<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Knockeen Nursing Home</th>
</tr>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000243</td>
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<tr>
<td>Centre address:</td>
<td>Knockeen, Barntown, Wexford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>053 913 4600</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:knockeennursinghome@yahoo.ie">knockeennursinghome@yahoo.ie</a></td>
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<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<td>Registered provider:</td>
<td>Knockeen Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Nicola Doran Kinsella &amp; Eimear Kiely</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Kieran Murphy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Ide Batan;</td>
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<td>Type of inspection</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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
From: To:
21 July 2014 10:30 21 July 2014 17:30
22 July 2014 09:00 22 July 2014 16:00

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

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

Summary of findings from this inspection
Since the last inspection there had been a change in the overall governance. Two members of the management team who had worked in the centre for a number of years were the new nominated registered providers. Inspectors were satisfied with the governance systems and in particular the introduction by the providers of a quality assurance framework to ensure that care was provided in a safe and effective manner.

Inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. A number of questionnaires from residents and
relatives were received prior to and following the inspection and the inspectors spoke to many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged with relatives and relatives stating they are welcomed at any time. Residents’ comments are found throughout the report.

Inspectors found that each resident’s well being and welfare was maintained by a high standard of evidence based nursing care and appropriate medical and allied health care. However, improvements were required in a number of areas including:

- Records management
- risk assessment
- medication management
- infection control.

The Action Plan at the end of this report identifies where improvements were needed.
Section 41(1)(c) of the Health Act 2007. 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.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose accurately described the service provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care was provided, reflected the diverse needs of residents.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Since the last inspection there had been a change in the overall governance. Two members of the management team who had worked in the centre for a number of years were the new nominated registered providers. The person in charge was one of registered providers and had specific responsibility for clinical and care issues. The second provider had responsibility for clinical support services including finance, recruitment, maintenance and catering. They were supported at a clinical level by a senior nurse who was experienced and well qualified.
Inspectors were satisfied with the systems in place to ensure the service was safe, appropriate and effectively monitored. The providers had introduced a quality assurance framework for 2014 which consisted of a monthly management meeting with a standing agenda of reviewing policies that required renewal, review of all audit results and a review of all incidents. In addition data was being collected and monitored on a three monthly basis on issues like the use of restraint, wound care, pain and the use of psychotropic medications. The person in charge had introduced a system of quality assurance reviews which included audit of nursing documentation, infection control and resident care plans. Following each audit an action plan to remedy the deficit was introduced.

There was evidence of a systematic analysis of reported adverse events. Over 90% of total reported incidents related to residents falling. A review undertaken each quarter examined the pattern of falls including location and time of day. A number of initiatives had been introduced including increased staffing until 22:00 hrs at night and education for staff at team meetings.

Since the last inspection the providers had begun a process of seeking formal feedback from residents. The providers now attended the residents’ committee meetings and were available to provide feedback on any issues raised at that forum. A satisfaction survey had been distributed in 2014 to cover issues such as management, menus and the activities provided. The results of the survey were displayed in the reception area. There was a suggestion box also in the centre. A centre newsletter was published every quarter which was used to make residents aware of the audits/reviews being carried out.

All residents and families that spoke with the inspectors were very happy with the care provided in the centre.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was an up to date policy on admission of residents which included the contract for the provision of services. A number of contracts of care were viewed by the inspectors. The contracts of care were found to be comprehensive and were agreed and signed.
within a month of admission. The contracts stipulated the services to be provided and the fees included in the contract.

The contract also outlined additional services provided in the centre, for example dental, optical chiropody, newspaper, physiotherapy and hairdressing. All these services were charged on a monthly basis in addition to the care and maintenance charge agreed. An invoice was issued every quarter which detailed all the charges for these additional services.Inspectors found this process to be transparent.

There was a policy on the provision of information to a resident which included the residents’ guide. This guide was compliant with the regulations as it contained a summary of services and facilities, the terms and conditions of admission, a summary of the complaints process and the arrangements for visits.

Judgment: Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was a registered general nurse since 1994 and had been director of nursing since October 2013. She had engaged in continuing professional development and had recently obtained a certificate in management for senior nursing staff from Waterford Institute of Technology.

The inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of this centre on a regular and consistent basis. The person in charge was one of registered providers and provided reports on a monthly basis to the board of management. Inspectors saw evidence of good supervision for staff at all levels in the organisation. There were house meetings attended by the person in charge for all staff, nurses meetings and carers meetings to facilitate communication throughout the organisation.

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors viewed the insurance policy and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The directory of residents was viewed by inspectors and found to contain comprehensive details in relation to each resident including name, contact details for relatives and contact details for general practitioner (GP).

Inspectors found that most policies, procedures and guidelines such as prevention of abuse and end of life care were available as required by the regulations. However, there were two policies in some areas like risk management and fire and it wasn’t clear which of the two policies was being implemented. The policies also outlined that they were to be reviewed after an interval of four years which was not within the timelines set out in the 2013 regulations.

Inspectors found that the medical and nursing records were comprehensive. The records were maintained securely to prevent any breaches of privacy. The care plans and the record of care provided to residents were accurately documented. There was evidence that residents were involved in the care planning process and were aware of their health and social needs. As an example of good practice an audit of resident assessment and care planning had been undertaken in January 2014 and actions included care plans to be signed by residents and reminders set to show when the care plan was to be reviewed.

**Judgment:**
Non Compliant - Minor

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**Outcome 06: Absence of the Person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.
**Theme:**
Governance, Leadership and Management

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

**Findings:**
There had not been any period where the person in charge was absent for 28 days or more since the last inspection and there had not been any change to the person in charge. The person in charge and the nominated registered provider were aware of the obligation to inform the Chief Inspector if there was any proposed absence of the person in charge.

There were clear arrangements to cover for the absence of the person in charge. Either the second nominated registered provider or the clinical nurse manager had responsibility for management of the centre when the person in charge was absent. The clinical nurse manager was a registered general nurse and had worked in the centre since 1997. The inspectors were satisfied that the senior had the requisite skills and experience in care of the older person.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe care and support

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

**Findings:**
Inspectors reviewed the policy on elder abuse which was compliant with the regulations. All staff had received in-house training on the protection of vulnerable adults which was coordinated by the person in charge and the clinical nurse manager. The inspectors observed staff interaction with residents to be respectful and caring at all times. All staff spoken with were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to. The provider outlined the results of a survey that had recently been undertaken by an independent facilitator which showed that all residents said they felt safe. The provider outlined that there were no ongoing investigations or issues relating to protection of residents and the Authority had not been notified of any such issues.
Inspectors reviewed the system in place to safeguard resident’s finances and were satisfied that the system was transparent, with invoices being issued for any additional services like hairdressing. While there was a property box and property book securely maintained, there was no money kept on behalf of residents and the provider was not acting as a pension agent for any resident.

There was an up to date policy on managing behaviour that is challenging. Two health care assistants had completed a Further Education and Training Awards Council (FETAC) level six qualification in challenging behaviour. These staff were providing support in the development of support plans for people who present with behaviours that challenge. The behaviour support plans seen were person-centred and included input from the psychiatric liaison support team, the resident and their families.

There was a policy on the management of restraint. There was a restraints register and three residents were using bed rails at night. One resident was using a specifically fitted wheelchair which had been prescribed and assessed by an occupational therapist for the resident to maintain posture. A number of residents who had been assessed as being at risk of absconding had a security tag in place. Each care plan outlining the use of the security tag management system was seen as comprehensive and person centred.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
There was an up to date safety statement. The current risk management policy was compliant with the regulations. There was an organisation risk register which outlined arrangements for issues like the management of challenging behaviour and smoking. However, there were no risk assessments available for:
- access to the pond in the enclosed garden
- access to kettles and containers containing hot soup in a galley kitchen which was used for serving residents in the second of the dining areas
- transportation of containers from the main kitchen to the galley kitchen
- sharp knife being inappropriately stored in the visitors’ kitchen area.

The emergency plan adequately addressed the centre’s response to fire and other emergencies like loss of power, loss of heating or water supply. It also included the accommodation arrangements to be implemented in the event of an evacuation.
However the policy didn’t specifically include the emergency contact details.

Facilities and procedures were in place to prevent and control the risk of infection. Hand washing facilities were located in the main entrance lobby, and wall mounted alcohol hand gel was available throughout the centre. The centre was visibly clean and cleaning staff were knowledgeable in the area of infection control. There was adequate sluicing facilities.

There was a valid infection control policy which covered issues like hand hygiene, environmental cleaning and disinfection guidelines. An internal audit of infection control had identified corrosion in the sink in the sluice room and the sink had been replaced in June 2014. All residents were assigned their own slings if required. Inspectors visited the laundry room where staff were aware of infection control principles and in particular the need for separate storage of dirty clothes, washed clothes and clean clothes. However, laundry staff collected dirty bed linen and night clothes during the morning and brought them to the laundry. A separate collection was then made for residents’ dirty clothes. There was only one bag on the laundry trolley for the dirty items. There wasn’t a separate bag for potentially infected items which were initially put in a pillow bag. This practice was contrary to the centre’s infection control policy which recommended the placing of soiled materials in alginate bags. They were then placed in either the clothes bag or linen bag on the laundry trolley, thus increasing the risk of potential cross contamination of other items. Inspectors also observed the practice of sponges that were used for cleaning residents not being discarded. These used sponges were transferred to the laundry for machine washing. This practice could lead to potential cross infection from a used sponge.

There was a valid fire certificate for the centre dated 22 April 2014. Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:
• servicing of fire alarm system and manual call points July 2014
• fire extinguisher servicing and inspection October 2013
• servicing of emergency lighting May 2014.

The fire safety management plan included details showing that all staff had been trained in fire safety within the last year. There was a schedule of fire and evacuation drills with the most recent completed in June 2014. The fire policy outlined that upholstered furniture should not be provided in corridors. However, two upholstered chairs and a table were on a corridor used as an evacuation route. A number of fire doors were held open with wedges.

Inspectors reviewed resident care plans which outlined patient handling assessments and saw evidence that these assessments were updated at least every three months. The manual handling assessment was available in each resident’s room.

Judgment:
Non Compliant - Moderate
**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
There was an up to date policy on medication management which included the transcribing of prescriptions by nursing staff and the administration of medication in a modified form to that prescribed i.e. crushing oral medication. Each resident stored their medication in a locked cabinet in their bedroom. However, the medication management policy in place did not specifically reference this practice.

Medication for each resident was dispensed by pharmacy and there was a daily delivery. The dispensed medication was checked and counted by nursing staff on receipt and stored in a locked cabinet in each resident’s bedroom. Medication prescribed for 08:00hrs medication was administered and signed in the administration record by nursing staff in the resident’s bedroom. A similar administration process was in place for medication timed between 16:00hrs and 20:00hrs. However, for medications prescribed between 12:00hrs and 14:00hrs nursing staff were transferring the medication from the storage press to a pill box. Even though the medication was not administered at this time nursing staff were signing the administration record at the time of transfer of the medication to the container. This practice could lead to a potential drug omission where for example the nurse who signed the administration record was not available to administer the medication.

The pill box for each resident requiring medication between 12:00hrs and 14:00hrs was put in the drug trolley and the medication was administered to the resident with their lunch. Inspectors found that this system could lead to a potential medication error as all boxes were stored together in the medication trolley and while the resident’s name was on the reverse side of the box there were no other identifying factors to ensure that the correct medication was administered to the correct resident at the correct time. The prescription and administration record sheets were also not available to the nurse at this time.

At the time of inspection seven residents had been assessed as suitable to take their own medication. Each of these residents had a care plan for self medicating and the sample care plans seen included education for the resident regarding the medication and advice regarding storage. The resident’s medication was put into a pill box by nursing staff to be taken by the resident at the correct time. However, the pill boxes were not labelled to enable identification of individual medications to be made which is a requirement of the Guidance to Nurses and Midwives on Medication Management (2007) issued by An Bord Altranais. There was the facility for residents to store their medication in a locked cupboard in their rooms.
In the sample prescription sheets reviewed it was not clear that a record of each drug and medication was signed and dated by the GP. The signature of the GP was not in place for each drug prescribed in the sample of drug charts examined. In some resident healthcare files a prescription had been faxed in and transcribed to the resident prescription sheet by nursing staff. However, this transcription had not been signed by a medical practitioner which was not in keeping with the centre’s medication management policy.

One resident’s care plan indicated that they required medication to be crushed and the care plan contained a check list including assessment, administration of prescribed medication only and the monitoring of the effectiveness of medication. The prescription for crushed medication for this resident had been transcribed by nursing staff but each drug requiring crushing was not signed and dated by a medical practitioner.

In relation to the reviewing and monitoring of safe medication management one of the nursing staff had undertaken the role of medication safety nurse and had developed a medication error alert. This was an effective communication to all nursing staff regarding medication errors and notes on best practice.

**Judgment:**
Non Compliant - Moderate

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**Outcome 10: Notification of Incidents**

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

**Theme:**
Safe care and support

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

**Findings:**
It is a requirement of the regulations that all serious adverse incidents are reported to the Authority and since the last inspection the centre had been compliant with this provision. The centre provided the Authority with a summary of all recorded incidents as set out in the regulations.

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

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

**Theme:**
Effective care and support

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

**Findings:**
There was a system of a named nurse being allocated to a resident on admission. There was evidence that each resident was assessed on admission for issues including falls risk, dependency levels and manual handling. In the sample of care plans seen, these assessments informed the care planning process. There was good evidence based practice in relation to management of wounds with care plans for each resident outlining skin condition and assessment of potential for pressure sores. There was a care planning review at least very three months. There was evidence that the resident and their families were involved in the development of care plans. In particular there was evidence of appropriate use of conferences to discuss care with the resident, family and medical personnel.

Inspectors saw evidence that residents’ health care needs were met through timely access to general practitioner (GP) services. Residents had the option of care from their own GP and there was evidence of a medical review of each resident at least once every three months. There was evidence of good access to specialist care in old age psychiatry, in particular via the community psychiatric liaison nurse who reviewed residents on site.

Healthcare records reviewed indicated that residents had appropriate access to allied health care services including physiotherapy and occupational therapy. Residents were referred for dietetic review as required. This referral was made following a malnutrition universal screening tool (MUST) outcome measure and the recording of a three day food and drink chart. Similarly there was evidence of reviews by a physiotherapist leading to care plans for mobility and passive movement interventions. Resident healthcare records also documented referrals for an optician review. The person in charge outlined in the self assessment questionnaire in relation to food and nutrition submitted to the Authority that while some residents had been assessed by an occupational therapist in relating to seating, in general residents there was a waiting period of six months for occupational therapy review.

There was evidence of good communication links between the centre and the acute general hospital when residents were transferred for specialist care. There was a policy on temporary absence and discharge of a resident. The healthcare record included summaries of medical reviews and transfer letters to and from hospital.
**Judgment:**  
Compliant

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**Outcome 12: Safe and Suitable Premises**  
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**  
Effective care and support

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

**Findings:**  
The centre was a purpose built nursing home and was bright, clean, spacious and well decorated. There were a number of lounge and quiet areas which were well furnished and comfortable. An internal garden was accessed via the main entrance hall and contained a large pond.

Accommodation was provided in 45 single en suite bedrooms and two double en suite bedrooms. There was adequate screening in shared rooms to ensure privacy for personal care. Each bedroom included sufficient space for storage of personal belongings in fitted wardrobes and lockable storage for valuable items. There was a functioning call bell system throughout the premises. In general inspectors found the premises to be well maintained with suitable lighting, ventilation and heating. There was a maintenance officer employed on a part-time basis.

There was appropriate assistive equipment available and stored conveniently to meet the needs of residents, such as electric profiling beds, hoists, pressure-relieving mattresses, wheelchairs and walking frames. Inspectors observed residents moving around independently on wide corridors which had hand-rails that promoted independence.

There was a smoking area provided for residents. However on the date of inspection there were no residents who smoked. The person in charge outlined a provisional plan to provide an external smoking area.

**Judgment:**  
Compliant
### Outcome 13: Complaints procedures

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

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

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

**Findings:**
Inspectors were satisfied with the complaints process. There was a complaints policy which was displayed prominently at the foyer along with a suggestions box. The person in charge was the nominated complaints officer and the policy also contained details of the independent appeals person if the complainant was not satisfied following investigation. Inspectors reviewed the complaints log for 2013. There was evidence that issues identified were followed up appropriately.

At the last inspection it was found that there was no recording of the outcome of the complaint and whether the complainant was satisfied or not. This had been rectified and there was evidence that the complainant’s satisfaction with the outcome of the complaint investigation was being recorded.

Prior to the inspection questionnaires relating to the services provided by the centre were distributed by the Authority to residents and their families. The returned questionnaires confirmed that residents and families were aware of the complaints process and who to make a complaint to.

**Judgment:**
Compliant

### 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

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

**Findings:**
The centre had participated in a national initiative by the Authority the purpose of which was to assess compliance with the specific themes of end of life care and nutrition. The centre had assessed itself as compliant with the regulations and standards in relation to end of life care and inspectors found evidence to support this assessment.
There was up to date policy on end of life care. There was also an information pack for new residents which outlined support arrangements in place for the resident and their families in relation to care at end of life.

There was a bright and spacious oratory. An adjacent large lounge area was utilised if the resident wished for a prayer and removal service from the centre. A family room was made available specifically for families of residents at end of life which was comfortable and contained a bed. Showering and dining facilities were also made available to families.

There was evidence of comprehensive care planning for residents in relation to end of life needs both at admission and also as part of the review of care every three months. Resident and family involvement was seen in the care planning process. Issues discussed included residents wishes regarding spiritual care, funeral arrangements and what medical supports the resident wished. The centre had two specific beds allocated for residents requiring palliative care who were referred by the Consultant in palliative care. A pre-admission assessment was undertaken by the palliative care team prior to referral. Following admission, residents had access to the specialist palliative care home care team who provided 24 hour support.

A number of nurses had specific third level qualifications in palliative care and all nursing staff had updated training on either end of life care or palliative care. The topic of end of life care had been an education subject as part of the centre’s monthly training programme in November 2013.

There was evidence of quality improvement following an audit of end of life care in February 2014. A formal debriefing programme following a resident’s death had been identified as a need for staff. Following an internal staff meeting in June 2014 a number of initiatives were introduced including the introduction of improved documentation for nursing staff and increased training for all staff on the care of residents at end of life.

**Judgment:**
Compliant

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

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

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
In relation to food and nutrition the centre had assessed itself as compliant during the national self assessment on food and nutrition undertaken by the Authority. During the inspection there was evidence to support this assessment.

There was a policy on the monitoring and documentation of nutrition. On admission each resident had an initial malnutrition universal screening tool (MUST) assessment. There was monthly recording of residents’ weight, body mass index and any weight loss. Of the sample care plans seen, the inspectors noted evidence of appropriate nutritional care planning. Residents who were identified as having a change in nutritional status were referred to the dietician. A three day food and drink chart was maintained prior to this referral. Recommendations from the dietician were communicated to the kitchen staff who maintained a copy of each resident’s dietary requirements. Catering staff spoken with were able to articulate each resident’s nutritional needs.

A menu plan for the week was available which offered good choice at all meals. The nutritional value of the meals was assessed regularly by the dietician and the nutritional content of the meals was shown beside the menu planner.

There were two spacious dining areas, the larger of which catered for residents who required more assistance at mealtimes. There was sufficient staff available to offer assistance at mealtimes and inspectors observed a pleasant dining experience. There was access to fluids and snacks throughout the day and tea trolleys were seen in circulation during the morning and afternoon. Changes had been introduced following feedback from residents regarding the timing of meals in the evening. The providers had reviewed staffing and made more staff available so that dinner could start at a later time.

The chef and catering staff had received up to date training on food safety. 11 staff had also received training on the use of MUST assessment and 24 staff had received training on dysphagia (swallowing difficulties).

Judgment:
Compliant

Outcome 16: Residents’ Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.
Findings:
While there wasn't a full time activities coordinator there was a schedule of activities including bowls, bingo and card playing. Recently a choir had been started and the feedback from residents was positive about this initiative. There was evidence in the care plans that residents received a comprehensive initial assessment on spirituality and social interaction. Issues outlined included participation in social interactions, going to mass and going on outings. The centre had organised a number of day trips during the summer including an outing to the circus and a visit to nearby gardens.

Inspectors saw evidence that residents were consulted about how the centre was planned and run. There was a policy on the provision of information to residents. Inspectors reviewed minutes of the residents’ forum which both providers were invited to attend so that they were aware of issues of importance to residents. Residents had been facilitated to vote in the recent local and European elections. Residents had access to television and radio in communal areas and a number of residents had televisions in their rooms. Daily newspapers were available.

Inspectors spoke with a number of families of residents who confirmed that there were no restrictions on visits. There were a number of areas throughout the centre where each resident could receive visitors in private.

Inspectors saw evidence that staff were aware of the different communication needs of residents. There was a policy on communication and inspectors saw a communication care plan available for a resident with impaired hearing which was person centered and addressed the resident’s needs.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
The inspectors reviewed a policy on residents’ personal property and possessions which satisfactorily outlined the arrangements in place for residents to retain control over their own possessions and clothing. The laundry staff adequately explained the process in place to ensure clothes were returned to the resident. The laundry costs were outlined in the fee. The complaints log outlined an issue relating to laundry where one resident
had been refunded the cost of a jumper that had shrunk in the wash.

Inspectors saw personalised living arrangements in resident’s rooms with photographs and personal effects.

Judgment:
Compliant

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

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

**Findings:**
Based on the review of the staff rota inspectors were satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. In response to a review of residents’ needs a new staffing rota had been created for weekend cover. In addition, to ensure adequate care a new evening shift had been introduced and a senior health care assistant was now rostered on duty every evening also.

There were effective recruitment procedures in place with a policy on staff recruitment, selection and appointment available. Current registration with an Bord Altranais was available for all nursing staff. Inspectors reviewed a sample of staff files which were found to include appropriate reference checking, evidence of vetting by an Garda Síochána and a medical certificate providing evidence that the person was physically and mentally fit for work, as required by the Regulations.

Inspectors saw evidence of good supervision for staff at all levels in the organisation. There were monthly house meetings for all staff, nurses meetings and carers meetings to facilitate communication throughout the organisation. Agenda items for these meetings included the introduction of new policies, results of audits, review of incidents and resident feedback. All staff had engaged in a staff performance review which gave an opportunity to discuss their role and also to discuss personal objectives and personal developments plans including further education. Staff confirmed to inspectors that they had been facilitated in accessing continuing professional education by the provider. As a result of the appraisal process new training had been introduced on bereavement and
counselling. There was a training programme in place and all staff had received mandatory training on fire and protection of residents from abuse as required by the regulations. All catering officers had completed food hygiene training with nursing and support staff having undertaken additional training on manual handling, management of dysphagia (swallowing difficulties), clinical audit, skin integrity assessment and an ear care programme.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Knockeen Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000243</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/07/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19/09/2014</td>
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</tbody>
</table>

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were two polices in some areas like risk management and fire and it wasn’t clear which of the two policies was being implemented.

Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The Risk management and Fire policies have been amended accordingly.

**Proposed Timescale:** 30/09/2014

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medication policy did not outline that medications for each resident were stored in a locked cupboard in the resident's room.

**Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The medication policy has been amended accordingly.

**Proposed Timescale:** 30/09/2014

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

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk assessments were not available for:
- access to the pond in the enclosed garden
- access to kettles and containers containing hot soup in a galley kitchen which was used for serving residents in the second of the dining areas
- transportation of containers from the main kitchen to the galley kitchen
- sharp knife being inappropriately stored in the visitors’ kitchen area.

**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:
All the above have been risk assessed.

**Proposed Timescale:** 31/08/2014
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The emergency didn’t specifically include the emergency contact details.

Action Required:
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
Fire policy has been amended accordingly.

Proposed Timescale: 30/09/2014

Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was only one bag on the laundry trolley for the dirty items without a separate bag for potentially infected items.

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

Please state the actions you have taken or are planning to take:
All dirty laundry is bagged at source (i.e. resident’s room or bathroom). Dirty laundry is placed in personal laundry bags. Potentially infectious laundry is bagged in alginate bags. They are now collected in separate colour coded laundry baskets and brought to the laundry.

Proposed Timescale: 06/10/2014

Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Sponges that were used for cleaning residents were not being discarded.
### Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
Sponges will no longer be laundered. Disposable wipes will be used. If a resident has their own personal sponge which they use for washing themselves it will not be laundered but disposed of by the resident.

**Proposed Timescale:** 06/10/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An evacuation route was blocked by two chairs and a table.

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

**Please state the actions you have taken or are planning to take:**
I measured the particular hall way and the above mention items did infringe by 6cm and 10cms on the evacuation route and have been relocated to a wider part of the corridor. Our fire consultant has reviewed the adjusted fire policy.

**Proposed Timescale:** 26/09/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A number of fire doors were held open with wedges.

**Action Required:**
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
The practice of wedging opening the administration office and the visitor’s room upstairs for ventilation on a warm day has been stopped since the day of inspection. The new dining room door which is a fire door is only opened to allow residents in and out of this dining room. It is the policy of the Nursing Home to keep all fire doors closed (unless they have an automatic door closer feature).
### Proposta Timescale: 23/07/2014

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Nursing staff were signing the administration record at the time of transfer of the medication to the container and not the time of administration.

**Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
Staff nurse now do not sign the administration record until the time of administration.

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### Outcome 09: Medication Management

**Proposed Timescale: 23/07/2014**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
When medication was transferred by nursing staff to the pill box there were no identifying factors on the box to ensure that the correct medication was administered to the correct resident at the correct time.

**Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
The drug prescription and administration sheets now stay with the pill box until administration. The resident’s name is clearly marked on the box and only administered by the nurse who signs the administration record stating the correct medication was given at the correct time.

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**Proposed Timescale: 23/07/2014**
<table>
<thead>
<tr>
<th>Theme: Safe care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>It was not clear that a record of each drug and medication was signed and dated by the GP. The signature of the GP was not in place for each drug prescribed in the sample of drug charts examined.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The nursing staff will request that the resident’s GP sign each drug prescribed individually rather than the common practice of bracketing down the list of medications and using an inclusive signature.</td>
</tr>
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</table>

| **Proposed Timescale:** From the date of inspection and ongoing. |

<table>
<thead>
<tr>
<th>Theme: Safe care and support</th>
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<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>In some resident healthcare files a prescription had been faxed in and transcribed to the resident prescription sheet by nursing staff. However, this transcription had not been signed by a medical practitioner which was not in keeping with the centre’s medication management policy.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All prescriptions signed by the GP faxed to the nursing home are kept with the prescription sheet until the GP is available to sign the transcription of the fax on the resident’s prescription sheet in the Nursing Home. Medication policy amended accordingly.</td>
</tr>
</tbody>
</table>

| **Proposed Timescale:** 23/07/2014 |
Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Prescription for crushed medication had been transcribed by nursing staff but each drug requiring crushing was not signed and dated by a medical practitioner.

Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
All orders for “may be crushed” will be under the method/route of administration section on for each individual drug. Again the nursing staff will request that the resident’s GP sign each drug prescribed individually rather than the common practice of bracketing down the list of medications and using an inclusive signature.

Proposed Timescale: 23/07/2014

Outcome 11: Health and Social Care Needs

Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In relation to residents self-medication the dosette boxes were not labelled to enable identification of individual medications to be made which was a requirement of the Guidance to Nurses and Midwives on Medication Management (2007) issued by An Bord Altranais.

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:
It is the policy of the Nursing Home that self-medicating residents only receive 24 hours of medication at one time. In line with our policy The resident must be able to identify theses medication. Anyone who is self-medicating will now keep a copy of their personal drug prescription sheet.

Proposed Timescale: 30/09/2014