

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Kerlogue Nursing Home
Centre ID:	OSV-0000240
Centre address:	Kerlogue, Wexford.
Telephone number:	053 917 0400
Email address:	info@kerloguenursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Candela Healthcare Limited
Provider Nominee:	Edele Lee Morris
Lead inspector:	Caroline Connelly
Support inspector(s):	Shane Grogan
Type of inspection	Unannounced
Number of residents on the date of inspection:	81
Number of vacancies on the date of inspection:	9

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.

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 Quality 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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 November 2015 10:30	17 November 2015 18:00
18 November 2015 08:50	18 November 2015 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
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 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a two day unannounced monitoring inspection of Kerlogue Nursing home. The inspection also looked at the care and quality of life for residents with dementia living in the centre. A very large percentage of residents who were residing in the centre on the day of the inspection had a diagnosis of dementia. The provider had submitted a completed self assessment on dementia care to the Authority with relevant policies and procedures prior to the inspection and these were assessed during the inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. The inspectors spoke to many residents and relatives during the inspection and the collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged with residents and relatives stating they are welcomed at any time. Residents' comments are found throughout the report.

The Authority was in receipt of unsolicited information in relation to food and

nutrition and in relation to staffing levels. A provider led inquiry was requested from the centre in August 2015 and was received by the Authority on completion and included the required evidential documentation. Inspectors reviewed documentation in relation to the unsolicited information such as care plans, medical records, policies and procedures, and reviewed staffing levels and care practices. The issues were explored throughout the inspection and are addressed and discussed under the relevant outcomes. The inspectors were satisfied that the issues raised had been dealt with appropriately by the provider and the person in charge.

Overall, the inspectors found that residents' healthcare and nursing needs were met to a good standard. Residents had access to medical, allied health and psychiatry of later life services. The management of complaints was compliant with regulations. Appropriate policies, procedures and practices were in place to protect residents from any form of abuse and residents had access to advocacy services as required.

There were systems in place to support residents with dementia and their representatives to participate in the assessments, care plans and the organisation of the centre. The environment supported and staff respected the privacy and dignity of residents. The social needs of many residents were met and the inspectors saw and the residents confirmed that there plenty of activities going on during the day which included music therapy, bingo, arts and crafts, religious activities.

The centre had a stable workforce of long term staff, with low levels of absenteeism. Staff had comprehensive training, including training to work with people with dementia and behaviours that challenge. Inspectors found that staffing arrangements facilitated continuity of care and supported a consistent positive approach to the behaviours and psychological symptoms of dementia. However over 50% of residents used bed rails and greater use of less restrictive alternatives was required. The environment was observed to be very clean and personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed.

The premises were not designed specifically for people with dementia. However most of the residents had a single room and free access to a suitable secure garden. One part of the centre was found to be particularly designed to meet the needs of residents with dementia with colour coding on doors, enhanced signage and the use of contrasting colours, secure gardens and safe walkways which enhanced the lives of residents with dementia living there. However the inspectors observed that the environment in one area of the centre was not conducive for creating a cosy homely environment. The day room was on a corridor and residents were sitting in a row with their backs to the window looking across the corridor at the television. There was a lift and three other exits off the sitting area and it was not conducive for positive engagement with residents as was observed by the inspectors during the inspection.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in

Designated Centres for Older People) Regulations 20 13and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

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):

No actions were required from the previous inspection.

Findings:

Kerlogue nursing home is a purpose built centre and was established in 2002. There are a board of three directors which includes the owners and person in charge who oversee the organisational, financial and management of the centre. The owner of the centre was on site on a regular basis and he attended weekly management meetings. The inspectors met the owners during the inspection. The governance structure included the provider nominee who was responsible for the non-clinical services including human resources, finance, maintenance and household services. The provider nominee worked full time in the centre and knew all the residents and their families. She met with the person in charge and management team on a formal basis to discuss ongoing management issues for the centre. The person in charge or the provider nominee was on call at all times in the event of an emergency. There was a human resources manager employed by the centre who managed all aspects of recruitment and retention of staff.

There were clear arrangements to cover for the absence of the person in charge with the assistant director of nursing deputising as required. The assistant director of nursing was a nurse with over twenty years experience and had worked in the centre since it opened. A clinical nurse manager/duty manager was the most senior nurse on duty in the absence of the person in charge and the assistant director of nursing. She also provided the clinical nurse management at the weekends, thus ensuring that a senior nurse was available seven days per week. There were two care supervisors who worked with the care staff and were involved in the induction of new staff. The household supervisor was responsible for overseeing the cleaning and laundry staff.

The inspectors were satisfied that there were systems in place to assess the quality of life and safety of care. The inspectors viewed audits completed by the provider, person in charge, management team and staff. Data was being collected on a number of key quality indicators such as medication management, accidents and incidents, infection

control, fire safety and risk management, and food safety. The audits highlighted a number of issues and action plans were identified. There was evidence of ongoing improvements following the audit and action plans were followed up on the re-audit.

There was evidence that the provider had sought regular feedback from residents by means of a satisfaction survey covering issues such as menus, staffing and the activities provided. There was also a suggestion box also in the centre. The inspectors noted that the residents' committee met regularly and minutes of these meetings including the minutes from the most recent meeting indicated actions were taken in response to issues identified at previous meetings such as routines and activities. The providers hold meetings with residents and relatives and last one took place on 14 September 2015 issues discussed included staffing, infection control and planned building works.

The provider and person in charge displayed a good knowledge of the standards and regulatory requirements in relation to their relevant roles. They demonstrated an ongoing willingness and ability to ensure compliance with the regulations and the standards.

The quality committee, which met monthly, coordinated the monitoring of the quality and safety of care for residents. This committee reviewed departmental reports from each supervisor, planned training for the upcoming month and undertook an analysis of complaints and incidents.

There was evidence of a systematic analysis of reported adverse events. An audit of reported resident falls had reviewed the patterns falls on a quarterly basis. A number of initiatives had been introduced including more education for residents on falls, a prioritisation of residents with a history of falls and the reinforcement of the protocol for staff to follow in the event of a resident falling. The person in charge undertook a six monthly review of care plans which examined whether the care plans were up-to-date and was there evidence of resident and family involvement.

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 person in charge is a registered nurse and the inspectors saw evidence that she was currently registered with the relevant nursing professional body. The person in

charge had been director of care in the centre since it opened in 2002 and is also a member of the board of directors for the centre. She was found to be an experienced nurse and manager who was involved in the day-to-day running of the centre and was found to be easily accessible and well known to residents, relatives and staff. Training records confirmed she had kept her clinical knowledge current and showed that she had attended relevant training courses.

The person in charge demonstrated sufficient knowledge to ensure suitable and safe care is provided to residents during inspection. The inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of this centre on a regular and consistent basis. The person in charge or the provider nominee was on call at all times in the event of an emergency.

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):

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

Findings:

This outcome was not looked into during this inspection with the exception of staff files. Inspectors reviewed a sample of staff files which were found to include appropriate reference checking, evidence of vetting by an Garda Síochána, however there were gaps in the employment history for two of the staff files sampled.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

The inspectors found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed by the inspectors demonstrated a good understanding of elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspectors saw that elder abuse detection and prevention training was ongoing and training records confirmed that staff had received this mandatory training. This training was supported by a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise. There was evidence to show that any previous allegations of abuse were fully actioned investigated and reported in accordance with the requirements of legislation.

The inspectors also reviewed the systems in place to safeguard resident's finances. The centre maintained day to day expenses for a number of residents. The inspector saw evidence that complete financial records were maintained and generally financial transaction which involved the receipt or return of monies was signed by the resident and was countersigned by staff and a copy was also kept electronically. However when the inspectors sampled a number of residents records there was a discrepancy noted in one residents file where there was a small sum of money unaccounted for. The centre had commenced spot checks on residents finances but this had not been completed consistently. The inspectors found that the current practice did not fully protect the resident or staff and was not sufficiently robust.

There was a policy on challenging behaviour and the person in charge told the inspector that staff were provided with training in the centre on behaviours that challenge including dementia training, which was confirmed by staff and training records. There was evidence that residents who presented with any behaviour that challenged were referred to psychiatry of old age or other professionals for full review and follow up. The inspectors saw evidence of positive behavioural strategies and practices implemented to prevent behaviours that challenged.

There was a policy on restraint and the inspectors saw that restraints used in the form of bed rails were subject to assessments, regular checks and ongoing review. However there was a large number of residents using bed rails which was in excess of 50% of all residents in the centre, some were used to enable residents to move in bed, whilst others were used to promote safety. The integrated full length bed rails in use were restrictive devices because residents were unable to release them in order to get out of bed. Although the assistant director of nursing said they are aiming to reduce bed rails in use and the inspectors saw some evidence of alternatives such as low low beds and alarm mats and sensors in use in the centre, the inspectors held the view that less

restrictive devices could be used to achieve the goals of care, whilst supporting the resident to be independent.

Judgment:

Non Compliant - Moderate

***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):

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

Findings:

Inspectors found that, overall, the health and safety of residents, visitors and staff is promoted and protected.

The centre has up to date policies and procedures relating to health and safety. A comprehensive risk management policy included all of the items required in the regulations was viewed by the inspectors. There was a robust system for identifying and mitigating risks in the centre.

The environment was observed to be very clean and personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was ongoing and staff demonstrated good hand hygiene practice as observed by the inspectors. Satisfactory procedures, consistent with the Authority's standards, were in place for the prevention and control of healthcare associated infections. During the inspection, staff were observed engaging in appropriate hand hygiene procedures. Inspectors noted that all staff carried hand hygiene toggles and good hand hygiene practice was observed for the duration of the two-day inspection.

Arrangements were in place for investigating and learning from serious incidents/adverse events involving residents, for example risk assessments identified that a change in floor level presented a fall hazard to the residents. This was mitigated through the fitting of an appropriate handrail and placing of a black and yellow strip on the floor.

As part of the inspection inspectors reviewed documentation in relation to the fire equipment maintenance, emergency lighting and fire drills. It was found that suitable fire equipment and emergency lighting was provided which was appropriately serviced and maintained. Staff had up to date fire training and were knowledgeable of the

actions to take in the event of an emergency.

Documentation reviewed by inspectors showed that regular fire drills were being carried out. Discussions with staff showed that there was learning from these fire drills and management within the centre were acting upon this, for example, a second fire panel had recently been installed to ensure greater awareness of the location of a potential fire and improve staff reaction times in an emergency. However, inspectors noted that these learning outcomes and issues highlighted during fire drills were not being routinely documented and inspectors recommended this be put in place to ensure appropriate learning and improvements are consistently applied.

There were adequate means of escape however not all fire escape routes were unobstructed. Inspectors observed two potential issues that could impede evacuation of the building during an emergency. Two draft excluder pillows were placed at the base of a door, which was also a fire exit, and a chair was placed against the inside of a second door. Inspectors highlighted these issues to staff who immediately mitigated the risk by removing the items.

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):

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

Findings:

There was an up to date policy on medication management which included ordering, prescribing, storage, administration and disposal of unused medication. Medications were dispensed and administered by means of a monitored dosage system which was delivered from pharmacy each week. Nursing staff reviewed the delivered dispensed medication to ensure it was correct.

Medications were stored and disposed of appropriately in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Medication Management practices were subjected to audit by the staff and by the pharmacy who dispensed the medication to the residents. The pharmacist also provided education sessions to the staff on relevant issues. The inspectors saw that staff were transcribing medications and this was completed in line with the centres policy in that two staff signed and checked transcribed medications which were signed by the GP prior to use.

In relation to prescriptions inspectors saw evidence that residents' medication were

reviewed every three months by the GP and the pharmacist. There was a locked pharmacy box for the secure return of any unused or discontinued medications. The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. Staff spoken with and the inspection findings supported competency in medicines management practice.

The medication fridge stored medication at the appropriate temperature and there were suitable records available in relation to the regular temperature monitoring of these fridges. Medication-related incidents were reported and followed up appropriately with evidence of improvements implemented as a result of learning. However the inspectors noted an ongoing number of errors in the medications dispensed from the pharmacy which were identified by nurses checking of medications, this had been highlighted to the pharmacy and formed part of the pharmacy audit, this needs to be kept under review to ensure these do not continue to happen. The pharmacist made himself available to discuss residents individual medication requirements with residents.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Inspectors saw evidence that residents' health care needs were met through timely access to GP services. Residents had the option of care from their own GP and a list of each resident and their GP was at each nurses station. There was evidence of a medical review of each resident at least once every three months. There was evidence of referral of residents to consultant specialists for further investigation as required. There was good communication between these specialist services, the resident and the person in charge to ensure continuity of care. There was evidence of good access to specialist care in old age psychiatry, both with residents attending as out-patients in the acute general hospital and via the community psychiatric liaison nurse who reviewed residents on site.

Residents had access to allied health care services. There was a physiotherapist

employed at the centre. Mobility assessments and falls risk assessments had been undertaken in all care plans seen by inspectors. There was appropriate referral of residents to other allied health services like speech and language therapy and dietetics. In the medical files seen residents had received timely reviews from other professionals including dentist, chiropodist and optician. As required some residents had been reviewed by an occupational therapist in relation to seating and the provision of appropriate wheelchairs and assistive equipment.

There was good evidence based practice in relation to management of wounds with care plans for each resident outlining skin condition and assessment of potential for pressure sores.

In relation to the planning of care there was a system of a named nurse being allocated to a resident on admission. This nurse had responsibility to ensure each resident had a personalised care plan. There was a care planning review at least very three months with evidence that the resident and their families were involved in the development of care plans. Care plans were reviewed by the inspectors and overall there was evidence of personalised plans to direct care. However the inspectors saw some core care plans in place that were not personalised to the individual and spoke about the resident and did not name the person. Further personalisation of care plans was required to enhance care provision. The inspectors also noted there were a number of care plans in place to deal with residents nutrition and nutritional needs, not only was this unnecessary duplication but there was conflicting directions given in relation to residents nutritional requirements and nutritional supplements which could lead to errors.

The end of life care policy provided guidance on assessment, care planning, advanced care directives and care after dying. In the sample of care plans reviewed by inspectors each resident had appropriate plans in place around end of life. Issues discussed included residents wishes regarding family involvement, funeral arrangements and advanced care directives regarding medical interventions.

There was a bright and spacious oratory. If the resident wished, the centre facilitated a prayer and removal service from the chapel for deceased residents. The meeting room on the first floor was used specifically by families of residents at end of life. This was a comfortable area with couches and a pull-out bed was made available.

A recently introduced initiative of a palliative care nurse on the staff was found by the inspectors to be a great addition to the team and to the care of residents and their families at end of life. The centre also undertook a death review reflection for staff following the death of a resident. Staff were encouraged to speak about their memories of the resident, the care provided and their own feelings regarding the resident's death. Staff outlined to inspectors that they found this process to be both helpful for themselves and also respectful of the resident.

The centre employed two activities coordinators and there was a schedule of activities including singing, reminiscence therapy, bingo and quiz time. There was a policy on music therapy and as part of the quality improvement plan specific music sessions were provided in each of the four units. There was a pet therapy programme and two staff members were trained pet therapists with their two golden retrievers. There were

systems in place to support residents with dementia and their representatives to participate in the assessments, care plans and the organisation of the centre. The environment supported and staff respected the privacy and dignity of residents. The social needs of many residents were met and the inspectors saw and the residents confirmed that there plenty of activities going on during the day which included music therapy, bingo, arts and crafts, religious activities.

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):

No actions were required from the previous inspection.

Findings:

The centre was a purpose built nursing home and residents' accommodation was laid out over two floors. Coolballow and Roxborough were on the ground floor and Ronan Avenue and Johnstown Avenue were on the first floor. The centre was observed to be bright, furnished to a high standard and clean throughout. There were appropriate pictures, furnishings and colour schemes. There was plenty of communal space and the design of the building allows freedom of movement for residents to walk around and choice as to where they spend their time. The bedrooms were found to be much personalised with photos, flowers, furnishings, residents own furniture and rugs. Residents were very complimentary about their homeliness of their rooms and the centre.

All bedrooms were en-suite with shower and toilet facilities. The three and four bedded rooms catered for residents with high dependency needs and were fitted with ceiling track hoists to aid residents with positioning and transferring.

On the ground floor there were two communal dining rooms, an oratory, a day room and a library or "snug". There was access to three enclosed gardens. There were a number of lounge areas on both floors which were well furnished and comfortable. The development of additional seating in the Ronan Avenue Unit had commenced and was near to completion.

In general inspectors found the premises to be well maintained with suitable lighting, ventilation and heating. There was a full time maintenance officer and the maintenance

log showed regular maintenance conducted and suitable repairs recorded. The lift between the first and second floors had been serviced most recently in June 2015.

The communal space in Roxborough was found to be not wholly fit for purpose. The space is accessible through three doors and forms part of a thoroughfare that links two accommodation areas. A lift, used to access the first floor, opens directly into the space and inspectors observed staff passing through the space and the residents were seated in a line facing away from the window, which was the only source of natural light in the space. Inspectors noted that the television was located on the opposite wall which meant that people passing through the space would impede the resident's view of the television should they choose to watch it.

Inspectors noted that the main staircase, used to access the first floor from the reception area, only had a handrail on one side of the stairs. This is not in line with the requirements of the regulations that require that handrails should be provided on both sides of stair cases except where there is a stair lift.

During the inspection, a first floor window was observed to be open fully. Inspectors were informed that the mechanism, used to restrict the window from opening fully, was broken and this had been noted in the maintenance log. Despite the risk having been identified by staff, the window had remained open until inspectors had highlighted this issue to management. The issue was mitigated immediately and steps were taken to ensure the window was repaired. However, the system for reporting and resolving urgent maintenance requires improvement.

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.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was an up to date complaints policy which was displayed prominently at the reception desk.

Inspectors reviewed the complaints log and the results of an internal complaints audit undertaken. The complaints from residents and relatives were mainly around food and laundry. These issues were being addressed via the quality committee, The complaint records included whether each complainant was informed of the outcome and whether

they were satisfied with the outcome.

Since the last inspection the Authority had been in receipt of unsolicited information which was explored during the inspection. Inspectors reviewed documentation in relation to the unsolicited information such as care plans, medical records, policies and procedures and were satisfied that the issues raised had been dealt with appropriately by the person in charge.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

There was a menu which was changed on a three weekly cycle and offered good choice at all meals. There was a recently appointed chef who had sought feedback from residents on the quality of meals. A number of recommendations had been introduced including the availability of home baked scones, colcannon and to have sauces provided separately. The chef had introduced tasting menus and had personally established individual residents food likes and dislikes. She was aware of any specified dietary needs of residents and had liaised with a dietician to review the portion sizes. The chef and catering staff had received up to date training on food safety.

There was a protected mealtime policy to respect the privacy and dignity of residents. There were two dining areas and the inspectors observed that there was sufficient staff available to offer assistance at mealtimes. Any resident who required assistance with eating and drinking was seen to be supported in a discrete and sensitive manner. There was access to fluids and snacks throughout the day and tea trolleys were seen in circulation.

On admission each resident had an initial malnutrition universal screening tool (MUST) assessment. There was monthly recording of residents' weight, body mass index, weight loss and risk assessment of nutritional status. Of the sample care plans seen, the inspectors noted evidence of appropriate nutritional care planning. Residents who were identified as having a change in nutritional status were referred to the dietician. Issues in relation to nutritional care plans were discussed under outcome 11.

There was a policy on referral of residents to a speech and language therapist and number of residents had been assessed as having swallowing difficulties by the speech and language therapist. Each resident's assessed swallow care plan were communicated to the chef and were available in the kitchen and dining areas.

The inspector met the environmental health officer (EHO) who also was undertaking an inspection of the food premises on the second day of the inspection. The centre was generally found to be compliant in food safety.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

Based on the review of the staff rota and from a review of residents care inspectors were satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times.

Residents spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents.

All staff had received mandatory training on prevention of abuse of residents, fire safety and manual handling as required by the regulations. A number of staff had undertaken "train the trainer" courses and there was a monthly programme of education including fire training, falls prevention and care of residents with a percutaneous endoscopic gastrostomy (PEG). Staff confirmed that they were supported to undertake additional courses as required with one staff member being supported to complete a masters degree in palliative care.

The governance structure which consisted of separate reporting arrangements for

clinical staff and clinical support staff ensured adequate supervision for staff at all levels in the organisation. Each department head provided a report for the quality committee each month.

Newly recruited staff outlined to inspectors that the induction process was robust and included all mandatory training, orientation to the building and codes of conduct. The inspectors saw a newly recruited staff nurse worked supernumerary to the existing staff complement and that support and training was available as required. All staff had engaged in a staff performance review which gave an opportunity to discuss their role and also to discuss personal objectives and personal developments plans including further education. A copy of the performance review was given to each staff member.

There was a human resources (HR) manager who ensured there were effective recruitment procedures in place with a policy on staff recruitment, selection and appointment available. Current registration with an Bord Altranais was available for all nursing staff.

Inspectors reviewed a sample of staff files which were found to include appropriate reference checking, evidence of vetting by an Garda Síochána, however there were gaps in the employment history for two of the staff files sampled. This is actioned under outcome five records.

Judgment:
Compliant

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate



Action Plan

Provider's response to inspection report¹

Centre name:	Kerlogue Nursing Home
Centre ID:	OSV-0000240
Date of inspection:	17/11/2015 and 18/11/2015
Date of response:	16/12/2015

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 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Inspectors reviewed a sample of staff files which were found to have gaps in the employment history for two of the staff files sampled.

1. Action Required:

Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

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

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

HR manager had a full audit file on each staff member for Gaps in employment. Due to her sickness on the day of inspection these weren't available but have since been located in full.

Proposed Timescale: 11/12/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

There was a large number of residents using bedrails which was in excess of 50% of all residents in the centre, there was not evidence of least restrictive alternatives having been tried for these residents.

2. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Reviewing each individual residents restraints. Re-educating again on national restraints policy.

Proposed Timescale: 01/03/2016

Theme:

Safe care and support

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

The system in place to manage residents finances was not sufficiently robust.

3. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

After investigation, and out of checking the 50 residents finances, the computer documentation was compliant on the one resident in question but the staff member had failed to sign out the envelope, which was human error. We document in two areas to ensure best practice. Manually and on a computerised system, which makes any errors to be easily addressed.

Proposed Timescale: 11/12/2015

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:

Not all fire exits were clear of obstructions

4. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

All are clear and checked daily by our maintenance person.

Proposed Timescale: 11/12/2015

Theme:

Safe care and support

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

Learning from fire drills, which were being performed, were not being systematically documented.

5. 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:

All fire drills now contain any lessons learnt or outcomes after any drill performed

Proposed Timescale: 11/12/2015

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:

The inspectors noted an ongoing number of errors in the medications dispensed from the pharmacy which were identified by nurses checking of medications.

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:

As we are compliant in house in relation to our medication management and we discussed the issue of near misses with our pharmacy, he has formalised a plan moving forward that no re occurrence occurs.

Proposed Timescale: 11/12/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Further personalisation of care plans was required to enhance care provision. The inspectors also noted there were a number of care plans in place to deal with residents nutrition and nutritional needs, not only was this unnecessary duplication but there was conflicting directions given in relation to residents nutritional requirements and nutritional supplements which could lead to errors.

7. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

On review of the care plans, they were all amalgamated into one current personalised plan.

Proposed Timescale: 11/12/2015

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 communal space in one of the units required review.

8. 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:

We are aware of the area in questions, but we are not in a position to do anything currently without moving forward without planning. Other private areas are available for families to visit and the residents have choice in moving to other communal areas if they wish.

Proposed Timescale: 30/11/2017

Theme:

Effective care and support

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

The main staircase, used to access the first floor from the reception area, only had a handrail on one side of the stairs.

9. 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:

After speaking with the fire officer, he stated we were fully compliant as there is a full lift system adjacent to the stairs but we will fit one anyway.

Proposed Timescale: 30/01/2016

Theme:

Effective care and support

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

The system for reporting maintenance issues was not sufficiently robust to escalate maintenance issues which require immediate attention.

10. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

All staff have been re-educated on the importance of reporting any deficient equipment immediately.

Proposed Timescale: 11/12/2015