

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



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| <b>Centre name:</b>                                       | Kylemore House Nursing Home                              |
| <b>Centre ID:</b>   | OSV-0000055  |
| <b>Centre address:</b>                                    | Sidmonton Road,<br>Bray,<br>Wicklow.                     |
| <b>Telephone number:</b>                                  | 01 286 3255  |
| <b>Email address:</b>                                     | info@kylemorehouse.ie                                    |
| <b>Type of centre:</b>                                    | A Nursing Home as per Health (Nursing Homes)<br>Act 1990 |
| <b>Registered provider:</b>                               | Kylemore Nursing Home Limited                            |
| <b>Provider Nominee:</b>                                  | Ruth Behan   |
| <b>Lead inspector:</b>                                    | Nuala Rafferty   |
| <b>Support inspector(s):</b>                              | None   |
| <b>Type of inspection</b>                                 | Announced  |
| <b>Number of residents on the<br/>date of inspection:</b> | 37   |
| <b>Number of vacancies on the<br/>date of inspection:</b> | 1  |

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).



**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

|                       |                       |
|-----------------------|-----------------------|
| From:                 | To:                   |
| 17 January 2017 10:30 | 17 January 2017 19:00 |
| 18 January 2017 08:00 | 18 January 2017 17:30 |

The table below sets out the outcomes that were inspected against on this inspection.

| <b>Outcome</b>  | <b>Our Judgment</b>      |
|---|--------------------------|
| Outcome 01: Statement of Purpose                                      | Compliant                |
| Outcome 02: Governance and Management                                 | Non Compliant - Moderate |
| Outcome 03: Information for residents                                 | Compliant                |
| Outcome 04: Suitable Person in Charge                                 | Compliant                |
| Outcome 05: Documentation to be kept at a designated centre           | Compliant                |
| Outcome 06: Absence of the Person in charge                           | Compliant                |
| Outcome 07: Safeguarding and Safety                                   | Compliant                |
| Outcome 08: Health and Safety and Risk Management                     | Non Compliant - Moderate |
| Outcome 09: Medication Management                                     | Non Compliant - Moderate |
| Outcome 10: Notification of Incidents                                 | Compliant                |
| Outcome 11: Health and Social Care Needs                              | Non Compliant - Moderate |
| Outcome 12: Safe and Suitable Premises                                | Non Compliant - Moderate |
| Outcome 13: Complaints procedures                                     | Compliant                |
| Outcome 14: End of Life Care  | Compliant                |
| Outcome 15: Food and Nutrition  | Substantially Compliant  |
| Outcome 16: Residents' Rights, Dignity and Consultation               | Compliant                |
| Outcome 17: Residents' clothing and personal property and possessions | Substantially Compliant  |
| Outcome 18: Suitable Staffing   | Non Compliant - Moderate |

**Summary of findings from this inspection**

This was an announced inspection further to the receipt of an application to renew the registration of the centre. The inspection took place over two days. Prior to the inspection the provider was requested to submit relevant documentation to the Authority. The fitness of the provider entity was assessed through an ongoing fit person process. The fitness of the recently appointed person in charge was also

assessed. They demonstrated some knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland, through the fitness process and throughout the inspection process.

As part of the inspection process, the inspector reviewed the documentation submitted, ascertained the views of residents, relatives, and staff members, observed practices and reviewed records as required by the legislation. The findings of the last inspection, a dementia thematic inspection in September 2016, and progress on the actions arising from that inspection, also formed part of this registration process. Progress on implementing improvements required was found in many areas.

Changes to the management team with some improvements to governance systems were found, although these were not yet fully embedded in practice.

Improvements to the variety of activities, both individually and in groups, and opportunities for access to the community and to religious services were also found. Feedback from residents and relatives was positive and complimentary with many commenting on the timely and patient response by staff to residents' needs.

Residents had access to medical officers and allied health professionals, such as physiotherapy and speech and language therapists, and access to community health services was also available. However, considerable improvements were still required to ensure residents' healthcare needs were fully met. These included improvements to governance and management, medication management, infection prevention and control, risk management, and documentation and the assessment, planning and recording of care.

The action plan of this report highlights the matters to be addressed and also identifies where issues require to be addressed, related to the premises which did not conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013(as amended) and the National Standards for Residential Care Settings for Older People in Ireland 2016.

The action plan response, submitted by the provider to the action required under Outcome 12- Safe and Suitable premises, does not satisfactorily address the failings identified in the report. As the response was not acceptable, HIQA have taken the decision not to include the response in the published report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the regulations. However, it was noted that clarifications, on how the needs of all residents admitted, can be met within the current physical environment of Kylemore Nursing Home, were needed.

Copies of the document were available in the centre.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Actions were required following the last inspection to improve the standard of clinical governance and establish effective management systems within the centre. Specific improvements were required to audit processes, communication, and staff allocation systems and the level of supervision, direction and guidance provided to staff. Progress towards several of these actions was found on this inspection and improvements were found in areas such as communication and nutrition.

The provider had engaged the services of an external consultancy firm to assist the management team to improve governance systems, and improvements from the last inspection in September 2016 were found. These included:

- Data collection on key performance indicators (KPIs) had commenced in areas such as pressure ulcers, use of restraints, pain management and nutrition.
- The handover sheet was updated to include key information on high risks associated with each resident's needs.
- A new computerised care planning and recording system was in place and training recently provided to staff on its operation.

In addition, the provider had progressed actions required from the September inspection to improve the safety of care for residents. The inspector found that an audit plan was in place for 2017. The person in charge had commenced the audit process with a review of falls in the centre throughout 2016. The audit tool was comprehensive enough to identify possible trends and put in place preventative measures to reduce the incidence of falls.

However, some actions required arising from the September inspection were not addressed, although it is acknowledged that the timeframe for completion of these actions had not fully expired.

These included:

- Effective clinical governance systems were not in place to discuss learning from the analysis of key performance indicators (KPIs) and agree measures to improve the quality and safety of care delivered to residents.
- A clinical governance team was not yet established. This was expected to be in place by February 2017. The proposed team would include: the provider, the person in charge, a GP, pharmacist and an assistant director of nursing.
- The operational management team, comprising provider, person in charge, assistant director of nursing and administrator were to meet monthly with separate weekly provider and person in charge meetings. These meetings had not yet commenced.

The findings of this inspection also identified that further improvements to management and governance systems were required in the following areas:

- medicine management processes
- assessment, planning and recording of care
- risk management and infection prevention and control systems
- staff knowledge of key policies and procedures
- clarity on roles and responsibility of staff, and
- supervision, direction and guidance of staff.

**Judgment:**

Non Compliant - Moderate

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***Outcome 03: Information for residents***  
***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
Each resident had an agreed written contract which dealt with the resident's care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged. This included a list of facilities and services provided including laundry, meals, and housekeeping. Services which incurred additional fees were listed such as prescription charges.  
A guide to the centre was available to all residents. This described the centre services, management, complaints procedure, and contact information for useful external bodies. Notice boards displayed information regarding the complaints procedure, evacuation instructions and contact details for advocacy services.

**Judgment:**  
Compliant

***Outcome 04: Suitable Person in Charge***  
***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
The centre was managed by a suitably qualified and experienced nurse who held authority, accountability and responsibility for the provision of the service. Through an assessment process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions.



**Judgment:**

Compliant

***Outcome 05: Documentation to be kept at a designated centre***  
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Records set out in Part 6 of the regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide was complete and available. A copy of the insurance cover in place was provided which met the requirements of the regulations.

The directory of residents was reviewed and was found to meet the requirements of the regulations and was up to date with records of admissions discharges and transfers maintained.

It was found that, overall, general records as required under Schedule 4 of the regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records and operational policies and procedures as required by Schedule 5 of the regulations. Some records require to be improved in terms of completeness and accuracy and this is detailed under Outcome 11 Health and Social care. Polices were reviewed on a regular basis and within the three year timeframe required by the regulations.

It was found that all records listed in Schedule 2 and Schedule 3 of the regulations were being maintained in terms of accuracy and were updated regularly. The inspector reviewed a sample of staff files and found that they met all of the requirements listed in Schedule 2.

**Judgment:**

Compliant

***Outcome 06: Absence of the Person in charge***

***The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Suitable arrangements were in place for periods of absence of the person in charge. The fitness of a senior nurse to replace the person in charge in the event of her absence was determined through observation and discussion during the inspection and the senior nurse had the qualifications and experience required by the legislation.

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***

***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Procedures in place on the previous inspection did not fully reflect HIQA guidance, where residents' monies, for whom the provider acted as pension agent, were not lodged to individual bank accounts. This was addressed by the provider. Evidence was available to show the names and bank account numbers for each individual with signed confirmation from the bank manager. The provider also had a separate client file with receipts and withdrawals co-signed by the residents. Audit of these accounts by a qualified accountant were also established.

All other aspects of this outcome were found to be compliant on the last inspection.

**Judgment:**

Compliant

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building. The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors. A health and safety statement and related policies and procedures were in place.

Certification and servicing documents were available on fire fighting equipment, emergency lighting and fire alarms. The building's fire and smoke containment and detection measures were appropriate to the layout of the building, and exits were free of obstruction.

Fire records were viewed which showed that daily checks to ensure fire exits were free from obstruction were conducted, but documented evidence of weekly checks of the fire alarm panel, to ensure it was in working order, were not available. The inspector was told that the fire alarm was tested, during the quarterly maintenance checks, or during fire alarm drills. Training in fire safety was provided within the past 12 months, although not all staff had attended and some staff were not fully familiar with what actions to take in the event of a fire alarm activation. In addition, although personal emergency evacuation plans (PEEPs) which identified the level of mobility and evacuation mode of each resident were in place for long stay residents, some staff were not aware or familiar with them. It was also noted that although fire drills, which checked the responsiveness of staff to an alarm activation, were regularly held, these did not include simulation of an evacuation. The inspector found that drills including simulated evacuation events would benefit staff particularly where some were unclear as to the appropriate procedure for vertical evacuation of immobile residents.

Appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks was in place. A risk register was established which was regularly reviewed and updated. There were arrangements in place to review accidents and incidents within the centre.

The inspector reviewed the emergency plan which detailed the procedures staff should follow in a variety of emergencies. It included contact details of emergency services, but although an emergency pack to support staff during these events was available it was not mentioned in the plan and staff were not aware of it.

Policies and procedures to support good infection prevention and control were in place,

however, evidence that these policies were implemented in practice was not found. The inspector found that systems, to ensure all equipment was adequately and appropriately cleaned, were not in place and appropriate products were not being used. In conversation with some household staff, the inspector found they were clear on some aspects of good infection control processes such as: the use of personal protective equipment, cleaning protocols and specific cleaning products for decontamination following infection outbreaks. However, roles and responsibilities for infection prevention and control systems required clarification. For example, the inspector was told that the maintenance, household and healthcare staff share the responsibility for termination or deep cleaning equipment and fixtures or fittings such as beds, mattresses, pressure relieving mattresses or cushions, lockers and wardrobes. However, staff, spoken with, differed in their understanding and interpretation of their roles and a procedure outlining definitive roles and a breakdown of tasks associated with each role was not in place. On the day of inspection products used by the cleaning staff were limited to a cleanser spray and air freshener.

On the day of inspection, there were no records to show that the provider had a system in place to ensure the necessary sampling of stored water for Legionella.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Some improvements to the administration of medicines to comply with professional regulatory requirements or guidance were found on this inspection. However, further improvements to ensure the processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation were required.

Actions addressed further to the last inspection included:

- A review of the prescription and administration times to align the timeframe of administration in line with professional guidance.
- Accurate recording of the actual time of administration of medicines.
- Nurses were wearing 'do not disturb' tabards, to reduce risk of interruptions when administering medicine.

Actions related to medicine reconciliation to reduce incidents errors and omissions were not addressed.

Systems relating to the ordering, storage, and recording of medicines, including controlled drugs, were reviewed. Improvements to the systems in place to ensure safe disposal and return of unused or out of date medications were needed.

A controlled drug register was used to manage the receipt, administration, stock balance and return of these medicines. However, it was noted that the register was not formatted to include all of the processes required to appropriately monitor and manage the use of these medicines. For instance:

- The pages of the register were not formatted to ensure the full name, dosage and type (liquid/powder/patch) of medicine was identified.

- Columns to enable recording of every part of the checking process such as date; time; amount administered or discarded; stock receipts, returns and balances and staff signatures were not formatted.

- The register did not contain a tracking system, such as page numbers, colours or indentations to follow the sequence of daily administration of these medicines.

This meant that it was difficult to find the most recent entry and also to ensure proper reconciliation of stock balance. In addition, poor consistency on the amount of detail recorded in respect of all controlled medicines was found.

- It was noted that full names and amounts of the medicines were not recorded on every page and the names of the medicines were not being recorded on each entry when administered.

- An error in the recording of the stock balance of a liquid morphine based analgesic which occurred four weeks earlier was noted. This error had not been identified on audits of practices by the management team.

The system in place to ensure the safe receipt and return of controlled medicines were not fully implemented. Records for the receipt of medicines from the pharmacy were signed by the receiving nurse. However, it was found that some were then being removed from their original package and decanted into the boxes of existing stock. It was also found that the records of the return of unused or out of date medicines were not dated or signed by either the nurse returning the medications or the pharmacist to show they were received.

**Judgment:**

Non Compliant - Moderate

***Outcome 10: Notification of Incidents***

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

On review of the record of incidents occurring in the centre since the previous inspection

it was noted that these, where required, were notified to the Chief Inspector.

**Judgment:**

Compliant

***Outcome 11: Health and Social Care Needs***

***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The findings of the last inspection required actions to improve care planning and assessment processes to make them more specific and ensure they meet residents' needs. On the last inspection it was found that the care plan system was not properly implemented and assessments were inadequate. Nurse progress notes and recording of care delivery was not sufficiently detailed, accurate or complete to give a clear picture of each resident's current condition. The transfer of information within and between the centre and other healthcare providers was also found to be ineffective and inconsistent. With the exception of improvements noted to records management and improved transfer of information processes, the remainder of these actions were not addressed and the findings are recurrent on this inspection.

Residents had good access to GP services. There was evidence of regular reviews of residents' overall health on admission, and on re-admission following return from acute hospital care, and as required, when clinical deterioration was noted.

There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietician, physiotherapy and speech and language were also available.

Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. However, clinical records viewed did not contain enough detail to ensure they were effectively managing the health problem.

-Recognised assessment tools used to check for risk of deterioration in areas such as; risk of falls, nutritional status, levels of cognitive impairment, skin integrity or pain were not always used. Some were in an abbreviated form and did not provide enough detail on which to base a good plan of care. Others were not fully completed. Examples

included:

- Residents' baseline vital signs not recorded on admission such as blood pressure pulse or weight.
- Wound assessments did not include measurements such as depth, extent, or presentation.
- Positive behaviour support plans did not include the form the behaviours might take, triggers associated with the behaviour, distraction or de-escalation techniques to manage the behaviours.
- Some wound care plans did not include the recommendations of the tissue viability nurse specialist (TVN). Some did not reference the wound dressing chart or wound assessment to ensure consistency with dressing type used or frequency of changes. It was noted that in some cases, the dressing recommended by the TVN was not being implemented by the nursing team.
- Pain management care plans did not reference the type of pain, triggers or level of pain experienced. Reviews of this care plan did not identify whether the plan was effectively controlling the pain.

Aspects of other nursing documentation required improvements to ensure it was clear and coordinated. The reviews of care plans, although regular, did not always consider the effectiveness of the interventions to manage and/or treat the need. Greater efforts, to plan care in a person centred and holistic manner, were required. Risk assessments, care plans and nursing progress notes were not fully linked or detailed enough to give an overall picture of residents' current condition.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The actions required from the previous inspection in respect of improved signage were addressed.

The premises were maintained to a good standard and the inspector found that the provider had made efforts to improve the décor, comfort and look of the premises by providing soft furnishings, warm and bright colours, fabrics and cushions.

However, further issues in respect of the design and layout of the centre, and the

broader facilities available to meet the needs of residents were identified on this inspection.

The centre is situated in a row of large period town houses in a quiet area between the busy shopping area and the seafront promenade. It is laid out over two floors.

The ground floor consists of two communal sitting rooms, a small quiet room and a dining room, assisted shower facilities and toilets, kitchen, offices and laundry room.

There were six single bedrooms, three without en-suite and three with en-suite consisting of a toilet and wash hand basin. There were four twin bedrooms without en-suite facilities.

The first floor consisted of a communal sitting cum dining room, small nurses station, one assisted shower room with toilet, a dirty utility area and four single and five twin bedrooms. Two twin bedrooms contained a toilet and wash hand basin en-suite.

A mid-landing area consisted of a total of six bedrooms, a visitor's toilet and one communal bathroom. There were no accessible shower or toilet facilities in this area. On arrival at the mid-landing from the front staircase, the stairway curves to the right with eight steps and a chair lift. This area contains one communal bathroom and five bedrooms, four twin, two with en-suite, and one single bedroom without en suite. One twin bedroom had a fully accessible shower en-suite. All bedrooms in this area (known as Victoria) met the needs of the current residents in terms of space access and privacy as all residents currently occupying these rooms were fully mobile. The communal bathroom contains a toilet and shower but is not suitable for use by anybody who requires assistance or the use of assistive equipment.

At the time of the inspection all residents in this section were mobile. The provider gave verbal assurances that prospective residents are fully assessed and only persons who are fully mobile, would be accommodated in this section.

The remaining single bedroom, with toilet and wash hand basin en-suite was located to the left of the main front staircase. There were a further four steps to this bedroom and a chair lift.

The inspector found that some twin rooms in the centre did not fully meet the needs of the residents. There were a total of 13 twin bedrooms. Of these six were found to be sufficiently spacious to enable both residents spend time in the room either together or with their visitors. There was space for seating and use of assistive equipment if required.

However, the inspector found that the design and layout of certain twin bedrooms did not fully meet the needs of residents in terms of space or privacy and dignity. For example:

- Screening in two twin bedrooms did not completely surround the beds and consequently was not adequate to ensure privacy.
- In some rooms, there was insufficient space to store personal belongings. As a result clothing, footwear, and accessories, were stored in baskets on the floors and this gave a cluttered and untidy look to the rooms. Closet space in the rooms was full, and although more storage space was required, the rooms were not large enough to facilitate more wardrobes or dressers.
- The limited space available in some rooms made it difficult for staff to assist residents due to limited space between beds to facilitate chairs or use of assistive equipment.



The inspector noted that space limitations in some of these twin bedrooms could impact negatively on residents' privacy in certain circumstances. The profile of residents accommodated in these rooms, at the time of the inspection, included a mix of mobility and dependency needs. Some required the assistance of one or two staff with all of their activities of living. Others were more independent. However, the space available in some of the twin rooms, was not sufficient to enable residents comfortably receive visitors in their bedroom, without potentially impacting on the personal space of their neighbouring resident. It is acknowledged that there are alternative communal rooms available within the centre for residents and visitors to use, and no complaints had been received from residents. Nonetheless, as residents become more dependent this option may not always be possible to use. The inspector observed that some residents did not leave their bedrooms throughout the day, and found that this was a choice for some and due to the frailty of others. These areas were discussed with the provider during the inspection, who was advised to review, and give consideration to the premises, in relation to meeting the regulations and the national standards prior to the end of December 2021.

Other facilities did not fully meet the requirements of Schedule 6 of the regulations including:

- The dirty utility area did not include all necessary equipment for safe infection control practices.
- The laundry room and cleaning store did not contain all necessary equipment for adequate storage.

The position of the high level windows and roof windows in the first floor sitting room did not afford the residents any view. Similarly, the window in the ground floor sitting room looked directly out onto a wall. However, an alternative sitting room is available on the ground floor with a view which could be used by residents.

The premises were found to be visually clean, tidy, and uncluttered. Assistive equipment was in place, available for use and in good working order, service records were up to date, and maintenance contracts were in place. Fire doors and stairwells were not obstructed and could be accessed freely in the event of an emergency. Maintenance work was ongoing throughout the centre. Many of the bedrooms viewed by the inspector were personalised with photos, pictures and other personal items. There was a functioning call bell system in place throughout the centre.

There was access to a small paved courtyard with external smoking area, pleasant seating and planted areas.

**Judgment:**

Non Compliant - Moderate

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

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| <p><b>Theme:</b><br/>Person-centred care and support</p>   |
| <p><b>Outstanding requirement(s) from previous inspection(s):</b><br/>No actions were required from the previous inspection.</p> <p><b>Findings:</b><br/>Clarification on the nominated persons in place to ensure complaints were responded to and recorded were sought further to changes in the management team. The person in charge is the identified complaints officer. The provider is nominated to maintain oversight of the implementation of the process, and appropriate recording and responsiveness. An independent appeals person is also identified.</p> |
| <p><b>Judgment:</b><br/>Compliant</p>  |

***Outcome 14: End of Life Care***  
***Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.***

|   |
|---|
| <p><b>Theme:</b><br/>Person-centred care and support</p>  |
| <p><b>Outstanding requirement(s) from previous inspection(s):</b><br/>No actions were required from the previous inspection.</p> <p><b>Findings:</b><br/>Equipment and facilities for residents and relatives were available to meet religious and spiritual needs.<br/>A determination on the standard of end of life care delivered could not be fully made as no resident was receiving end of life care at the time of the inspection.<br/>Access to specialist palliative care services were available when required.<br/>Some evidence was available that the resident's will or preference was sought in relation to issues such as emotional, social and spiritual needs, place of death or funeral arrangements.</p> |
| <p><b>Judgment:</b><br/>Compliant</p>   |

***Outcome 15: Food and Nutrition***  
***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Actions required from the last inspection to ensure residents' privacy and dignity were maintained through person centred attention at meal times were fully addressed on this inspection.

Other actions addressed included;

- Colour coded plates were used for all modified diets.
- A heated trolley was in use to bring meals to residents on the upper floor and to maintain them at the appropriate temperature.
- An improved menu and updated diet sheet was in place and the diet sheet was available to the catering team.
- The menu was reviewed by a nutritionist to determine the nutritional value of the food provided.
- The menu was displayed in both word and pictorial format to aid understanding for residents.

However, further improvements were required to ensure the provision of high quality nutritious food at all times.

For example:

- It was noted that while the menu was reviewed by the nutritionist, a review of the dietary needs of all residents, based on a nutritional assessment, in accordance with their care plan had not yet taken place.
- All of the nutritionist's recommendations to improve the nutritional value of the food provided were not yet implemented. For instance, including more fresh cuts of oily fish such as salmon: healthy and hot breakfast options such as: homemade scones, waffles or brown bread: Boiled/poached or scrambled eggs.
- The heated trolley was used only for plated meals and the soup and sauces or gravy were left on the worktop in plastic jugs. The inspector found that these went cold very quickly after leaving the main kitchen and meant lukewarm gravy or sauce was being poured onto hot food.
- The displayed menu did not accurately reflect the choices available on the day.

**Judgment:**

Substantially Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful***

***activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Improvements to the variety of meaningful activities appropriate to residents' interests and abilities were found on this inspection.

Evidence was found that residents were being afforded opportunities to access the community with regular weekly walks, outings for coffee, trips to the seafront and to the local bookies. Time was set aside on a daily basis for individual hand massage with relaxing background music and aromatherapy oils for residents who were frail or did not enjoy group activities. Access to religious services had improved. Some residents were facilitated to attend Mass in the local church each Sunday and Mass was now celebrated in the centre on a monthly basis.

Increased involvement of healthcare staff in offering residents opportunities for stimulation was noted. The inspector observed staff playing bingo and holding quizzes with residents on the afternoon of both inspection days.

In conversation with them, the inspector found that some residents really enjoyed the exercise sessions and the quiz sessions as they found them stimulating and fun.

Residents were very positive in their comments about staff. In particular they appreciated the patient and gentle manner in which they gave assistance and how quickly they responded to their needs.

Information on how residents could access independent advocacy services was displayed on notice boards.

**Judgment:**

Compliant

***Outcome 17: Residents' clothing and personal property and possessions  
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.

There was a policy in place of residents' property in line with the regulations and a list of residents' valuable property and furniture was maintained where required.

Residents had access to a locked space in their bedroom and wardrobes and dressers were also available to store clothing and personal belongings. However, it was found that, for many residents, the size of the furniture or the amount of storage space available within the rooms was not sufficient to contain all of their belongings. In some rooms, clothing was hanging on the back of chairs or on the wardrobe doors. In others, the wardrobe doors could not close properly. For some residents, shoes, accessories and other items were stored in small baskets on the floor or on the windowsills. The tops of some lockers were also completely covered.

**Judgment:**

Substantially Compliant

***Outcome 18: Suitable Staffing***

***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**

Workforce

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Sufficient direct care staffing numbers and skill mix were found to be in place to meet the needs of the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. Cover for planned and unplanned leave was provided, primarily through a bank of relief staff.

Actions required further to the last inspection included the need to provide training and development opportunities to some staff, particularly catering staff, and to ensure improved communication with, and appropriate supervision of staff. These were partially addressed. Training opportunities were provided, although it was found that all staff had not attended. Training was delivered in areas of clinical practice specific to the

residents profiles and further to findings of the last inspection including; nutrition planning, care planning and assessment; medicine management; recording of care and recognising and responding to signs of deterioration. There was evidence of opportunities, to avail of updated training in areas such as safeguarding, moving and handling and fire safety, but evidence that all staff had attended the training in these mandatory areas was not available.

Staff were familiar with residents' needs and preferences and appropriate and respectful interactions were observed throughout the day between residents and staff. Overall it was noted that resident's dignity and choice was respected during care interventions and in their daily lives. However, it was found that the roles and responsibilities of all grades of staff were not clear and staff were not familiar with all policies and procedures in place. This lack of knowledge and role clarity, in conjunction with some staff not attending updated training, negatively impacts on the management of risks in the centre in respect of infection prevention and control practices and implementing fire evacuation procedures. Findings related to this are detailed under Outcome 8 of this report.

Some improvements to supervision and communication processes were found, including: the creation of a handover sheet that detailed the needs and key risk areas for each resident, such as falls, absconsion, and responsive behaviours. An additional handover at midday had commenced. Nevertheless, a clear system of direct supervision of staff practice by the person in charge or senior nursing staff had not been established, and the inspector found that governance systems were not effective. The establishment of a clear, effective supervision system should be prioritised, given the recent recruitment of new staff due to commence in post. These new staff members will require induction and mentoring by the management team, and will look to existing staff to help them become familiar with the workplace and work systems.

Good recruitment processes were in place, including a Garda vetting process, and all staff had completed a vetting process. Identity checks were also conducted for all overseas staff recruited. Verification was available that all nurses were registered with the Irish Nursing Board.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Nuala Rafferty  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

|                            |                             |
|----------------------------|-----------------------------|
| <b>Centre name:</b>        | Kylemore House Nursing Home |
| <b>Centre ID:</b>          | OSV-0000055                 |
| <b>Date of inspection:</b> | 17/01/2017 and 18/01/2017   |
| <b>Date of response:</b>   | 17/07/2017                  |

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

#### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Effective management and governance systems were not fully implemented to ensure that the service provided was appropriate to residents' needs, consistent and effectively monitored

#### 1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.



ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A number of effective management and governance systems were introduced following the last inspection in September 2016 and are now fully operational. The systems were not fully in place at the time of the inspection on the 17th and 18th January as the timeframe for completion of ensuring these systems were in place was the 31/01/2017 as outlined in the response to the September inspection.

The new person in charge took up her post on 7th November 2016.

Monthly collection of data related to clinical key performance indicators commenced from 1st November 2016.

The person in charge has developed a planned audit programme which is subject to change if trends are identified by the KPI's. The outcome of all audits will be included on the agenda for clinical governance meetings and results will be disseminated to appropriate staff.

The person in charge has undertaken audits of falls and incidents which identify trends and recommend appropriate actions. Action plans for all required actions are in progress as detailed in each of the audits.

A new handover sheet was introduced which provides comprehensive information for each resident. This document is reviewed by the person in charge, deputy director of nursing or staff nurse on duty on a daily basis and is made available to all staff involved in providing direct care to residents

Since the inspection a new Governance and Management policy has been developed and implemented which displays a clearly defined management structure that identifies who is in charge and what the reporting structure is. The policy states the responsibilities of all grades of staff and was fully circulated to each staff member so that they have a clear understanding of their roles and responsibilities.

All job descriptions have been reviewed to ensure they accurately reflect the roles and responsibilities set out in the policy. Meetings with all staff have taken place in respect of roles and responsibilities

Clinical governance meetings took place as scheduled on 24th January 2017, 27th February 2017, 27th March and 24th April.

Monitoring of progress is reviewed and action plans prioritise actions and detail timeframes for action as well as the person(s) responsible for each action.

A review of all incidents that have occurred since the previous meeting is carried out as part of the format of clinical governance meetings, including identification of learning and actions to disseminate that learning.

Further actions related to this outcome are detailed in outcomes 8, 15 and 18.

**Proposed Timescale:**

Governance and Management policy complete. Distribution of policy to all staff on 17th March 2017. Review of job descriptions completed on 15th March 2017. Staff meetings about revised job descriptions commenced 18th March 2017 and concluded by 31st March 2017.

**Proposed Timescale:** 31/03/2017

## **Outcome 08: Health and Safety and Risk Management**

### **Theme:**

Safe care and support

### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Practices to support good infection prevention and control were not found. Appropriate infection and prevention control was not being implemented or monitored. Appropriate products were not being used and systems to ensure all equipment was adequately and appropriately cleaned were not in place. Records that showed sampling of stored water to prevent risks from Legionella were not provided.

### **2. Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Routine water sampling to reduce the risk of Legionellosis commenced as per national guidelines. In addition weekly tap runs in all areas have been put in place and documented.

b)

- The person in charge and centre manager have met with staff and their roles in relation to infection control have been clearly explained to them. This will be further supported by the action plan detailed in Outcome 2.
- On line infection control training has been provided for household and maintenance staff. An external consultant provided initial infection control training to staff on the 31st March.
- Our cleaning policy has been reviewed by the person in charge and centre manager to ensure it contains all relevant cleaning processes.
- A written protocol to ensure all areas of the centre are regularly cleaned has been developed and appropriate staff sign to say each area has been completed.
- The person in charge and centre manager review these records monthly to ensure compliance.
- Appropriate products were in place on the days of the inspections, however, it is acknowledged that they were not in use.
- All products have been clearly labelled with the name of the products and the area/areas in which they are used.

### **Proposed Timescale:**

a)Initial testing completed end March and weekly tap runs in place since 11th March

b)An external consultant provided initial infection control training to staff on the 31st March. Training is an on-going process and all staff will be facilitated to attend training. The last session took place on June 12th.

Cleaning protocol has been developed and implemented.

Training in the use of chemicals completed

**Proposed Timescale:** 31/03/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Simulated fire drills and practices that reflect night time staffing were not conducted and drills during day time were not conducted to include the use of equipment such as evacuation sheets and ensure staff were fully familiar with the procedures and competent in the use of equipment.

**3. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Simulated fire drills are undertaken on a continuing regular basis. A fire drill simulating night-time conditions for night-time staff were held on 15th and 17th February and will continue on a quarterly basis for all staff.

Fire drills now incorporate evacuation procedures which include the use of evacuation sheets.

Resident's personal emergency egress plans will be discussed with all staff at planned meetings.

Proposed Timescale: Fire drills reflecting night time staffing completed by 17th February. Fire drills for all staff on a quarterly basis

**Proposed Timescale:** 17/02/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Documentary evidence of regular testing of the fire alarm panel to ensure it was in working order was not found.

**4. Action Required:**

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

Procedures for documenting testing of the fire alarm have been revised. The weekly test is now documented in the Fire Register

Proposed Timescale: Completed and on-going

**Proposed Timescale:** 17/07/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some staff had not attended training in the fire procedures or had not been fully inducted in the procedures to follow.

**5. Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Two fire safety training sessions were held on the 16th March. Detailed fire safety information is included in the Induction Manual for all new staff.

The training required under Action 4 is carried out on a regular basis and the training in March referred to, covered all staff who to date had not yet received this training in the previous year. This action is on-going and further dates will be arranged to ensure that all staff members receive this training including new staff.

Proposed Timescale: Completed and on-going

**Proposed Timescale:** 16/03/2017

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Robust processes were not in place to ensure safe medication practices in line with relevant legislation or professional guidance issued.

**6. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident

concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The person in charge has undertaken an audit of the documentation and administration of controlled drugs.

- As a result of this audit, the recording of the stock balance of liquid morphine based analgesic has been discontinued as it is no longer in a category that requires stock balance to be recorded.
- A new formatted controlled drug register has been put in place with completed documentation for each drug completed. The practice of not storing medicines in the original containers has also ceased.
- All nursing staff were provided with the result of the audit at a meeting with the person in charge on 20th February and of the new procedures to follow as a result of this audit.
- A further audit has been undertaken by the person in charge to ensure these deficiencies have been corrected

Proposed Timescale: Medication audit completed 30th March 2017

**Proposed Timescale:** 30/03/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Records to show safe disposal or return of unused or out of date medications were not dated or signed by either the nurse returning the medications or the pharmacist to show they were received.

**7. Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

During the course of the inspections it came to light that a return of a controlled drug was not recorded in the administration book. Subsequent investigation by the person in charge revealed that the return had been entered and correctly signed for in the stock control book but not in the administration book. This systems error has been addressed.

- In future both the administration book and the stock control book will be signed and

dated both by the nurse and the pharmacist receiving the returns.

- All nurses were reminded of the correct procedure for recording the return of controlled drugs at a meeting with the person in charge on 20th February 2017.
- A further audit was undertaken at the end of March. All Nurses were made aware at a meeting on the 20th February of the correct procedures for recording the return of controlled drugs.

Proposed Timescale: Medication audit completed

**Proposed Timescale:** 30/03/2017

## **Outcome 11: Health and Social Care Needs**

### **Theme:**

Effective care and support

### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

### **8. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

- A comprehensive pre- admission assessment is now undertaken by either the person in charge or her deputy using the assessment form on the new electronic system. This assessment gives a complete overview of the residents' health, personal and social care needs. The assessment is hand written initially and is then transferred into the electronic system so that the information is readily available to all nursing staff.
- The person in charge has also developed a detailed list of the essential information to be collected and documented on the day of admission.
- These processes will be audited to ensure compliance.

Proposed Timescale: Checklist complete. Pre- admission assessment and day of admission documentation audited at end May.

**Proposed Timescale:** 30/05/2017

### **Theme:**

Effective care and support

### **The Person in Charge (PIC) is failing to comply with a regulatory requirement**

**in the following respect:**

Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

**9. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Reviews of care plans will now incorporate documented evidence of resident participation and feedback on the effectiveness of treatment provided to include any MDT feedback

**Proposed Timescale:** 15/05/2017

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The documentation of care was not sufficiently accurate or appropriately linked to evidence the continuous delivery of a high standard of evidence based nursing care or give a clear and accurate picture of residents' overall health management.

**10. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

- All residents now have assessments completed using validated assessment tools. No assessments are abbreviated. Care plans are now in place on the new electronic recording system and give a clear and accurate picture of resident's overall health management. A booklet has been developed with sample care plans to guide all nursing staff.
- The person in charge has worked with each individual member of nursing staff to ensure that care plans include review of risk, incidents and complaints to ensure care plans meet the necessary standard
- The person in charge has audited these processes

Proposed Timescale: Care plan audit completed 30th May 2017.

**Proposed Timescale:** 30/05/2017

## Outcome 12: Safe and Suitable Premises

### Theme:

Effective care and support

### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The premises did not fully meet the requirements of the regulations as set out in Schedule 6. These included:

- The dirty utility area did not include all necessary equipment for safe infection control practices.
- The laundry room and cleaning store did not contain all necessary equipment for adequate storage.

Consideration should be given on how privacy and dignity can be ensured for residents in shared bedrooms during care provision and to facilitate visitors. This is required to ensure the availability of suitable adaptations and such support, equipment and facilities as may be required for residents.

### 11. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

### Please state the actions you have taken or are planning to take:

The action plan submitted by the provider, for this action was not acceptable to HIQA, as it does not satisfactorily address all of the failings identified in this outcome of the report.

### Proposed Timescale:

## Outcome 15: Food and Nutrition

### Theme:

Person-centred care and support

### The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A review of the dietary needs of all residents based on a nutritional assessment in accordance with their care plan had not yet taken place. All of the nutritionist's recommendations to improve the nutritional value of the food provided were not yet implemented

### 12. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.



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

- A review of all resident's dietary needs based on a nutritional assessment has been completed and their care plans reflect this information.
- The person in charge met with the nutritionist on 7th February to discuss some individual residents who are classified as being in the obese category. They had a further meeting on 14th February and the dietician compiled some suggestions based on the information she was given by the person in charge.
- The centre manager met with a number of residents on 15th February and some expressed an interest in trying some new meal options.
- The breakfast menu now includes the nutritionist's recommendations.
- Since the inspection further menu recommendations have been implemented and the nutritionist has developed a 4 week menu cycle which the person in charge has implemented, following discussion with and agreement of the residents.

Proposed Timescale: Completed and on-going

**Proposed Timescale:** 14/02/2017

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Systems to ensure all food was maintained at safe temperature levels were not fully implemented.

**13. Action Required:**

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

- Stainless steel vacuum jugs had been provided and the catering staff have been reminded of the essential requirement to ensure they are used for soups, sauces and gravies.
- Soups are poured from these jugs into individual bowls for each resident at the point of service. Gravy and sauces are decanted into delph gravy/sauce boats at the point of service for each resident.
- The temperature of these liquids are recorded at the point of decanting into the vacuum jugs in the kitchen and are checked again at the point of each service to ensure they are maintained at satisfactory temperature levels.
- The accuracy of the food temperature probes are checked and recorded monthly.

Proposed Timescale: Complete and ongoing

**Proposed Timescale:** 17/07/2017

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The amount of storage space available to many residents was not sufficient to contain all of their belongings

**14. Action Required:**

Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

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

We have reviewed the layout of all rooms and where necessary prepared a revised design for the storage space for each resident, maintaining of their clothes and other personal possessions.

Proposed Timescale:

Review completed and new wardrobes and storage units on order for 2 rooms due no later than mid -August 2017

**Proposed Timescale:** 31/08/2017

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Evidence that all staff attended updated training provided for fire safety or safeguarding was not available.

**15. Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

- In relation to fire safety training see Actions 3 and 4 above.
- Training for all staff on elder abuse is being provided in-house.
- New training on safeguarding, which is only just being rolled out within our sector, has been undertaken by a senior staff nurse on the 24th February 2017 and was attended by the person in charge on 25th May 2017

Proposed Timescale: on-going for safeguarding and see proposed timetable for Actions

3 and 4 for fire safety training

**Proposed Timescale:** 17/07/2017

**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

A clear, effective system of direct supervision was not established.  
The roles and responsibilities of all grades of staff were not clear and staff were not familiar with all policies and procedures in place.

**16. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Systems have been put in place to ensure that all staff are appropriately supervised

These systems are as listed in the attached Appendix A and the timetable for same is as set out below.

Proposed Timescale:

Protocol for Nurse's Routine has been developed and implemented.

New handover system in place since 27th February 2017.

Midday handover system in place since 23rd February.

Additional feedback meetings implemented on 20th March 2017.

Performance appraisals commenced on 13th March and now completed

Completion of Staff Nurses management training is dependent on future availability of dates.

Policy display commenced 3rd April 2017.

Person in charge works alongside individual nurses and this is ongoing.

Induction programme in place and ongoing.

**Proposed Timescale:** 03/04/2017

