<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Kiltormer Nursing Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000352</td>
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<tr>
<td>Centre address:</td>
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<tr>
<td>Telephone number:</td>
<td>090 962 7313</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@kiltormernursinghome.com">info@kiltormernursinghome.com</a></td>
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<td>Registered provider:</td>
<td>D &amp; G Nursing Home Limited</td>
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<tr>
<td>Lead inspector:</td>
<td>Geraldine Jolley</td>
</tr>
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<td>Support inspector(s):</td>
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**About Dementia Care Thematic Inspections**
The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 Compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 21 January 2020 08:30  To: 21 January 2020 18:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 01: Health and Social Care Needs</td>
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<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
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<td>Compliant</td>
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<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
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<td>Outcome 06: Safe and Suitable Premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Governance and Management</td>
<td>Not applicable</td>
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Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

As part of the thematic inspection process, providers were invited to attend information seminars given by the office of the Chief Inspector. In addition, evidence-based guidance was developed to guide providers on best practice in dementia care and the inspection process. Prior to the inspection, the provider and person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
This inspection focused on how the care needs of residents with dementia were addressed in the centre. The inspection also considered progress on the findings of the last inspection carried out in July 2018 and reviewed progress on the actions arising from that inspection. The inspector met with residents, relatives, the provider representative, the person in charge, nurses and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia and observed care practices and interactions between staff and residents using a validated observation tool. The inspector also reviewed documentation such as care plans, medical records, training records, relevant policies and the self assessment questionnaire submitted prior to inspection.

At the time of inspection there were 26 residents residing in the centre and almost half had a diagnosis of dementia or some cognitive impairment. The inspector observed that many residents required a high level of support from staff due to the complexity of their individual needs but also observed that some residents were very independent. Overall, the inspector found the person in charge and staff team were committed to providing a good quality service for residents with dementia and the majority of staff had attended training on dementia care and managing responsive behaviours related to dementia. However there was poor governance and management of the overall service with significant shortfalls identified in the following areas:

- care planning and reviews of care,
- risk management,
- complaints management and
- the maintenance of records.

There was for example no separate record of complaints or accidents and social care needs and background information was not always described in residents care records which meant that staff did not have essential information that would guide their day to day practice and interactions with residents.

The inspector saw that residents’ overall healthcare needs were met and they had access to medical and allied healthcare services however there was a failure to ensure residents were referred to Health Service Executive services to which they were entitled under the medical card scheme. Despite a poor layout of communal space the quality of residents’ lives was enhanced by the availability of interesting things for them to do during the day and the focus on respect for residents was evident. There was a staff member allocated to the role of activity co-ordinator daily however the time allowed for social care was inadequate. Residents and visitors who talked with the inspector provided positive feedback regarding life and the care provided in the centre. Dementia care needs and the impact of dementia on residents’ daily life was not described in all care records however despite this staff were knowledgeable about residents’ level of orientation and how they liked to spend their day and the activities they enjoyed. Staff interacted with residents in a respectful and warm manner. The inspector spoke with ten residents and all said they felt safe and were happy living in the centre. They particularly liked living in their local area and being able to see neighbours and friends regularly.
The overall atmosphere in the centre was home like and comfortable however some arrangements did not ensure that residents experienced a good quality of life. The way communal space was organised required review as there was insufficient dining space or dining tables available for all residents to sit at a table to enjoy their meals. The inspector saw that many residents had their meals at small tables sitting in their armchairs. Some furniture required attention as it showed signs of wear and tear. Many bedrooms were seen to be very personalised and there were pictures on doors to help residents identify their rooms. The person in charge said that more signage that reflected dementia specific design principals was being sought to enable residents find their way around more easily. Closed circuit television cameras (CCTV) were in place on internal corridors and in the sitting room. The cameras were monitored by management and nursing staff. This impacted on the privacy of the residents and their visitors and also on the rights of people to live their lives in private in areas where privacy would be expected.

The completed self-assessment tool on dementia care was submitted to the office of the Chief Inspector with relevant policies and procedures prior to the inspection. The person in charge and provider had assessed the compliance level of the centre through the self-assessment tool. The inspector found that significant improvements were required in areas that included care planning, record keeping, risk assessment and in the organisation of the premises. Actions and improvements described in the last report in areas that included fire safety and the management of complaints continued to need attention the inspector found. The inspector found that evacuation of entire compartments/fire zones was not completed during fire exercises which was a similar finding during the last inspection when the fire procedure did not describe evacuation through zones and fire doors. These matters are all discussed throughout the report and the Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016. The inspector found that there had been a deterioration in compliance with regulations from the previous inspection and concluded that the governance and management of the centre needed to be strengthened to ensure that the service met residents' needs appropriately and complied with regulations to a satisfactorily level.
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: Health and Social Care Needs

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:
This outcome sets out the inspection findings relating to healthcare, assessment of residents' needs, care planning and reviews of care. The social care of residents with dementia is discussed in Outcome 3.

Care records were maintained in hard copy and on an electronic system. The introduction of the latter was in progress and some records were in hard copy and some on computer. This caused some confusion as it was not always evident where records were. The system was also not being used to its full capacity.

There were 26 residents in the centre during the inspection. Over half had a formal diagnosis of dementia or had symptoms of dementia or cognitive impairment. The inspector found that residents could keep the service of their own general practitioner (GP). Residents' medical records were reviewed and these reflected the medicine reviews, referrals to other services, blood tests and immunisations relevant to residents' care. Residents' additional healthcare needs were met. Physiotherapy services were available in house once a week and residents' mobility was assessed on admission. Several residents told the inspector that physiotherapy had been very helpful to them and they had improved their capacity to walk since admission. The inspector saw that staff encouraged residents to walk around and some residents were observed to take walks outside in the garden. Dietician and speech and language therapy services were available as required. Access to services for people with medical card entitlements required improvement to ensure that their entitlement was recognised and that they were referred to Health Service Executive Services when required. The inspector was told that allied health services were not provided to private nursing homes. Residents who have medical cards are entitled to services and arrangements should be in place to assist them to access their entitlements when required. Residents and relatives expressed satisfaction with the health and personal care provided.

The inspector saw that residents had a comprehensive nursing assessment completed prior to and on admission. The ongoing assessment process involved the use of a variety of validated tools to assess health changes and resident’s risk of deterioration.
For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. The centre had recently changed to a computerised record format however some essential information was not recorded on the system. For example falls and other incidents were recorded in residents' daily records which made it difficult to assess if falls management and falls prevention practices were in place to promote residents' wellbeing and safety. Consideration to streamlining the documentation is required to ensure records are maintained in a way that ensures ease and accessibility of information.

The inspector saw that each resident had a care plan compiled within 48 hours of their admission. The care plans in place detailed some of the interventions that staff should employ to meet residents’ assessed healthcare needs. However significant improvements were required as there was an absence of care plans in areas that included social care and falls prevention. There was information on residents' backgrounds and leisure interests to guide staff on how to effectively meet the social care needs of residents. Dementia care needs were assessed however information on how dementia impacted on the day to day life of residents for example, if they were orientated in time and place and who they recognised was not consistently recorded.

Care plans were not regularly reviewed or updated to reflect residents’ changing needs. There was no information recorded to indicate that residents and their family, where appropriate were consulted or contributed to care plans or care reviews. The reviews completed did not provide an overview of residents' health and wellbeing, progress or change since the previous review. Consent to treatment was documented. Nursing notes were completed on a daily basis. The inspector concluded that the care plans required improvement to ensure they conveyed meaningful person centred information and were adequate to guide staff day to day practice. Nursing staff and health care assistants spoken with were familiar with and were knowledgeable about residents current needs.

Residents at risk of developing pressure area problems had care plans and pressure relieving mattresses and cushions to prevent skin deterioration. There were no residents with pressure area problems at the time of the inspection.

The inspector observed that residents appeared to be well cared for, which was further reflected in residents’ comments that their daily personal care needs were met appropriately. Residents were encouraged to keep as independent as possible and the inspector observed residents moving freely around the hallways, gardens and enjoying the activities organised during the day. However, the layout of the main communal room did not provide all residents with an environment that ensured their freedom and well being. Many residents had tables in front of their armchairs and while many used these for newspapers and to have access to activity materials the inspector judged that the arrangements would restrict the freedom of many residents who had a cognitive impairment who may not be able to move the tables when they wished to get up and walk around.

Medicines for residents were supplied by a community pharmacy and residents had access to their pharmacy of choice if required. Medicines were stored in a locked...
cupboard or in the medicine trolley. Medication administration was observed and the inspector found that the nursing staff adhered to professional guidance issued by An Bord Altranais agus Cháimhseachais. The inspector reviewed a number of medication prescription charts and noted that all included the resident’s photo, date of birth, general practitioner (GP) and were signed appropriately.

The inspector saw that there were suitable arrangements in place to meet residents end of life needs including the needs of residents with dementia. However care plans for end of life were generic and described general good practice interventions and did not include the personal wishes or choices expressed by residents for their care at this time. The community palliative care team was available to provide support and advice to staff if required. A small number of staff had undertaken end of life care training according to the training record provided however the proportion of staff trained needed to be increased to ensure that residents received end of life care that met their individual needs and reflected good practice standards.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate nutrition and hydration. Residents were screened for nutritional risk on admission and weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss or gain was observed. Residents were provided with a choice at mealtimes and all residents spoken to were complimentary about the food provided.

The service of the mid-day and evening tea was observed and the inspector found that the opportunity for meal times to be engaging social occasions was hindered by the layout of the communal room. Only one dining table was available and while this was used by several residents there were nineteen residents who had their meals from small tables in front of their chairs. This meant that most residents did not have the opportunity to come together and socialise at meal times.

Staff sat with residents while providing encouragement or assistance with their meal. Nursing staff told the inspector that if there was a change in a resident’s weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT) services. Files reviewed by the inspector confirmed this to be the case residents who had lost weight were scheduled to see the dietician. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT. Residents were provided with water and juice throughout the day and beverages were also served regularly. Staff were seen to be very responsive to residents individual needs.

The provider had assessed the centre as substantially compliant however the inspector made a judgment of moderate non-compliance due to the range of compliance breaches found.

**Judgment:**
Non Compliant - Moderate
**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
According to the training matrix provided to the inspector on the day of inspection all staff had received training in relation to safeguarding vulnerable older persons during 2018 and 2019. Staff spoken with were aware of the procedures to be followed in relation to any allegation or suspicion of abuse. The person in charge confirmed that An Garda Síochána (police) vetting was in place for all staff and persons who provided services to the centre.

Residents spoken with said that they felt safe in the centre. Staff told the inspector that they felt able to manage incidents of responsive behaviour in a manner that promoted residents' well-being. Over 75% of the staff team had completed training on managing such behaviours. Incidents of responsive behaviours were documented in daily records and appropriate interventions had been communicated to staff. However, a separate incident record that included behaviour incidents was not maintained which meant that the frequency, duration or type of behaviour problem could not be monitored. This issue is addressed under Outcome 8, Governance and management.

The centre had systems and arrangements in place to safeguard residents' finances. The procedures and processes for safeguarding residents' finances were clear and transparent. The centre does not have agent responsibility for any resident's finances.

**Judgment:**
Compliant

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**Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**
Person-centred care and support

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

**Findings:**
The inspector found evidence that residents were consulted and offered choice as part of the everyday culture in the centre. Feedback was sought from residents formally and informally and residents confirmed that they were consulted about food, activities and
their day to day routines. An independent advocate visited the centre regularly and talked to residents about their experience of living in the centre.

The inspector noted that the privacy and dignity of residents was respected in relation to how their personal care was delivered. Many bedrooms had residents’ own personal effects on display and there were photographs of varied events that residents had participated in and enjoyed. Bedroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. However the presence of closed circuit television (CCTV) in the communal areas compromised privacy and residents’ rights to a private life. There was some signage to indicate the presence of this equipment but this was not adequate to effectively remind residents that this surveillance was always in place.

The inspector found that efforts were made to provide a restraint-free environment and no bedrails were in use. However as previously discussed the layout of the main communal area required review as the practice of placing tables in front of residents was restrictive, curtailed residents' capacity to move freely and reflected an institutionalised practice. Residents were observed to have free access to the outdoor gardens and several residents were observed to go in and out as they wished.

Residents' political and religious rights were respected and facilitated. Residents had access to religious services and to clergy in the centre and in the local community. Residents told the inspector that they were registered to vote and could vote in the centre or at their local polling stations.

The social activities were organised by a carer who had a dual role as the activity coordinator. They organised a range of activities daily and was familiar with the activities that each resident enjoyed. Residents were seen to be engaging with and enjoying varied activities on the day of inspection. However according to the rota only two hours in the morning was devoted to social care daily. Despite this the inspector saw that activities were provided in the afternoon. Residents said that discussions about the local and national news took place daily and residents were well informed about current events. The inspector observed residents with dementia being encouraged and facilitated to engage in conversations and to express their views. Residents told the inspector that they enjoyed the activities provided by the centre and many said they enjoyed the garden and used it well throughout the year. Residents said they enjoyed planting the raised planters and seeing the hens, ducks and other animals that were kept to provide interest for residents.

During the inspection, the inspector spent periods of time observing staff interactions with residents. A validated observational tool (the quality of interactions schedule, or QUIS) was used to rate and record the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place over three thirty minute periods.

The inspector found that there was regular and meaningful communication between staff and residents. Staff ensured they acknowledged residents when they entered
rooms and greeted them warmly. Residents were addressed respectfully and in a personal way. Residents were offered a choice when meals and beverages were served and could opt to take part or not in activities.

The provider self-assessment had judged the centre as compliant however the inspector formed the view that residents' tights were adversely impacted by the presence of the CCTV and the tables in front of chairs and judged the centre to be moderately non-compliant.

**Judgment:**
Non Compliant - Moderate

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**Outcome 04: Complaints procedures**

**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:**
The inspector found that a separate record of complaints as outlined in regulation 34- Complaints procedure was not maintained. Complaints were recorded in residents’ care records which does not comply with this regulation or the centre’s own procedures. The inspector was told that there were no complaints being investigated at the time of the inspection.

The complaints procedure was on display however it required review as it did not describe accurately the process to be followed to meet the requirements of regulation 34.

Residents spoken with said that would tell any member of staff about a concern and said the person in charge and provider representative were available most days if they needed to discuss any concerns with them.

The office of the Chief Inspector had received unsolicited information that described a poor standard of decoration in the centre, residents sitting for long periods and not helped to be active, poor staffing levels, no stimulation for residents, poor attention to complaints and inadequate dining arrangements. The concerns relating to this information were largely substantiated by the findings of this inspection.

**Judgment:**
Non Compliant - Moderate
**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
The inspector observed that staff were attentive to residents’ needs throughout the day and were available in adequate numbers to supervise the communal area and to assist at meal times. However, the inspector formed the view that the staff allocation and skill mix required review as the person in charge was the only nurse on duty during the morning of the inspection. Only two hours during the morning were allocated to the carer with responsibility for organising activities according to the rota provided during the inspection. Despite this activities were observed to take place throughout the day and were facilitated by varied staff. There was one nurse and a carer on duty during the night. On the day of inspection there was 26 residents accommodated in the centre. While the inspector did not observe the staffing levels having a negative impact on residents’ care during the inspection the non compliances found in documentation such as complaints, care records and organisation of records indicated that the deployment of nurses required review to ensure the required records were maintained and the person in charge had adequate time to undertake their management responsibilities.

Unsolicited information received by the Chief Inspector identified concerns in relation to staffing levels and training of staff were substantiated on inspection. The inspector reviewed the training records for the staff team and while mandatory training on topics that included moving and handling, safeguarding and fire safety was up to date training on topics such as end of life care or infection control was not recorded for the majority of staff. The deficits in care planning and the under utilisation of the computer programme for care planning indicated that staff required training in this area. The findings of the inspection also indicate that staff require training on promoting a restraint free environment.

The inspector judged the service to be moderately non-compliant. The self assessment conveyed that the centre was substantially compliant.

**Judgment:**
Non Compliant - Moderate

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**Outcome 06: Safe and Suitable Premises**

**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 centre is a single storey premises that is surrounded by a large area of garden that is accessible to residents. Residents were accommodated in single and double rooms. The size and layout of the bedrooms was suitable to meet the needs of the residents. Screening was provided in the shared bedrooms ensuring privacy was protected during personal care. Bedrooms were observed to be individualised and had pictures, ornaments and photographs belonging to residents on display.

The premises had good levels of natural light, were comfortably warm and appropriately ventilated. The centre was visibly clean. There were varied features throughout the centre that provided interest for residents. Items of memorabilia were displayed to prompt residents' interest and memory. Photographs of events and outings that residents had participated in were also on display in hallways. There were several fish tanks located in areas where residents could see them easily.

The inspector found the following areas required attention:
• The furnishings in some areas required replacement or repair. Armchairs for example showed signs of wear and tear with foam noted to be exposed on several chairs.
• There is adequate communal space however some of it particularly the conservatory area is largely unused and there is inadequate provision of dining space for residents. The main communal area is used for both sitting and dining however there is only one accessible table laid out for residents to sit at during meal times meaning that the majority of residents (19) sat in their armchairs and had meals served on tables in front of them.
• There is no appropriate smoking area as residents who smoke do so in the covered canopy area outside the conservatory which is largely exposed to the elements as it is not fully enclosed
• The sluice is not appropriately organised as the wash hand-basin is obstructed and it needs cleaning and appropriate racking for continence equipment.

The dayrooms were monitored by CCTV. This has been addressed under Outcome 3, Residents' rights, dignity and consultation.

The layout of the centre supports some residents to have freedom of movement and many were observed to walk around freely and to go in and out to the garden as they wished. The layout provided residents with good opportunities to be involved in ordinary activities such as planting the raised beds and observing the varied animals in the gardens.

There was a call-bell system in place.

The provision of signage in the centre required further development to effectively prompt and guide residents to the varied facilities. Most of the bedroom doors had identifying features to help residents locate their bedrooms.
Residents have access to appropriate equipment that promoted their independence and comfort such as appropriate beds, wheel-chairs and comfort chairs. The inspector found that supportive equipment was in good working order, well maintained and serviced regularly.

The provider had assessed the centre as substantially compliant however the inspector judged the centre to be moderately non compliant due to the issues described above.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk 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:
The inspector found that the risk management system and the implementation of the health and safety policy required attention as the following areas presented hazards and required remedial action:
• Falls, near misses and incidents were recorded in residents care records and could not be reviewed or audited easily to determine the number of incidents that had occurred, the care and treatment provided or if prevention measures had been put in place to prevent further incidents
• Chemicals such as cleaning sprays were left in toilets and on handrails and this presented a risk to residents with dementia
• The presence of the above items and personal protective equipment on handrails disrupted access to handrails and presented a risk to residents who needed full access to the handrails to support them when walking along the hallways
• Some toilets had raised handrails and seats that were not fixed which could create a risk for residents or others with mobility problems
• The fire in the sitting room while it had a protective rail to prevent anyone getting near it required a more effective screen to achieve this.

The fire safety measures were reviewed. The inspector found that residents had personal evacuation plans that clearly described their mobility needs and there was adequate equipment to ensure safe evacuation in an emergency. Regular training was provided for staff and this included fire drills. The inspector found that improvements were required in the way fire drills were completed. While a role play exercise was enacted regularly, evacuation of a compartment was not regularly completed to determine that staff could effectively evacuate residents taking into account the
probability of their changing needs. Other areas that required attention included adjustment of some fire doors to ensure that they closed effectively. It is also required that confirmation that the doors and exit arrangements for two bedrooms near the reception area adequately protect residents in a fire situation. The provider representative agreed to have a fire safety expert review this again as it had been assessed as satisfactory in the past.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

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:
Governance and leadership arrangements in the centre required review to ensure that appropriate systems were in place to effectively monitor the service delivered and to ensure it was safe, appropriate, consistent and met with regulatory requirements. While there was a defined management structure within the centre there was inadequate attention devoted to ensuring that compliance with legislation was achieved and maintained. The findings of this inspection indicate that there had been a deterioration in compliance particularly in the areas of care planning and reviews, risk management and the organisation of the premises since the last inspection.

Poor compliance with Regulation 23, Governance and management is evidenced by:

• failure to ensure that management systems were in place to ensure that the service delivered was safe, appropriate, consistent, effectively monitored and audited to ensure compliance with regulations.
• failure to ensure that residents had appropriate dining arrangements and that their freedom was not restricted
• failure to maintain required separate records of complaints, of accidents and incidents that included responsive behaviours.

The inspector was assured by the provider representative and the person in charge that the non compliances described would be addressed.

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:

Geraldine Jolley
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were improvements required to the way assessments and care plans for residents were completed. For example:
- There was an absence of care plans in relation to social care. There was a deficit of information on residents' backgrounds and leisure interests that would guide staff on how to effectively meet the social care needs of residents.
- Dementia care needs were assessed however information on how dementia impacted on the day to day life of residents for example, if they were orientated in time and place

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
and who they recognised was not consistently recorded to guide staff practice.

1. 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:
- All residents have detailed assessments & careplans, These incorporate likes/dislikes, hobbies/interests (Key to me). These careplans are reviewed every 3-4 months or when required.
- We have commenced a review of all Dementia careplans to ensure all residents’ needs are assessed and consistently recorded to guide staff practice.

Proposed Timescale: 15/04/2020

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not regularly reviewed or updated to reflect residents’ changing needs. There was no information recorded to indicate that residents and their family, where appropriate were consulted or contributed to care plans or care reviews. The reviews completed did not provide an overview of residents' health and wellbeing, progress or change since the previous review.

2. 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:
- We have commenced a review of all careplans to ensure all residents’ needs are assessed and consistently recorded to guide staff practice. We will encourage family involvement where possible, we revise each resident careplan at no more than 4 months intervals. To date we have 5 completed and the review is ongoing

Proposed Timescale: 30/04/2020

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Access to services for people with medical card entitlements required improvement to ensure that their entitlement was recognised and that they were referred for access to
services. The inspector was told that allied health services were not provided to private nursing homes by the Health Service Executive however where residents have an entitlement to services the provider is required to have a system in place to facilitate access to such services.

3. 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:
We have forwarded a letter to the Physio Dept on 10th February 2020 re services to residents on the GMS card Scheme in our centre. And are awaiting response. And we followed up on this letter on the 13th March 2020.

Proposed Timescale: 13/03/2020
Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans for end of life were generic and did not include the personal wishes or choices expressed by residents for their care at this time.
The proportion of staff trained needed to be increased to ensure that residents received end of life care that met their individual needs and reflected good practice standards.

4. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
We have commenced a review of all Careplans at the moment and training on End of life is arranged for 24th April 2020. – Training is being reviewed in accordance with the corona virus guidelines.

Proposed Timescale: 25/04/2020
Theme: Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Care records were maintained in hard copy and on an electronic system. The introduction of the latter was in progress and some records were in hard copy and
some on computer. This caused some confusion as it was not always evident where records were. The system was also not being used to its full capacity.

Complaints and incident records were not maintained in accordance with legislative requirements.

5. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
• We are upskilling staff with online training on our electronic system to utilise it to its full capacity.

• All complaints and incidents records are now recorded on the electronic system

Proposed Timescale: 10/05/2020

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The layout of the main communal area required review as the practice of placing tables in front of residents was restrictive, curtailed residents' capacity to move freely in accordance with their ability and reflected an institutionalised practice.

6. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
We have commenced a review of our communal area and are putting a plan in place for the removal of the table in front of residents so as they can move freely in accordance with their ability.

Proposed Timescale: 30/03/2020

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The presence of closed circuit television (CCTV) in the communal areas compromised
privacy and residents' rights to a private life. There was some signage to indicate the presence of this equipment but this was not adequate to effectively remind residents that this surveillance was always in place.

7. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
CCTV has been removed from the communal area.

Proposed Timescale: 11/03/2020

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector found that a separate record of complaints as outlined in regulation 34 - Complaints procedure was not maintained. Complaints were recorded in residents' care records which does not comply with this regulation.

8. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
• Records of complaints are now recorded on the electronic system.

Proposed Timescale: 01/03/2020

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was on display however it required review as it did not describe accurately the process to be followed to meet the requirements of regulation 34.

9. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.
Please state the actions you have taken or are planning to take:
- The complaints procedure has been reviewed and is being updated to ensure it meets the requirements of the regulations 34. Staff training has been completed

**Proposed Timescale:** 30/03/2020

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<thead>
<tr>
<th><strong>Outcome 05: Suitable Staffing</strong></th>
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<td><strong>Theme:</strong> Workforce</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The staff allocation and skill mix required review as the person in charge was the only nurse on duty during the morning of the inspection. Only two hours during the morning were allocated to the carer with responsibility for organising activities according to the rota provided during the inspection.

**10. Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
- We now review dependancies weekly and apply rosters accordingly. We ensure an appropriate skill mix is on duty at all times as per care hours required.

**Proposed Timescale:** 15/03/2020

| **Theme:** Workforce |

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

Training on topics such as end of life care or infection control was not recorded in the training record for the majority of staff. The deficits in care planning and the under utilisation of the computer programme for care planning indicated that staff also required training in this area. The findings of the inspection also indicate that staff require training on promoting a restraint free environment.

**11. 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:
Training for staff has been arranged for this coming 7th April & 24th March. (End of Life, Dementia Care). There is ongoing online training re utilisation of computer
programme for staff. Matrix is reviewed and updated weekly - training being reviewed in accordance with the corona virus guidelines.

**Proposed Timescale:** 01/06/2020

### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

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

The inspector found the following areas required attention:

- The furnishings in some areas required replacement or repair. Armchairs for example showed signs of wear and tear with foam noted to be exposed on several chairs.
- There is adequate communal space however some of it particularly the conservatory area is largely unused and there is inadequate provision of dining space for residents. The main communal area is used for both sitting and dining however there is only one accessible table laid out for residents to sit at during meal times meaning that the majority of residents (19) sat in their armchairs and had meals served on tables in front of them.
- There is no appropriate smoking area as residents who smoke do so in the covered canopy area outside the conservatory which is largely exposed to the elements as it is not fully enclosed
- The sluice is not appropriately organised as the wash hand-basin is obstructed and it needs cleaning and appropriate racking for continence equipment.

**12. 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 furniture is being reviewed and replaced/ repaired as required.
- The conservatory has been converted into a designated dining space which will allow for adequate dining space for residents should they wish to dine there. There is another large dining table in the communal area to cater for residents dining needs also.
- A new smoking area has been completed at the rear of the building which is fully enclosed
- The sluice area has been re painted and upgraded.

**Proposed Timescale:** 10/03/2020
Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector found that the risk management system required attention as the following areas presented hazards and required remedial action:
- Falls, near misses and incidents were recorded in residents care records and could not be reviewed or audited easily to determine the number of incidents that had occurred, the care and treatment provided or if prevention measures had been put in place to prevent further incidents
- Chemicals such as cleaning sprays were left in toilets and on handrails and this presented a risk to residents with dementia
- The presence of the above items and personal protective equipment on handrails disrupted access to handrails and presented a risk to residents who needed full access to the handrails to support them when walking along the hallways
- Some toilets had raised handrails and seats that were not fixed which could create a risk for residents or others with mobility problems
- The fire in the sitting room while it had a protective rail to prevent anyone getting near it required a more effective screen to achieve this.

13. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Falls, near misses and incidents are now recorded on the electronic system and are easily accessed for auditing and review.

- Falls risk assessments are completed on all residents on their assessments (Cannards Fall Risk)
- Chemicals such as cleaning sprays are to be kept in a locked cleaning room in the centre.
- Toilet with raised hand rails not secured to the ground have been replaced with wall mounted handrails for residents with impaired mobility.
- The fire protective rail in the sitting room is been reviewed and risk assessment completed.

Proposed Timescale: 10/04/2020
Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector found that improvements were required in the way fire drills were
completed. While a role play exercise was enacted regularly, evacuation of a compartment was not regularly completed to determine that staff could effectively evacuate residents taking into account the probability of their changing needs.

14. **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:**
Fire training is due to take place in 16th April and we will be reviewing fire drills and role play in relation to evacuation of zones with our trainer. All residents have a PEEP record on their files and we are allocating an even spread of dependencies to each zone to ensure ease of evacuation from any zone if required. - training being reviewed in accordance with the corona virus guidelines.

**Proposed Timescale:** 01/04/2020

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Confirmation from a suitably qualified fire expert that the doors and exit arrangements for two bedrooms near the reception area adequately protect residents in a fire situation is required.

15. **Action Required:**
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

**Please state the actions you have taken or are planning to take:**
• We have requested the services of a fire expert to ensure and certify that the doors and exit arrangements for two bedrooms near the reception area adequately protect residents in a fire situation is required.

**Proposed Timescale:** 15/04/2020

**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Poor compliance with Regulation 23, Governance and management is evidenced by:

- failure to ensure that management systems were in place to ensure that the service delivered was safe, appropriate, consistent, effectively monitored and audited to ensure compliance with regulations.
- failure to ensure that residents had appropriate dining arrangements and that their freedom was not restricted
- failure to maintain required separate records of complaints and of accidents and incidents.

16. **Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
- We are currently reviewing our management system to ensure the our service delivered is safe, appropriate, consistent & effectively monitored and audited to ensure compliance with the regulations 23C.
- The conservatory has been converted into a designated dining space which will allow for adequate dining space for residents should they wish to dine there. There is another large dining table in the communal area for dining needs also.
- Records of complaints and accidents are now recorded on the electronic system

**Proposed Timescale:** 15/04/2020