Centre name: Kilcara House Nursing Home
Centre ID: ORG-0000241
Centre address: Kilcara, Duagh, Listowel, Kerry.
Telephone number: 068 45 377
Email address: Kilcarahouse@gmail.com
Type of centre: A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider: Mertonfield Limited
Provider Nominee: Marian Kneafsey
Person in charge: Marian Kneafsey
Lead inspector: Mary O'Mahony
Support inspector(s): Cathleen Callanan, Day 2
Type of inspection: Announced
Number of residents on the date of inspection: 35
Number of vacancies on the date of inspection: 0
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 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

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<td>06 March 2014 09:30</td>
<td>06 March 2014 14:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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Summary of findings from this inspection
This was the fourth inspection of Kilcara Nursing Home by the Health Information and Quality Authority’s (the Authority) Regulation Directorate. Previous inspection reports can be viewed on the Authority’s website www.hiqa.ie, centre no. 0241. The purpose of this inspection was to inform a registration renewal decision. On the day of inspection there was one resident in hospital. As part of the inspection process inspectors met with residents, the provider, the person in charge, the key senior manager (KSM), staff nurses, care staff, catering staff, household staff, and visitors. Inspectors observed practices and reviewed documentation such as care plans, medical records, training records, complaints log as well as the required policies. A number of staff files were checked for compliance with regulations. The findings of the inspection are set out under 18 outcome statements. These outcomes are based
on the requirements of the Health Act 2007 (Care and Welfare of Residents in
Designated Centres for Older People) Regulations 2009 (as amended) and the
National Quality Standards for Residential Care Settings for Older People in Ireland.

A new key senior manager (KSM) had been appointed since the last inspection and
she met with the inspectors. She displayed a good knowledge of best practice in
older adult care and demonstrated a commitment to the delivery of person-centred
care to the residents.

The person in charge and the provider had attended to the actions required from the
previous inspection and the inspectors viewed a number of improvements. The
inspectors found the premises, fittings and equipment were of a good standard
although some improvements were required in the area of maintaining a safe
environment. There was a good standard of cleanliness throughout and inspectors
noticed that residents were walking around the centre unrestricted, where their
physical abilities allowed.

Questionnaires from residents and relatives were viewed by inspectors during the
monitoring event. The feedback from residents and relatives was one of satisfaction
with the service and the care provided in Kilcara Nursing Home. Both relatives and
residents praised the staff, the facilities and the care provided.

The person in charge was involved in the day-to-day running of the centre and was
found to be easily accessible to residents, relatives and staff. There was evidence of
individual residents’ needs being met and the staff supported residents in
maintaining their independence where possible. Community and family involvement
was encouraged in the centre and residents said visitors were welcome throughout
the day. There was a varied activities programme and access to an advocacy service
for both residents and relatives.

Some actions are required to comply with the Health Act 2007 (Care and Welfare of
Residents in Designated Centres for Older People) Regulations 2009 (as amended)
and the National Quality Standards for Residential Care Settings for Older People in
Ireland. These involve risk management, medication management, records to be
kept in the centre and contracts of care.
Outcome 01: Statement of Purpose

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

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
The statement of purpose and function was viewed by the inspectors. It described the service and facilities provided in the centre. It contained the information required in Schedule 1 of the Regulations and also outlined the aims, objectives and ethos of the centre. The statement of purpose was found to be very comprehensive, easy to follow and met the requirements of legislation.

It was available for viewing in all areas of the home and was stored at an accessible height for residents and visitors.

Outcome 02: Contract for the Provision of Services

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Minor

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

Findings:
Contracts of care had been implemented for residents and a sample of these records were viewed by the inspectors. The contracts were comprehensive and were agreed within a month of admission. However they did not specify the fees for extra services as
| **Outcome 03: Suitable Person in Charge** |
| The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. |

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
The person in charge was an experienced nurse manager and was actively involved in the day-to-day organisation and management of the service. Staff, residents and relatives all identified the person in charge as the person with the overall authority and responsibility for the delivery of care. Residents and relatives identified her as being easily accessible. She worked full-time in the centre and was supported in her role by the key senior manager.

| **Outcome 04: Records and documentation to be kept at a designated centre** |
| The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended). |

**Theme:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The centre was adequately insured against accidents and incidents and the required stipulation re liability for residents' property was included in the policy.
All the records for staff, required under Schedule 2 of the Regulations, were not held for staff working in the centre.

The inspectors found that there were centre-specific policies in place but not all policies were being implemented in practice: the risk assessment policy, the elder abuse policy and the medication policy.

The directory of residents was not well maintained or in good order and did not have all the details required under legislation: the name and phone number of the general practitioner (GP), the resident’s home address or the phone number of the next of kin were not entered for all residents. The person in charge showed the inspectors that she had purchased a new directory and undertook to get the active directory repaired.

Some aspects of residents’ care plans needed updating and new plans of care for specific health needs were not in place. A resident with nutritional challenges did not have a continuous record of his food intake recorded despite being assessed as at high risk of malnutrition.

Records relating to inspections by other regulatory bodies were maintained in the centre and viewed by inspectors. There was evidence that policies required under Schedule 5 of the Regulations were reviewed regularly.

**Outcome 05: Absence of the person in charge**

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

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge for more than 28 days.

The person in charge worked full-time and was supported in her role by a key senior manager who covered for the person in charge in her absence. The key senior manager had taken up post since the last inspection and the inspectors met with her during the inspection.

The provider was aware of his responsibility to notify the Authority of the absence of the person in charge and the arrangements in place to cover that absence.
### Outcome 06: 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.**

<table>
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<th>Theme:</th>
<th>Safe Care and Support</th>
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<td><strong>Judgement:</strong></td>
<td>Non Compliant - Minor</td>
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**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

The inspectors viewed the training records for the prevention of elder abuse. A staff member who recently commenced work in the home told inspectors that she had centre-specific training in the prevention of elder abuse.

Staff informed the inspectors that they had attended training on elder abuse and that they had discussions at staff meetings in order to increase their awareness of their responsibilities. Inspectors spoke with members of staff who demonstrated an awareness of what to do if an allegation of abuse was made to them. Residents to whom the inspector spoke expressed that they felt safe in the centre.

There was a system in place to safeguard residents' money. The inspector saw records of all money kept in the safe for residents. These were not signed by the resident to whom the money belonged or their representative. There was no witness signature on some of the records kept. The nursing home was also a pension agent for three residents. Inspectors viewed these records and found that they lacked some detail about bank transactions, which were relayed verbally to the inspector by the provider. The provider undertook to maintain these records in a manner that would ensure clarity and transparency.

### Outcome 07: Health and Safety and Risk Management

**The health and safety of residents, visitors and staff is promoted and protected.**

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<td>Non Compliant - Moderate</td>
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**Outstanding requirement(s) from previous inspection:**

The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Clinical risk assessments were seen by the inspectors in the residents' care plans. These included fall risk assessment, nutritional assessments, skin assessments, social involvement, continence, moving and handling and restraint.

The inspector viewed the centre-specific health and safety statement which was reviewed in 2014. Risk assessments were viewed in this statement which identified hazards for residents, staff and visitors. It dealt with risks in the environment and set out actions and controls to manage these. There was evidence that improvements had been made to this document. Handrails were present in the corridors, grab-rails were seen in the bathroom and toilet areas and floor covering was in good repair throughout.

An audit of health and safety issues was undertaken in all areas recently and the inspectors saw records of these checks. Inspectors were aware of the benefits of promoting a home like environment for the residents, however, the lighted open fire was not adequately secured. The provider was asked to reassess the risk and has put a secure fire guard in place since this inspection. There was a lift from the ground floor to the upstairs section and inspectors were informed that one resident uses this independently. This use of the lift in the centre required a risk assessment to indicate to inspectors that all precautions were in place to prevent an accident.

There was a risk assessment policy in place which adequately addressed the specific areas outlined in Regulation 31. The inspectors viewed a risk register with evidence that risk assessment was ongoing. However, there were other risks that were unidentified throughout the centre and these required controls to be put in place.

Inspectors noted an open low level gate at the top of a steep stairwell, near to the upstairs bedrooms of mobile residents. This was open on three occasions during the inspection. The gate, even when shut, would not safeguard a resident in the event of a fall or other unexpected event. The provider undertook to replace this gate with a door.

Some of the windows, with large openings, in what was called the "new wing" had no restrictors fitted, however this was being addressed at the close of the inspection.

There was no call-bell in the dining room of the new wing and this could present a problem in the event of a choking episode or other emergency. The laundry room door was concealed by a curtain. However, it was unlocked and provided access into the unlocked staff room where personal belongings of staff were stored. There was an incorrectly labelled ointment on the locker of a resident and also a discontinued ointment with the same resident. The light bulbs over the bathroom sinks were not working in most of those checked by the inspectors. However, the provider said these are no longer in use as residents use the main bathroom light. Inspectors noticed an unused bedrail stored on top of a wardrobe in bedroom 15.

There was a hairdressing trolley stored in an unlocked bathroom and there were two scissors seen on top of this. This had not been risk assessed. The treatment room door was unlocked when checked on three occasions during the inspection. There was an open "sharps" container of used syringes and needles on the floor and other items which needed to be kept secure.
The fire policies and procedures viewed by the inspector were centre-specific. The fire safety plan was viewed by the inspector and found to be comprehensive. There were notices for residents and staff on 'what to do in the case of a fire' appropriately placed throughout the building. Fire maps indicating escape routes were clearly displayed. Fire equipment training and fire evacuation training was provided. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector examined the fire safety register with details of all services carried out which showed that fire fighting, fire safety equipment and fire alarms had been serviced as required. Fire alarm checks and automatic fire door release checks were carried out weekly and there was a daily fire door checking system.

The inspectors observed staff carrying out best practice in infection control, with regular hand washing and appropriate use of personal protective equipment such as gloves and aprons. Hand sanitisers were in place throughout the centre. A resident recently returned from hospital had the universal infection control protocol in place.

There was an emergency plan for the centre and the inspectors were informed that the nearby home of the provider and the local resource centre could be used to provide accommodation for residents, in the event that an evacuation was necessary. Inspectors saw that this was formalised and outlined in the emergency plan.

The provider had contracts in place for the regular servicing of all equipment and the inspectors viewed these records for hoists, wheelchairs, and electric beds. The service record for the lift could not be sourced on the day of inspection but the provider located the invoice and emailed it to the Authority the following day.

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**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The medication trolleys were secured and the medication keys were held by the nurse in charge. Medications were stored and disposed of appropriately in line with An Bord Altranais (ABA) agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). The centre had a policy on medication management which was viewed by inspectors. However, some medication practices were not in line with regulations and best practice guidelines. The inspectors observed a nurse undertaking medication rounds and administering the lunch time medications. The
inspector observed medications being administered from the pharmacy sheet which resulted in a resident being given a medication which was not prescribed by the GP. The nurse later showed the inspector a previous prescription which had the drug written on it. This was not the prescription that was in use at the time of inspection. Even though most prescriptions viewed outlined the maximum dose in 24 hours of PRN (when necessary) medication, inspectors noted one prescription sheet did not state this and it concerned a sedative medication.

A resident who was prescribed a specific drug did not have the necessary documentation filed with his prescription which would indicate the daily dose to be administered and the doctor's signature. This form was later found filed in the resident's medical notes. A resident who had been prescribed medications for 6.00 am was administered them at 2.00 pm, while the inspector was observing. The system for recording medication errors was not robust and inspectors could not discern that practice improvement occurred as a result of examination of these errors, as required by the professional regulatory body. Where medications were to be crushed there was no evidence on the individual residents' medication administration sheets that this had been authorised by a registered medical practitioner as required by ABA guidelines (2007) and as outlined in the centre's policy on medication management. Some of these issues were addressed while the inspectors were on the premises.

There was a good medication system in place for the centre and the nurse indicated that it is much more comprehensive that the previous system. Inspectors also found it easy to comprehend. The residents' photographs were available in the medication file to enable staff to identify the residents prior to administration of the medications. A local pharmacist provided the service and was available on a daily basis. The pharmacist also undertook annual audits of the medication processes. Inspectors saw evidence that the GP undertook a three monthly review of medications. There was a system in place to review and audit medication practices but this needs to be formalised to demonstrate learning from any errors noted.

The supply, distribution and control of scheduled controlled drugs was checked and was correct against the register, in line with legislation. Two nurses were checking the quantity of these medications at the start of each shift. The nurse spoken with displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

**Outcome 09: Notification of Incidents**

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

**Theme:**
Safe Care and Support

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

Findings:
The inspectors saw that notifications to the Authority were forwarded within the required timeframes. These notifications were viewed prior to and during the inspection and inspectors were satisfied with the actions taken and medical care provided.

There was an incident and accident log maintained for both residents and staff. The person in charge had notified the Authority of incidents and accidents in line with the requirements under Regulation 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). A recent notification to the Authority correlated with a incident recorded in the log maintained by the nursing home.

Outcome 10: Reviewing and improving the quality and safety of care
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:
Effective Care and Support

Judgement:
Compliant

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

Findings:
The person in charge was employed full-time in the centre and together with her management team monitors the quality of care which the residents receive. She told the inspector that she speaks with residents and relatives daily. There was an active residents' committee in place which allowed them to raise issues and highlight suggestions for improvement. Inspectors viewed minutes of these meetings.

There was evidence of regular audits which included audits on health and safety, the catering department, care planning, infection control, pharmacy audits and a laundry audit.

There was evidence that the suggestions from residents were acted upon and improvements made where necessary. Outcomes were discussed at staff meetings and inspectors viewed minutes of these meetings. Inspectors spoke with members of staff who expressed the view that the outcome of these meetings results in better care for the residents.

Relatives and residents indicated to the inspectors that their suggestions and concerns are acted upon and that they are consulted about quality of life in the centre.
**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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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

**Judgement:**
Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was evidence that residents' healthcare needs were met through timely access to the general practitioner (GP) service. Residents were facilitated to retain their own GP. However, most of the residents were under the care of one GP who visits the centre regularly. Medications were reviewed by the GP at least every three months and sooner if required. Inspectors were able to verify this by viewing the medication administration sheets and the medical notes. Staff indicated to the inspectors that the service provided is prompt and responsive. There was an out of hours medical service also available.

Care plans were individualised and risk assessment tools were used to inform best practice and assess the residents' needs. A daily nursing note was present and residents were involved in the planning of their care. The person in charge informed inspectors that a resident could access personal information if requested.

There was evidence of access to a multidisciplinary service for residents. There was evidence of referrals to consultants in a nearby hospital. A chiropodist visited regularly. Speech and language services and dietician services were available. Training for staff on nutritional supplements, diet consistency and swallowing difficulties was also facilitated by this service. Inspectors saw evidence in the residents' care plans that there had been referrals and reports from these services for individual residents. The hairdresser visited twice weekly or as required and provided a full hairdressing service.

However, in the sample of care plans viewed by the inspectors not all of the care plan assessments were supported with an individualised plan of care where indicated. There was a particular issue in the area of nutrition where the dietary need of a resident was not supported by a comprehensive record of daily food intake. The residents' clothing inventories were not updated regularly. A management plan was not in place for a resident whose behaviour had been an issue for a period of time, according to the complaints book seen by the inspectors. Inspectors saw that some initial care
assessments required updating due to the passage of time since they were first carried out. Some skin assessments and moving and handling assessments were not reviewed on a three monthly basis as required. Where care plans were reassessed three monthly a staff member’s signature was present on the care plan of one resident for 18 reassessments, which indicated that the original care plan was in place for a couple of years.

The centre had a staff member employed as a rehabilitation co-ordinator and residents advocate. While the inspectors were on the premises the residents were engaged in activities in the dining room and in the sitting room. On the day of inspection inspectors saw the residents painting and also saw evidence that they were involved in planning the upcoming celebrations for St. Patrick’s Day. There was evidence of reminiscence opportunities and inspectors viewed photographs of the residents enjoying their life actively with staff and local children as well as on family occasions.

The activity programme included bingo, music sessions, social outings, hairdressing, arts and crafts, newspaper reading and also individualised activities. The activities coordinator spoke to inspectors about the life story work she undertakes with the residents and inspectors viewed a sample of these. She was committed to this work and also told the inspectors about attending the residents' meetings. The inspectors also saw a sample of individual life style plans which she said were informed by the life stories of the residents.

**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. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Care and Support

**Judgement:**
Compliant

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

**Findings:**
The Nursing Home was a two-storey building that was purpose built in 1994 and has a lift and stairs to the top floor. It provided long term residential care and respite care for up to 35 residents. At the time of inspection 8 residents had a diagnosis of dementia.

Bedroom accommodation consisted of 17 single rooms with en suites, six twin rooms, three of which had en suites and two three-bedded rooms which had adjoining shared bathrooms. The bedrooms which did not have en suite facilities had a wash-hand basin in the room.
On the ground floor there was one shared toilet and wash-hand basin and one assisted
bathroom with bath, toilet and wash-hand basin. On the first floor there was one
communal bathroom which has a bath and shower area. There was also a separate
communal toilet and wash-hand basin.

Each resident had an individual locker and wardrobe and in the communal bathrooms
each resident had an individual bathroom cabinet for their belongings. Inspectors saw
call-bells and individual lights over each bed.

Inspectors found that there was adequate private and communal space in the centre.
The communal living space for residents was on the ground floor and consisted of two
dining rooms, a conservatory, two sitting rooms, a small prayer room and an indoor
smoking room. The three bedded rooms were not conducive to affording much privacy
to residents, however, inspectors found that the curtains used to screen the beds were
in good repair. These were seen to be utilised when care was being delivered.

Outdoor space consisted of surrounding concrete paths and a secure accessible patio
area to which residents had free access. To the front of the building there was a parking
area for staff and relatives. The gardens were maintained in good repair.

Staff changing facilities were seen and staff had adequate storage facilities for personal
belongings.

Hoist, wheelchairs, walking frames, electric beds and electric mattresses were available
for use depending on the assessed needs of residents. Inspectors viewed the service
records where appropriate.

Upstairs access to the stairwell was not secure and has been addressed under Outcome
7. The premises was noted to be warm, well lit and ventilated and appropriate signage
was in evidence. The colour scheme in the dining rooms was bright and the centre was
kept clean and in good repair. Inspectors saw evidence of a cleaning schedule for all
areas.

There was a separate kitchen with sufficient cooking facilities and equipment. This was
located in the centre of the home and was easily accessible to staff, serving meals to the
residents.

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<th>Outcome 13: Complaints procedures</th>
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<td>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.</td>
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| Theme: |
| Person-centred care and support |

| Judgement: |
| Compliant |
Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There was a policy and procedure for making, investigating and handling complaints. The complaints procedure was displayed in the main reception area. The person in charge informed the inspector that complaints were discussed at staff meetings and inspectors viewed the complaints book. The statement of purpose and the residents’ guide also contained details of the complaints procedure.

Residents told inspectors that they knew who to complain to. Staff were aware of the complaints procedure and there was evidence that the satisfaction of the complainant was recorded. Relatives’ questionnaire results also revealed their knowledge of the facility to complain if not happy with the service.

The name and contact details of a nominated independent appeals person was displayed for use in the event that a complainant was unhappy with the internal investigation. Inspectors saw evidence that the services of this person had been employed to support residents making complaints.

The provider undertook to get a new complaints book as the layout of the current book did not lend itself to a clear outline of the details of the complaint, the outcome, and whether the complainant was satisfied.

Outcome 14: End of Life Care

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

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
There was a centre-specific policy on end-of-life care and residents had access to specialist community palliative care services if required. The policy on end-of-life care outlined the procedure to ensure residents received end-of-life care in a way that met their individual needs and respected their dignity and autonomy.

Inspectors spoke to residents who used the prayer room in the centre. There was a weekly communion service available. One resident and relative said that they would like more regular access to the religious service of their choice within the centre.
There was evidence that staff had recently received training on end-of-life care.

**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

**Judgement:**  
Compliant

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

**Findings:**  
There was a centre-specific policy on nutrition and inspectors saw evidence that residents were referred to a dietician where necessary. Residents’ weights were recorded and an evidence-based tool was used to assess their nutritional status. The menu was displayed in the dining room on a notice board and residents’ special dietary requirements were catered for. Residents had access to fresh drinking water and hot drinks and snacks as they required.

At dinner and tea time residents dine in the bright and colourful dining rooms. Other residents were supported with their meals by staff members, in the conservatory area. The tables were decorated with flowers and appropriate cutlery. Residents expressed satisfaction with the food, the menu choice and the dining experience. Residents had their choice respected as to where they would like to dine but the majority came to the dining room. Mealtimes were seen to be sociable occasions with many residents remaining at the table after the meal to chat with each other.

Inspectors spoke with residents who expressed satisfaction with the food and inspectors also spoke with the kitchen staff who demonstrated knowledge of the dietary requirements and preferences of the residents. Inspectors saw the choice of homemade food on offer and viewed the menu cycle which was varied and offered choice throughout the month. Communication between the kitchen staff and the nursing staff was apparent.
Outcome 16: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
Inspectors observed that residents’ privacy and dignity was respected and promoted by staff. Adequate screening was provided in shared bedrooms and inspectors saw staff knocking before entering residents’ bedrooms. Closed circuit TV (CCTV) cameras were in use but only in the main hallways and a sign was present to indicate this. There was a policy on the use of CCTV in the centre.

The manner in which residents were addressed by staff was seen to be appropriate and respectful. Staff were seen walking and talking with residents throughout the day. Residents had a personal phone in their bedroom allowing for privacy in making and receiving phone calls. The residents had places to meet relatives and visitors in private. The centre had a policy on communication

Surveys were undertaken with residents and relatives to establish their views on the service. There was a large display notice board in the centre of the dining room wall where information on the weather, the day, the time and the season was displayed in a manner that was accessible to the residents. Inspectors saw residents reading this during the day.

There was a residents’ committee in place that meets every three months. This was run by the activities coordinator. This committee allowed residents the opportunity to have their say, share their views and discuss relevant items such as menus, care issues, and activities. The inspectors read minutes of these meetings and heard from residents that improvements had occurred and that planning was taking place with them, for example in relation to Easter festivities. Staff also confirmed this to inspectors. Residents had access to newspapers, TV and radio.

The person in charge, the nurses and the care staff met the residents and relatives daily and are proactive in addressing their concerns.

There was an open visiting policy in operation, however some restrictions are in place when residents are dining, due to space restrictions. There was an explanatory notice about this on display in the centre.
**Outcome 17: Residents clothing and personal property and possessions**

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

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

**Judgement:**
Non Compliant - Minor

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

**Findings:**
Inspectors saw evidence that residents were encouraged to personalise their rooms. The bedrooms were comfortable and were decorated with residents’ pictures and photographs. There was adequate storage space for clothing and belongings and a lockable cupboard was also provided. Most of the bedrooms had an en suite facility with storage space for toiletries.

The system in place for managing residents’ clothing was effective. There was a central laundry in the centre where personal items of clothing could be be laundered. All clothing was discreetly marked on admission. This helped to ensure that clothing from the laundry was returned to the correct resident. The laundry was well organised and staff spoke with the inspectors about the system in use. Residents stated that they were happy with the way their clothing and personal belongings were managed in the centre and there was no issue with missing clothing. Inspectors saw that residents' wardrobes were tidy and that the clothes were arranged in a neat manner.

While inspectors noted that there was a personal inventory being kept of residents clothing there was no indication that this was being updated or that it was being signed by the resident or their representative.

**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.

**Theme:**
Workforce

**Judgement:**
Non Compliant - Moderate
Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The roster showed that the skill mix and number of staff on duty was appropriate to meet the needs of the residents as assessed by the person in charge.

Inspectors viewed staff training records and staff demonstrated relevant knowledge of the areas of training received. One staff member did not have updated training in relation to the moving and handling of residents. There was evidence that a staff nurse was on duty at all times in the centre. Inspectors viewed up-to-date registration details with the relevant professional body.

The inspectors reviewed a sample of records that were required to be maintained in staff files, as set out in Schedule 2 of the Regulations. In the files checked, inspectors noted that the required references were not in all the staff members' files. Following the inspection one set of references was forwarded to the Authority. However the second set of references was not forwarded.

Staff were supervised in their role, as evidenced by the minutes of staff meetings and the ongoing interactions between nurses and healthcare assistants, during the inspection. The inspectors spoke to the person in charge about the number of staff on duty after 11 pm as it is a two storey building. The person in charge assured inspectors that there are continuous checks on residents throughout the night. Staff informed the inspectors that an extra staff member comes on duty at night, in the event of a resident requiring end-of-life care. Inspectors spoke with staff about the staffing levels on day and night shift and no issues were raised by them.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Mary O'Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Action Plan**

**Provider's response to inspection report**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Kilcara House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000241</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>05/03/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>09/04/2014</td>
</tr>
</tbody>
</table>

**Requirements**

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 02: Contract for the Provision of Services**

**Theme:** Leadership, Governance and Management

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

The contacts of care viewed by inspectors did not stipulate the fees to be charged for services such as hairdressing and chiropody.

**Action Required:**

Under Regulation 28 (2) you are required to: Ensure each resident’s contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

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

The fees have now been added to each resident’s Contract of Care.

**Proposed Timescale:** 04/04/2014

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Outcome 04: Records and documentation to be kept at a designated centre

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records listed under Schedule 3 and Schedule 4 of the Regulations were not complete and were not stored in a easy to retrieve manner.

**Action Required:**
Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

**Please state the actions you have taken or are planning to take:**
Under schedule 4 (General Records) Staff files/ missing references have been obtained. Both folders (Maintenance/Staff files) have been filed in order to make retrieving of documentation easier.

**Proposed Timescale:** 07/03/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records were not in good order, particularly the directory of residents.

Not all records were stored securely, as a private医疗 appointment letter was on the notice board in the open staff office. This contained some sensitive data.

**Action Required:**
Under Regulation 22 (1) (ii) -(iii) you are required to: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

**Please state the actions you have taken or are planning to take:**
Under schedule 3 all resident records were update. They were stored in a closed/not locked cupboard in the nursing office. It would not be appropriate to have the door locked at all times as nursing staff use records regularly.

The directory of residents was worn as it has been in use since 2003. A new directory had been purchased.

It had been highlighted that records were not stored securely, i.e. a resident's medical appointment letter was on the notice board in the office. This was filed in the resident's care plan when the inspectors highlighted the issue.

**Proposed Timescale:** 09/04/2014
**Theme:** Leadership, Governance and Management

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The directory of residents did not contain all the details as specified in the Regulations.

**Action Required:**
Under Regulation 23 (2) you are required to: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

**Please state the actions you have taken or are planning to take:**
The new directory of residents is now in use in and all appropriate information will be documented.

**Proposed Timescale:** 06/03/2014

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**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A resident assessed as at high risk of malnutrition did not have a daily record of his dietary intake maintained.

**Action Required:**
Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

**Please state the actions you have taken or are planning to take:**
At time of the inspection the resident at risk of malnutrition had a dietary intake recorded for three days. He had been reviewed by the dietician and medical team in acute services as he was taken an adequate dietary intake, despite losing weight. The resident's diet and weight are been monitored closely both by nursing staff and GP and this will be reviewed.

**Proposed Timescale:** 09/04/2014

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**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were inconsistencies with drug recording, administration and documentation which will be addressed under outcome 8.

Documentation concerning the dose of a particular drug was not assessable to the nurse administering medications but was found in the resident's medical notes when
highlighted by the inspector.

**Action Required:**
Under Regulation 25 (1) (d) you are required to: Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

**Please state the actions you have taken or are planning to take:**
The particular drug dosage was faxed by the GP, following routine blood tests, and was filed in the Medical notes by error. The results should have been filed in Drug Kardex.

All RGN revised Medication Management policy.

Continue with regular Medication Management audits.

**Proposed Timescale:** 19/03/2014

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**Outcome 06: Safeguarding and Safety**

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Money kept in the safe for residents did not have the sufficient documentation to safeguard the money. Records of financial transactions between the bank and residents accounts were not clear and were not detailed enough to verify that these transactions took place.

**Action Required:**
Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
All money now kept in safe will be signed by two persons, i.e., person in charge and resident, if resident unable to sign next of kin will sign on their behalf.

All financial details were provided at time of inspection but were not very clear.

All transactions between the bank and resident’s accounts will be in print form to make details more clear.

Ongoing for all new transactions.

**Proposed Timescale:** 09/04/2014
<table>
<thead>
<tr>
<th>Theme: Safe Care and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The risk assessment policy was comprehensive but was not implemented throughout the centre.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 31 (1) you are required to: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>At the time of inspection Kilcara had Risk Management policy in place. All staff will review same. Our aim is for all staff to review policy by 30/05/2014.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 30/05/2014</td>
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</tbody>
</table>

<table>
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<th>Theme: Safe Care and Support</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>All risks in the centre were not identified, were not assessed and precautions were not in place to control these risks as outlined in the report.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>At the time of inspection the risks identified by inspectors were: fire guard not secured into the wall, low open gate at the top of the stairs, windows on one corridor were not restricted, risk when using lift.</td>
</tr>
<tr>
<td>Of these Kilcara did have Risk Assessment for safe use of open fire, it did not specify fire-guard should be secured onto the wall, same has been done.</td>
</tr>
<tr>
<td>An overall Risk Assessment for safe use of the lift has now been implemented.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 19/03/2014</td>
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</table>

<table>
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<tr>
<th>Theme: Safe Care and Support</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>All reasonable measures were not being taken to prevent accidents to any person in the centre.</td>
</tr>
</tbody>
</table>
**Action Required:**
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**
Fire guard was in place but not secured onto the wall. Same has been done.
All windows have now been restricted;
A secure, raised key coded gate has been installed at the top of the stairs.
Also the door to the treatment room is closed at all times.

**Proposed Timescale:** 08/04/2014

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**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector observed medications being administered from the pharmacy sheet which resulted in a resident being given medications which were not prescribed by the GP. Even though most prescriptions viewed outlined the maximum dose in 24 hours ofPRN (when necessary) medication, inspectors noted one prescription sheet did not state this and it concerned a sedative medication.

A resident who was prescribed a specific drug did not have the necessary documentation filed with his prescription which would have indicated the daily dose to be administered and the doctor’s signature. A resident who had been prescribed medications for 6.00 am was given them at 2.00 pm.

The system for recording medication errors was not robust and inspectors could not discern that practice improvement occurred as a result of examination of these errors, as required by the professional regulatory body. Where medications were to be crushed there was no evidence on the residents' medication administration sheets that this had been authorised by a registered medical practitioner, as required by an An Bord Altranais agus Cnaimhseachais na hEireann guidelines (2007). Inspectors did not see a robust system in place to review and monitor safe medication practices.

**Action Required:**
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

**Please state the actions you have taken or are planning to take:**
The drug which was not prescribed (being Paracetamol) was prescribed on the old Kardex which had been updated two weeks prior to inspection.
The specific drug which did not have the necessary documentation was a slow-releasing drug. The name of the drug was correct, but when the GP updated the residents Kardex “slow release” was not documented.

Same happened with a resident that have been prescribed medication for 6 am and given at 2pm. This particular resident unable to take medication whilst in bed. Therefore on discussion with her GP he agreed to administration at 2pm. Again the GP updated the residents drug Kardex and forgot to change the times.

Kilcara have in place written policies relating to: “ordering, prescribing, storing and administration” of medication to residents.

The errors identified at the time of inspection came about as a result of GP’s updating residents drug Kardex.

It was also highlighted that authorisation by GPs for crushed medication was not individualised. Kilcara did have a general authorisation for the three residents requiring crushed medications.

We had at the end of inspection individualised authorisation for crushed medication on each drug Kardex as protocol under An Bord Altranais agus Cnaimhseachais na HEireann Guidelines on medication management 2007.

All RGN to review and read Medication Management Policy by 31/03/2014

**Proposed Timescale:** 31/03/2014

### Outcome 11: Health and Social Care Needs

#### Theme: Effective Care and Support

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

A resident who had been assessed as at high risk of malnutrition did not have a continuous food intake record maintained.

Plans of care required updating and some assessments were out of date. A resident who had a leg wound had a skin assessment done which needed updating. This resident, who was overweight, did not have an up-to-date moving and handling assessment.

A bedrail assessment for one resident did not have a three monthly review as required by the Regulations. It was last done on 23/07/2013.

**Action Required:**

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.
Please state the actions you have taken or are planning to take:
All Care plans are reviewed on a monthly basis. Some assessments are carried out three monthly basis.

The residents leg wound required only a protective dressing. It was healed and this was documented on his Wound Assessment chart.

As the resident requires assistance of one person to mobilise, a manual handling assessment has now been put in place as it was highlighted by the inspectors that this was out of date.

Staff at the time of the inspection did highlight that they found a particular resident demanding. He had been reviewed by his GP. A behavioural management care plan has now been put in place.

Proposed Timescale: 20/03/2014

Outcome 17: Residents clothing and personal property and possessions
Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The residents' clothing inventory was not signed by the resident or their representative and the clothing inventory was not updated at regular intervals.

Action Required:
Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

Please state the actions you have taken or are planning to take:
Some residents unable to sign clothing inventory; our plan is to get them all signed and keep updated.

Proposed Timescale: 09/04/2014

Outcome 18: Suitable Staffing
Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A staff member was not provided with manual handling training to enable her to provide care in accordance with evidence-based practice.

Action Required:
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
Please state the actions you have taken or are planning to take:
The staff member was offered Manual Handling Training but was unable to attend due to unforeseen circumstances. She has since completed her course on manual handling.

Proposed Timescale: 19/03/2014
Theme: Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to obtain all the documents required, for employees, as specified under Schedule 2 of the Regulations, i.e. references were not available for two staff members on the day of inspection.

Action Required:
Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

Please state the actions you have taken or are planning to take:
Kilcara has a Recruitment policy in place. The documents which were not available on the day of inspection were references for two staff members. One set was emailed to the authorities the following day.

Proposed Timescale: 09/04/2014