, staff misconduct and others.

In total, there were 10,572 notifications issued in 2015 – well over half (6,187) of these had to do with a potential risk to the health, safety or wellbeing of nursing home residents.

As well as this, three centres for the elderly were shut down last year – two of which were forced to close by Hiqa (and one of which closed voluntarily).

The figures are contained in Hiqa's annual report on the regulation of centres for old people.

411 nursing home inspections were carried out last year in 343 registered residential centres across the country – half of which were unannounced.

In general, Hiqa said that "good levels of compliance with regulations" relating to the appropriate care of residents were found in the centres inspected… Mary Dunnion, chief inspector with HIQA said that progress had been made in "some areas" in 2015, but that providers of residential care services "must continue to drive improvements in 2016".

There are a total of 577 centres to care for the elderly in Ireland, the vast majority of which (76%) are privately operated.

Commenting on the figures, ***CEO of elderly advocacy organisation Age Action, Justin Moran***, said that he was "concerned" about the rise in allegations of abuse.

"It is essential that all of these cases are reported to the HSE's elder abuse case-workers and properly investigated," he said.