<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killiney Grove Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000051</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Killiney Hill Road, Killiney, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 285 1855</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:killiney@silverstream.ie">killiney@silverstream.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Eclipse Care Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Joseph Kenny</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Liam Strahan</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>31</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>6</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.
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**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>21 October 2014 09:30</td>
<td>21 October 2014 18:30</td>
</tr>
<tr>
<td>22 October 2014 07:30</td>
<td>22 October 2014 18:00</td>
</tr>
</tbody>
</table>

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

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

This inspection was carried out in response to an application from the provider to renew registration. Inspectors assessed compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2009. It also focused on the issues arising from the previous inspection carried out in March 2013. As part of this inspection, inspectors met with residents and staff members, observed practices and reviewed documentation such as care plans, accident logs, policies and procedures.
Inspectors were not satisfied with the participation of the person in charge in relation to clinical governance and leadership of the centre. In particular, inspectors found the person in charge had not appropriately responded to allegations of abuse and had not notified the Authority of such incidents. Inspectors found a high level of incidents and accidents involving residents occurred in the centre and these had not been fully investigated. These matters were of concern to inspectors and were brought to the attention of the person in charge and the operations manager who was present in the absence of the provider nominee on the second day of the inspection. Inspectors requested immediate action to address the concerns raised. An action plan was required to be submitted by the provider in response to these concerns on the 30 October 2014.

Furthermore, inspectors found that significant improvement was required in order to bring about substantial compliance with the requirements of Regulations with other areas of non compliance identified related to the management of complaints, the ongoing management of risk, staff knowledge around fire safety and the notification of incidents to the Authority.

Information received by the Authority prior to the inspection was also reviewed, which related to concerns around staffing levels and supervision provided to visiting allied health professionals. A provider led investigation had been submitted to the Authority in response to this concerns. At the inspection there was evidence of suitable staffing levels however, supervision arrangements were not clearly outlined.

Questionnaires returned by residents and relatives were reviewed. They expressed a high level of satisfaction overall with the service provided. Inspectors spoke to residents and family members, while there were some positive comments, there were also concerns raised in relation to health care, response to accidents and staffing levels in the centre. These matters were followed up during the inspection. These issues are further discussed in the body of the report and in the Action Plan at the end of the report.

This inspection also assessed the six required actions from the previous inspection. At this inspection it was noted that only one action was completed and five were not fully completed. These included:

- residents expressing not feeling safe
- structural deficits in the premises,
- the ongoing management of risk.

Inspectors found evidence of improved practice in relation to the provision of light in two bedrooms in the centre and the completion of social care plans for residents.

These items are discussed in the body of the report and are included in the Action Plan at the end of this report.
### 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:**
Inspectors were satisfied the statement of purpose for the centre met the requirements of Regulation 3 and Schedule 1 of the Regulations.

A revised version of the Statement of Purpose was read by inspectors at the inspection. It contained amendments to reflect the Regulations. The updated version was submitted to the Authority following the inspection. 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

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### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors found there was a governance structure in place and sufficient resources to ensure the effective deliver of care. However, improvements were identified as the management system was not effective or robust to effect positive outcomes for
The governance arrangements and management structure in the centre were outlined to inspectors. However, they found the lines of authority and accountability were not robust and resulted in poor outcomes to residents as outlined in Outcome 7 (Safeguarding and Safety), Outcome 8 (Health and Safety and Risk Management) and Outcome 11 (Health care needs). While there were regular management meetings, they were not effective to ensure appropriate care. A number of significant incidents had occurred and allegations of abuse were noted to have been made. However, there was insufficient evidence of appropriate action taken to address these issues. Although there was a comprehensive system of auditing in the centre, there was no evidence of the learning and improvement to prevent similar incidents or allegations of abuse occurring again.

**Judgment:**
Non Compliant - Moderate

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**Outcome 03: Information for residents**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors found residents had a guide in respect of the centre available to them and had a written contract agreed on admission. However, an area of improvement was identified in the contract of care provided to residents.

A sample of written contract of care reviewed were developed within the mandatory time frame for all residents'. The contracts of care set out the services to be provided and the fees to be charged. Inspectors noted a monthly levy of €75 was mandatory for additional services, yet a breakdown of the services were not outlined. Although it was reduced in certain individual circumstances, residents could not opt out of paying the fee.

The residents guide to the centre was read by inspectors which included the information set out by the Regulations.

**Judgment:**
Non Compliant - Minor
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:
While the requirements for the role of person in charge were met with regard to qualifications and experience, inspectors had a number of concerns regarding this outcome.

The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre. However, inspectors found the response to and the investigation of allegations of abuse was not adequate and significant improvement was required, this is discussed under Outcome 7. Inspectors also found that there was unsatisfactory management of risk by the person in charge and a failure to show leadership and implement improvements in response to incidents occurring in the centre. Inspectors observed a number of issues in relation to clinical governance which included falls management. These issues are discussed further under Outcome 11.

The person in charge had been in post since 2012. Inspectors found she was familiar with the residents and their health care needs. A number of residents along with families informed inspectors they were aware of the person in charge. Staff spoken to informed inspectors they felt supported by the person in charge. In preparation for the inspection, the person in charge had organised information and documentation for inspectors to review and information signs had been displayed in the centre. While the person in charge was familiar with the Regulations and her responsibilities therein, improvement was identified. For example, a number of notifiable incident had not been reported to the Chief Inspector as outlined in Outcome 9 (Notifications). The person in charge was familiar with the centre key operational policies, however, this was not fully reflected in practice. For example, the policies on the protection of vulnerable adults, the management of risk and the management of complaints, as outlined in Outcomes 7, 8 and 13 respectively.

Inspectors found that she had participated in continued professional development and had completed a certificate in leadership management. The person in charge stated that she maintained her professional development by attending clinical courses and had plans to complete a diploma in gerontology in the near future. Inspectors saw documentary evidence that she had attended mandatory training in fire safety and the protection of vulnerable adults. She was a manual handling instructor and facilitated training to staff.
Inspectors were satisfied that there were satisfactory deputising arrangements in place provided by an assistant director of nursing (ADON). The ADON participated fully in the inspection process and demonstrated good clinical knowledge and a satisfactory understanding of their roles and responsibilities under the Regulations.

The person in charge was supported in her role by the operations manager and met with him formally on a monthly basis to discuss staffing and management issues.

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 found the operational policies and procedures as required by Schedule 5 were in place however, improvements were identified in relation to the implementation of policies, documentation to be kept for each resident, and the information contained in directory of residents.

The policies and procedures as outlined under Schedule 5 of the Regulations were reviewed. However, some policies did not provide direction to staff, for example, the medication management policy as outlined under Outcome 9 (Medication Management) did not describe the "as required" (PRN) procedures in the centre.

The systems in place to ensure staff were suitably knowledgeable of the policies were not robust and required improvement. While the person in charge discussed a different policy at each staff meeting and staff appeared to be aware of them, this was not always reflected in practice, for example, the policy on restraint and falls were not fully implemented, as discussed under Outcome 7 and Outcome 11.

Inspectors found records required to be kept in respect of each resident were generally maintained. However, an area of improvement was identified. For example, records of medicines administered were not consistently completed in accordance with professional guidelines, as discussed under Outcome 9. Also an up-to-date record of furniture
brought by residents into the centre, as outlined under Outcome 17 (Residents Clothing and Personal Possessions) was not completed.

The records required to be kept in respect of staff under Schedule 2 of the Regulations were reviewed. There were gaps in the documentation contained in the files read by inspectors, this is discussed in more detail under Outcome 18 (Suitable Staffing).

The directory of residents was reviewed. Whilst it contained most of the information required by Regulations, gaps were identified, for example, the cause of death was not recorded and the address of resident's general practitioner was not included.

Overall inspectors saw evidence that records were maintained in the centre, were up-to-date, secure, but easily retrievable.

There was evidence to confirm the centre was adequately insured against injury to residents, along with insurance against loss or damage to residents property.

Judgment:  
Non Compliant - Moderate

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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 designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:  
Governance, Leadership and Management

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

Findings:  
The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. There were appropriate contingency plans in place to manage any such absence. The ADON deputised for the person in charge in her absence.

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

**Findings:**
Inspectors found that the systems in place to protect residents from abuse were not robust. Allegations of abuse made by residents had not been appropriately acted on and investigated, and the person in charge was not fully aware how to respond to certain incidents and allegations of abuse.

Inspectors were not satisfied that appropriate action had been taken by the person in response to incidents of alleged abuse reported to her. Complaint records read included two incidents of alleged abuse raised by residents at a residents committee meeting in July 2014. One related to a resident being spoken to in an inappropriate manner by staff causing upset to the resident. The second concern related to a resident reporting not feeling safe and the lack of response by staff. While the person in charge met the residents after the issues were reported, effective action had not been taken to address their concerns. In addition, residents were reported as stating they were fearful to have the incidents investigated. The provider and person in charge were required to take immediate action to address these issues.

Furthermore, along with these incidents, two other allegations of abuse reported on 12 October 2014 were brought to inspectors attention by the person in charge during the inspection. They had not been notified to the Chief Inspector as required by the Regulations. These allegations were subsequently notified during the inspection, this is discussed under Outcome 10 (Notifications). The person in charge was in the process of investigating the two allegations and assured inspectors a report would be submitted to the Authority on their completion.

There was a policy on the protection of vulnerable adults which was comprehensive and guided staff practice. While the person in charge described the arrangements in place to respond and investigate any reports of alleged or suspected abuse made to her, as discussed in the paragraphs above, inspectors found this was not reflected in practice.

As outlined above, some residents had reported to not feeling safe and staff were not responsive. However, there was no evidence these matters had been responded to or fed back to residents. This had been an action at the previous inspection, and although action was taken at the time, it continued to be an issue at this inspection.

The training records showed that staff had received regular training on how to respond to any allegation of abuse. However, an area of improvement was identified as one nurse was not familiar with the types of abuse and how they would respond if an allegation was made. This was brought to the attention of the person in charge, who took appropriate action to address the matter.
Inspectors found the system in place for safeguarding residents’ money required improvement. There was a detailed policy in place to guide staff, however, practices and information reviewed was not in line with policy. For example, there were two record books with differing information and invoices or receipts were not maintained for transactions carried out. This put both residents and staff completing transactions on their behalf at risk.

Inspectors found some good practices in the management of restrictive practice although improvements were required. A policy on restrictive practices was reviewed by inspectors and found to guide practice. There were a low number of residents with physical restraint in place. There were five residents using bedrails. It was evident that bedrails were routinely risk assessed, although the alternatives to the use of restraint were not consistently documented. There were care plans put in place, however, improvement was identified as they did not guide practice and were merged into care plans for falls prevention. This is discussed further under Outcome 11.

Inspectors found good practices in the management of behaviours that challenge. There was a policy on the management of behaviours that challenged that guided practice. The person in charge said there were a small number of residents who exhibited behaviours that challenge in the centre. Inspectors read detailed care plans that outlined the triggers and strategies to de-escalate behaviours that challenge. Where incidents occurred, evidence based tools were completed. Inspectors spoke to staff who could describe residents with behaviours that challenged and the interventions they would follow. The person in charge confirmed training in this area that was being considered for staff in the future.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Inspectors were not satisfied that the provider had ensured the health and safety of residents was fully promoted and protected. Incidents and accidents involving residents that had occurred in the centre were not appropriately investigated. The management of risk required improvement, with further improvements required in relation to aspects of fire safety.
Inspectors were not satisfied that the arrangements in place for investigating and learning from serious incidents involving residents were robust. While there was a process of recording and notification of incidents, there was no system for investigating and learning from incidents. For example, inspectors found a high number of incidents had occurred such as falls, skin tears, bruising and other injuries, there was no investigation into the incidents to identify how they occurred and what action would be taken to prevent similar occurring in the future.

Furthermore, while there was a system of review of incidents, it did not identify what improvements and change would be brought about to reduce the number of incidents and the risk of residents experiencing injury. The provider was required to address these matters with immediate effect.

Inspectors found a risk management policy was in place. However, it did not fully meet the requirements of the Regulations, for example, it did not include the measures in place to control risks such as abuse, elopement or self harm. This had been an action at the previous inspection and was not completed.

There was a safety statement seen by inspectors, that incorporated a risk register for the centre. However, improvements were required as the ongoing management of risk was not robust enough, for example, a number of areas of risk identified in the risk register were not effectively controlled and monitored such as:

- unlocked sluice room accessible to vulnerable residents
- two windows were not provided with restrictive opening devices
- the smoking room.

The risks identified were brought to the attention of the person in charge, however, no action was taken to address the issues during the inspection. Although there were monthly health and safety checks carried out, these issues had not been identified.

Inspectors found smoking risk assessments were completed for residents that smoked however, improvements were identified as the assessment tool was not fully completed for all residents, and the control measures to prevent harm were not clearly outlined.

Inspectors found the management of fire safety in the centre at night-time required improvement. While most staff were knowledgeable of fire safety procedures, a nurse who worked night duty was not familiar with the procedures on what to do in the event of a fire in the centre. This was brought to the attention of the person in charge, who later informed inspectors the staff member would attend training and would not be rostered on nights in the interim period.

Fire procedures were prominently displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. Inspectors noted that the fire panels were in order and fire exits, which had daily checks, were unobstructed. Inspectors read training records which confirmed that most staff had attended training within the last year. While four staff had not completed annual training, a plan was in place for them to complete training. Regular fire drills were conducted including evacuation procedures, with
detailed records maintained of the outcome and learning from the drills.

An emergency plan was in place which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency.

Inspectors did not review infection control procedures at this inspection. However, measures to control infection were in place with hand gels, aprons and gloves available to staff throughout the centre. Staff spoken with were knowledge of infection control practices.

**Judgment:**
Non Compliant - Major

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**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:**
Inspectors found residents were protected by the designated centres’ policies and procedures for medication management. However, areas of improvement were identified in relation to the policy on as required (PRN) medications and record keeping.

A policy on medication management was read by inspectors. An area of improvement was identified where the procedures for PRN medication did not guide practice. This is discussed under Outcome 5 (Documentation).

Inspectors read completed prescription and administration records and found that one residents prescription did not include the conditions of administration, that is, crushed medications. In addition, inspectors observed the maximum dose of PRN medications was not prescribed as per best practice guidelines, and there was no space to records comments on withholding medications. These are discussed under Outcome 5.

Staff nurses involved in the administration of medications had undertaken training in medication management practices. Inspectors read records of medication audits were completed by the pharmacy. The most recent audit took place in September 2014 and a number of findings were identified.

Medication errors were reviewed. There had been one error since the previous inspection. The person in charge had completed an investigation and there was evidence that appropriate action had been taken. At the time of the inspections no residents were self medicating. There was no system of transcribing medications in the
centre. Written evidence was available that medications were regularly reviewed by resident’s general practitioner (GP).

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked the balance of a sample of medication and found it to be correct.

**Judgment:**
Compliant

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<tr>
<th><strong>Outcome 10: Notification of Incidents</strong></th>
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<tr>
<td>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</td>
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**Theme:**
Safe care and support

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

**Findings:**
Inspectors found a record of all incidents occurring in the centre was maintained however, a number of incidents had not been notified to the Chief Inspector where required.

Inspectors reviewed the complaints log, and found a number of incidents of alleged abuse had not been notified to the Chief Inspector as required. These are outlined in Outcome 7. This was discussed with the person in charge and operations manager. At the time of report writing notifications for the incidents had not been submitted to the Chief Inspector.

**Judgment:**
Non Compliant - Major

<table>
<thead>
<tr>
<th><strong>Outcome 11: Health and Social Care Needs</strong></th>
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<tr>
<td>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.</td>
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**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found residents received care from nursing staff who were familiar with their health care needs. However, improvements were identified to ensure a timely response was provided where a need arose. In addition, the documentation of care plans and aspects of health care such as the management of falls required improvement.

Inspectors found a timely response was inconsistently provided where reported incidents such as bruising and skin tears had occurred. Records read indicated a high number of incidents had occurred as outlined in Outcome 8, however, a timely response was not consistently provided to ensure residents' health care needs were met. For example, inspectors read a report of bruising on a resident's legs. Documents read by inspectors advised that the resident was required to wear specialist equipment to prevent such bruising or injuries. The resident had not been provided with these and it was not addressed by staff until the matter was reported by family members. Furthermore, incident reports read provided no explanation as to the grounds for the incidents or evidence if a timely response had taken place.

Arrangements to meet residents' assessed needs were set out in individual care plans were based on a range of assessments which had been carried out at routine intervals. Inspectors found residents had care plans developed to address the identified needs of residents. However, care plans did not sufficiently guide the care to be delivered or the interventions in place to direct care. For example, restraint care plans were incorporated into falls care plans and provided insufficient guidance; catheter care plans did not outline the cleaning regime, frequency of change or fluid monitoring, and percutaneous endoscopic gastronomy (PEG) care plan did not outline the flushing regime and oral care.

An action from the previous inspection was reviewed and residents had social care plans developed for their assessed needs.

Inspectors found the management and prevention of falls required improvement. A notification of a resident's fall resulting in a serious injury was submitted to the Authority prior to the inspection. Inspectors were concerned regarding this incident and the provider was requested to carry out an investigation into the incident. At the time of writing, the investigation had not yet been completed and a response was required by the 13 November 2014.

Although there was evidence of regular assessments and post falls assessments being carried out and some controls measures were in place to protect residents such as bed alarms and crash mats, improvements were required in falls prevention. There was a falls management policy in place, however, the post falls procedures were not fully implemented by staff. For example, neurological observations were not consistently carried out for un-witnessed falls. Furthermore, where neurological observations were completed, they were not recorded in line with best practice, as incomplete records were read. Inspectors saw care plans were developed for residents at risk of falls,
however, they were inconsistently updated if a resident had a fall, and did not clearly outline the interventions and strategies to prevent future falls occurring.

There was evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans. Residents health care needs were supported by good access to the GP and an out-of-hours service was available. There was evidence that resident's were seen by a range of allied health professionals, with records of appointments and referral letters seen for occupational therapy, physiotherapy, dietician, speech and language therapy, optical and dental services. However, inspectors noted that recommendations made by allied health professionals were not consistently incorporated into residents' care plans.

Inspectors found good practices in the management of wound care, there was one resident with a wound at the time of the inspection and staff were familiar with the wound care procedures for the resident.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Inspectors found the centre was well maintained and kept in a clean condition, the house was located in a scenic area with views over the Irish Sea. However, aspects of the design and layout of building did not fully met the requirements of the Regulations and the Authority’s Standards, and the individual and collective needs of the residents. These matters were discussed with the operations manager and the person in charge who were aware of the deficits with the centre. The operations manager explained to inspectors that there were no formal plans in place to address the issues.

The issues are outlined as follows:

- two -three bedded rooms do not meet the requirements of the Authority’s Standards. There were no en-suite toilet facilities. A communal toilet and bathroom was provided in the hallway opposite the bedrooms. There was sufficient space for residents to sit out by
their bed, and space to move a hoist between beds. A screen was provided between each bed.

- the layout of one three bedded room did not meet the residents' needs in terms of accessibility to bedside lockers

- two residents bedrooms were only accessible by steps

- the light switches in bedrooms were inaccessible to some residents and did not meet their needs

- there was inadequate storage space, with hoist and assistive equipment stored in hallways, shower and bath rooms.

There were wash hand basins provided in each bedroom. Some bedrooms were provided with en-suite facilities. There was sufficient communal toilets, bathrooms and showers provided. A communal bathroom was located across the hallways of the two three bedded rooms.

A number of residents' bedrooms were visited by inspectors. An action from the previous inspection regarding the lack of natural light into two bedrooms had been completed and the trees outside had been cut back to allow more light in. The call bells fitted were regularly serviced. Each bedroom was provided with a wardrobe and a locker space with lock. Inspectors visited a number of residents in their rooms and observed they had added their own personal touches to them.

There was a large veranda directly accessible from the centre. It was pleasantly laid out, with paved tiling, and seating areas, along with many potted plants and flowers. While the action from the previous inspection had been partially addressed and the large veranda was accessible to residents, the lower garden continued to be inaccessible to most residents.

An internal, smoking area with mechanical ventilation was located on the ground floor. There was assistive equipment such as hoists, chair lift and a lift provided, and reports read by inspectors confirmed they had been recently serviced and were in good working order.

Judgment:
Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:
Person-centred care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found the overall management of complaints in the centre required improvement.

The complaints procedure was not prominently displayed in the centre. Inspectors could not locate the procedure initially and when asked, staff were not aware of a procedure. Inspectors brought this to the attention of the person in charge and they were later informed the procedure would be displayed in more prominent position in the reception area.

There was a policy on the management of complaints that met the requirements of the Regulations. However, the details outlined in the policy did not reflect the complaints procedures outlined in the Statement of Purpose. For example, the appeals process for the centre was different in both documents. An updated version of the Statement of Purpose was submitted after the inspection.

Inspectors reviewed the complaints log. Although there was evidence that complaints were investigated, and action taken to address some issues raised, in general the overall response to complaints was not appropriate and there was no evidence of learning and change brought about from complaints made. For example, inspectors read where allegations of abuse reported were treated as a complaint, but appropriate and timely action was not taken address the concerns raised. This is discussed in more detail under Outcome 7. Furthermore, inspectors read where concerns raised by families repeatedly had not been appropriately addressed. In addition, as reported previously, residents have been reported as stating they were fearful of retribution if they raised complaints against staff. However, there was no evidence of action taken to address this fear.

Judgment:
Non Compliant - Major

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:
Inspectors were satisfied that policies and procedures were in place to ensure each resident's end-of-life care needs were met. A detailed policy was reviewed by inspectors which provided guidance to staff.
There were no residents receiving end-of-life care on the day of inspection. There were arrangements in place to elicit resident’s end-of-life preferences. Residents and families were consulted with regarding their end-of-life preferences. The person in charge outlined meetings held with families and residents to inspectors to illicit end-of-life wishes. So far six residents have had meetings, and care plans developed which also outlined residents spiritual and emotional wishes. A plan was in place to complete the process by the end of 2014.

There was access to the local palliative care team who provided support and advice when required. The person in charge had attended training on discussing end-of-life care along with the ADON in 2014.

A visitor’s room was available for relatives and friends for privacy if required. The person in charge advised inspectors a single room would be provided to ensure residents received privacy and dignity at their end-of-life if required.

**Judgment:**
Compliant

### Outcome 15: Food and Nutrition

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

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

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

**Findings:**
Inspectors were satisfied that resident’s were provided with meals that were wholesome and in accordance with their assessed needs.

There was a comprehensive policy which provided guidance on the practice regarding residents nutritional and dietary needs. There were systems in place to ensure residents did not experience poor nutrition with regular assessments of residents using a malnutrition universal score test (MUST) assessment tool. There were care plans to guide practice, along with monthly weights of each resident. Where residents were at risk of malnutrition, the person in charge carried out increased monitoring of weights, food balance records commenced and referral to the dietician. Inspectors read that recommendations were followed up by staff for example, supplements were prescribed by the GP where required.

Inspectors spent time with residents in the dining room at lunch time and found residents were discreetly and respectfully assisted with their meals where required. A menu was displayed on each table in the dining room that outlined the choice of meal
for the day. A number of residents who spoke to inspectors expressed their satisfaction with the quality of meals served and choice they had. Tables were pleasantly set and residents were served as they sat. Inspectors observed meals were well presented. The chef served meals to residents in the dining room. Staff were observed to chat quietly with residents.

There was evidence of choice for residents on a modified consistency diet. The staff were familiar with the special dietary requirements and preferences of residents’ and were knowledgeable of the residents’ assessed needs. Inspectors met the chef who was familiar with the residents dietary requirements. The chef discussed the menu which had a four weekly cycle, which he regularly reviewed along with input from the dietician. The chef regularly met residents after each meal and this was observed during the inspection. Inspectors reviewed a recent food satisfaction survey carried out, and an action plan was developed to address the issues raised. There was a documented list of residents’ dietary requirements kept in the kitchen for staff that included information on residents diet, fluids, and what assistance was required. The chef also compiled a handover note for weekend staff to ensure residents dietary requirements were met.

Inspectors saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

**Judgment:**
Compliant

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**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:**
Inspectors were satisfied that residents were consulted with and participated in the organisation of the centre. Residents were facilitated to communicate and there were opportunities for residents to participate in meaningful activities. However, improvements were identified to ensure resident’s dignity was respected.

Inspectors observed routines and care practices carried out by staff that appeared to be in a friendly manner that respected residents privacy. While staff were courteous to residents, some practices observed may have compromised residents’ dignity. For example, on one occasion, inspectors observed staff interacting with a residents in what
could be perceived to be playful, however, it was in a rough manner and not done with the resident’s permission. This were brought to the attention of the person in charge who assured inspectors it would be addressed.

There were facilities for recreation with a sitting room and smaller sitting room for residents to choose to sit in. However, improvements were identified as it was noted that a mobile wash hand basin used by the hairdresser was located in the smoking room. This was not appropriate as the room was used by residents who smoked. This is discussed further under Outcome 8.

It was evident that residents were consulted with about how the centre was planned and run. An advocate facilitated resident and relative meetings, and visited residents individually prior to each meeting. These meetings were held on a monthly basis and records read confirmed they enhanced and maximised residents right to provide feedback and inform practice. Inspectors read the minutes of a sample of meetings held, and a wide range of issues were discussed. While it was evident these issues were acted on as these were reported to the person in charge after each meeting, improvements were identified as outlined in Outcome 7. The findings of each meeting were shared with residents and minutes were displayed in the centre.

Voting rights were respected, and the ADON outlined the arrangements in place to inspectors.

Religious and spiritual needs of residents were respected. Inspectors were informed residents could attend mass in the locality and mass was celebrated in the centre each month. The person in charge outlined the services available to the residents. Residents of other religious denominations were facilitated also.

There were no restrictions on visits except where requested by residents. There were arrangements in place for residents to receive visitors in private and a private room was available. The residents had access to a hands free telephone if they needed to make phone calls. There were televisions provided and available in each bedroom. The newspapers were available each day including weekends.

Residents communication needs were highlighted in care plans and reflected in practice. For example, residents with a cognitive impairment had a detailed care plan that outlined additional communication needs.

Inspectors were satisfied residents had opportunities to participate in activities that were meaningful and purposeful and in accordance with their interests. A full time activities coordinator facilitated activities. Inspectors spoke to the coordinator who outlined the programme of activities, including outings, art and chatting and reading with residents. Some residents enjoyed observing activities taking place. An external service provider facilitated siel bleu (an exercise therapy for residents) that took place twice a week in the centre. Each resident was assessed and a care plan was completed that outlined the activities they participated in were in accordance with their needs and preferences.

**Judgment:**
Non Compliant - Minor
**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:**
Inspectors were satisfied that residents had adequate space for their personal belongings and their clothes were suitably laundered and returned to them.

There was a policy on residents personal property and possessions. While there were up-to-date lists of personal possessions for some residents, a number of resident property lists had not been updated since 2011. This is discussed under Outcome 5.

Residents were encouraged to personalise their bedrooms. Many of the bedrooms were decorated with pictures and photographs from residents’ own homes. There was adequate storage space for residents clothing and belongings.

Clothing items were clearly marked with the name of the resident. An internal laundry service was provided and was available seven days a week. Inspectors talked to staff working in the laundry who outlined the procedures in place and care provided to residents clothing. Where laundry had gone missing or was damaged, action had been taken to find or to replace the lost clothing.

**Judgment:**
Compliant

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**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:
Inspectors found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents on the day of inspection. However, improvements were identified in the documentation required to be maintained for staff. Further improvements were required in relation to vetting of external service providers and training needs.

Inspectors found there were adequate staffing levels and skill mix on the days of inspection. The person in charge explained that staff levels were based on the number of residents and their dependency levels. There was a minimum of one nurse on duty at all times. A two week roster was read that accurately outlined the staff on duty. Since the last inspection, a third care assistant worked a 4pm to 10pm shift to supervise residents on the ground floors. This had been an action at the previous inspection and was addressed. However, at this inspection, some residents and relatives commented that staff were not responsive when they called for assistance. Inspectors discussed this with the person in charge and operations manager who assured inspectors they would review staffing levels.

There was a recruitment policy in place. However, it was not fully implemented in practice as gaps were identified in staff documentation. For example, there was no reference from the last employer of one staff and no explanation for a large gap in the CV for another staff member. This is discussed under Outcome 5.

Inspectors reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014.

The person in charge informed inspectors that there was one volunteer. However, there was a gap in the information required by Regulations as the written agreement of the volunteers roles and responsibilities were clearly outlined.

There was education and training available to staff. A training programme was reviewed by inspectors, which confirmed most staff had up-to-date training in mandatory areas. There was a range of training completed by staff that included dementia care, nutrition and end-of-life. However, staff required additional training in the management of falls to ensure residents health care needs in this area were being met.

There were annual appraisals completed by the person in charge and the ADON, and was due to be completed for all staff for 2014. An induction programme had been developed for new staff, that was outlined to inspectors by the person in charge.

Judgment:
Non Compliant - Moderate
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killiney Grove Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000051</td>
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<tr>
<td>Date of inspection:</td>
<td>21/10/2014</td>
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<td>Date of response:</td>
<td>20/11/2014</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not demonstrate appropriate clinical governance in the provision of care to residents.

The system of investigation and review of incidents in the centre was not effective.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
The establishment of the Corporate Clinical Governance committee will deliver a health care process that involves setting key care outcome standards and then comparing care performance within the home. This committee will provide guidance and support to the person in charge and will enable very clear outcomes to better improve the care delivered to residents.

All accident/incidents, falls, complaints, allegations of Elder Abuse, incidents of self harm, incidents of violence or aggression will be reported by the person in charge within 24hrs to a member of the committee who will aid the person in charge in the investigating, notifying and resolving of any issues noted.

**Proposed Timescale:** 12/01/2015

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**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care did not include details of all services which incurred an additional cost.

**Action Required:**
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

**Please state the actions you have taken or are planning to take:**
The contract of care is being reviewed at present and will be amended to include the breakdown of the services included in the monthly levy for residents.

**Proposed Timescale:** 19/12/2014
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<th>Theme:</th>
<th>Governance, Leadership and Management</th>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff did not consistently implement policies in relation to the management of falls and restraint.

**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 policy on Falls Management is to be updated and will include a detailed procedure for staff to follow in relation to the management of falls for residents.

A new Fall reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of falls in the home.

All care staff will receive training in Falls Management and reducing Risk.

The use of Restraints in the home will continue to be risk assessed and alternatives will be documented into each individual care plan.

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**Proposed Timescale: 12/01/2015**

Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the management of medication did not contain procedures on the management of PRN medication.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
A Full review of our medications management policy will take place with our pharmacist with particular attention to the use and documentation of PRN medications. Following this review each residents GP will be formally met with to review the medications prescribed.
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<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were gaps in the documentation required to be contained in the Directory of Residents.

**Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
The Directory of Residents is now completed.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A record of each medicine administered was not fully in accordance with professional guidelines.

Records of residents furniture brought into the centre was not kept up-to-date.

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

**Please state the actions you have taken or are planning to take:**
A Full review of our medications management policy will take place with our pharmacist with particular attention to the use and documentation of all medications. Following this review each residents GP will be formally met with to review the medications prescribed.

Each residents has had a full inventory completed and this will be updated each time a new piece of furniture is acquired by the resident.

| Proposed Timescale: 12/01/2015 |
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The information required to be kept in respect of each staff under Schedule 2 of the Regulations was not fully in place.

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

Please state the actions you have taken or are planning to take:
Each staff file has been reviewed by our HR manager and any gaps will be rectified.

Proposed Timescale: 06/01/2015

Outcome 07: Safeguarding and Safety

Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place to protect residents' from abuse were not robust and a full and comprehensive review was required.

The systems in place to safeguard residents' finances were not robust.

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

Please state the actions you have taken or are planning to take:
The policy on Responding to allegations of Elder Abuse and Recognising Elder abuse is to be updated and will include a detailed procedure for staff to follow in relation to the correct and timely response to an allegation made.

A new Elder Abuse reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of issues raised by residents/families/staff in the home.

All care staff received training in Recognising and responding to Elder abuse on the 7th and 8th November 2014 and further training will be given when our new policy is introduced.
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<td><strong>Theme:</strong> Safe care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Incidents of abuse were not appropriately investigated by the person in charge.

A review of all incidents in the centre shall be carried out and if allegations of abuse have occurred they shall be investigated, acted on and retrospectively notified to the Chief Inspector.

**Action Required:**
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

**Please state the actions you have taken or are planning to take:**
A full review of incidents has taken place and clear actions have been identified and acted upon.

Following this review a new Elder Abuse reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of issues raised by residents/families/staff in the home.

This format will require the person in charge to inform the Corporate Clinical Governance Group that an allegation has been made. Details of the Allegation will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and acting on the allegation made.

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<td><strong>Theme:</strong> Safe care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some staff were not familiar with the types of abuse and how to respond to an allegation of abuse.

**Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
All care staff received training in Recognising and responding to Elder abuse on the 7th and 8th November 2014 and further training will be given when our new policy is
Proposed Timescale: 12/01/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not outline the controls in place to prevent abuse.

Action Required:
Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

Please state the actions you have taken or are planning to take:
The Risk Management policy is to be reviewed and amended to include the control measures that we are putting in place to prevent abuse. These will include a new Elder Abuse reporting structure and format that will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of issues raised by residents/families/staff in the home.

This format will require the person in charge to inform the Corporate Clinical Governance Group that an allegation has been made. Details of the Allegation will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and acting on the allegation made.

Proposed Timescale: 12/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of areas of risk had not been effectively controlled and monitored as outlined in the inspection report.

There were incomplete or no risk assessments completed for residents who smoked.

Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.
Please state the actions you have taken or are planning to take:
All residents that smoke have been reassessed and their care plans now reflect the needs and risks the residents who smokes have.

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<td><strong>Theme:</strong> Safe care and support</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The risk management policy did not outline the controls in place to prevent residents going missing.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> The Risk Management policy is to be reviewed and amended to include the measures and actions that we are putting in place to control the unexplained absence of any resident.</td>
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<td><strong>Theme:</strong> Safe care and support</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The risk management policy did not outline the controls in place to prevent accidental injury.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> The Risk Management policy is to be reviewed and amended to include the measures and actions that we are putting in place to control the accidental injury to residents, visitors and staff.</td>
</tr>
<tr>
<td>Following the implementation of this policy a comprehensive reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of accidents for</td>
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residents/families/staff in the home.

This format will require the person in charge to inform the Corporate Clinical Governance Group of any serious accidents to residents. Details of the accident will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.

**Proposed Timescale:** 12/01/2015  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The risk management policy did not outline the controls in place to prevent the violence and aggression.

**Action Required:**  
Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

**Please state the actions you have taken or are planning to take:**  
The Risk Management policy is to be reviewed and amended to include the measures and actions that we are putting in place to control to prevent aggression and violence.

Following the implementation of this policy a comprehensive reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of incidents of aggression or violence for residents/families/staff in the home.

This format will require the person in charge to inform the Corporate Clinical Governance Group of any serious accidents to residents. Details of the episode of aggression or violence will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.

**Proposed Timescale:** 12/01/2015  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The risk management policy did not outline the controls in place to prevent the risk of self harm.
**Action Required:**
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

**Please state the actions you have taken or are planning to take:**
The Risk Management policy is to be reviewed and amended to include the measures and actions that we are putting in place to control self-harm.

Following the implementation of this policy a comprehensive reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of incidents of self-harm for residents.

This format will require the person in charge to inform the Corporate Clinical Governance Group of any serious accidents to residents. Details of the incident of self-harm will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.

**Proposed Timescale:** 12/01/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system in place to investigate and learn from serious incidents and adverse events involving residents requires improvement and a full and thorough review of all incidents occurring in the centre is required.

**Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
The policy on Management of incidents and adverse events involving residents is to be updated and will include a detailed procedure for staff to follow in relation to the correct and timely response to an incident.

A Incident tracker reporting structure has been introduced that is assisting staff in reviewing, notifying and establishing learning outcomes for staff that will reduce the impact to residents of incidents and adverse events.

The person in charge to inform the Corporate Clinical Governance Group of any serious incidents or adverse events involving a resident. Details of the incident will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.
**Proposed Timescale:** 12/01/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff were aware of the procedures to follow in the event of a fire.

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

Please state the actions you have taken or are planning to take:
Fire training took place with staff on the 11th and 18th November 2014.

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**Proposed Timescale:** 18/11/2014

**Outcome 10: Notification of Incidents**

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Allegations of abuse were not notified to the Chief Inspector.

**Action Required:**
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
The person in charge to inform the Corporate Clinical Governance Group of any reports of any allegations of Elder abuse. Details of the allegation will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted. This will ensure that all notifications are submitted within three working days.

**Proposed Timescale:** 20/11/2014
<table>
<thead>
<tr>
<th><strong>Outcome 11: Health and Social Care Needs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective care and support</td>
</tr>
<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>Care plans for residents assessed needs did not consistently guide the care to be delivered, as outlined in the report.</td>
</tr>
<tr>
<td>Recommendations from allied health professionals were not incorporated into all residents care plans.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All residents Care plans are being reviewed and we are introducing an identifying care needs approach that will consistently guide the care that each resident requires to meet their needs. The care plans will be reviewed every 3 monthly and will be audited by the person in charge with support from a member of the Corporate Clinical Governance committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Proposed Timescale:</strong> 12/02/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>A timely response to residents health care needs was not consistently provided.</td>
</tr>
<tr>
<td>There were improvements required in the management of falls.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All residents Care plans are being reviewed and we are introducing an identifying care needs approach that will consistently guide the care that each resident requires to meet their needs. The care plans will be reviewed every 3 monthly are will be audited by the person in charge with support from a member of the Corporate Clinical Governance committee.</td>
</tr>
</tbody>
</table>
The Corporate Clinical Governance committee will identify and support the person in charge in the implementation of any evidence based nursing care that will guide and improve the care that is delivered to our residents.

Falls Management will be aided by the policy on Falls Management that is to be updated and will include a detailed procedure for staff to follow in relation to the management of falls for residents.

A new Fall reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of falls in the home.

All care staff will receive training in Falls Management and reducing Risk.

**Proposed Timescale:** 12/02/2015

**Outcome 12: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no plans in place to address the needs of residents in the two three bedded rooms.

Two bedrooms could only be accessed by means of steps.

The layout of one three bedded room did not meet residents needs.

Light switches were not accessible to residents in all bedrooms.

The garden was not fully accessible to all residents.

There was inadequate storage for assistive equipment.

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

**Please state the actions you have taken or are planning to take:**
There were no plans in place to address the needs of residents in the two three bedded rooms.

There is a planning application currently lodged with Dun Laoghaire/Rathdown to extend and remodel Killiney Grove Nursing Home to remove any multi occupancy.
bedrooms and provide new single en suite bedrooms. In the interim, we feel that Room 19’s layout is sufficient to meet the our residents needs in terms of space and dignity, but that Room 20 will only accommodate fully ambulant residents who do not require the use of assistive equipment, this is currently the case.

Two bedrooms could only be accessed by means of steps. These two rooms are only occupied by fully ambulant residents who will have their needs and mobility assessed and will move to an alternative room should that be required.

The layout of one three bedded room did not meet residents needs. We have remodelled room 20 in terms of layout to ensure access to lockers and light switches. We are also looking at the provision of new built in furniture to improve space and allow increased mobility in the room.

Light switches were not accessible to residents in all bedrooms. Our company electrician will carry out a review of all lighting by November 12th and ensure that all light switches are accessible to all residents, repositioning units if necessary.

The garden was not fully accessible to all residents. The gardens at Killiney Grove have traditionally been more aesthetic than practical. Our residents enjoy the views but given the steep slopes of Killiney Hill have never accessed the lower grounds since it became a nursing home many years ago under previous owners. We believe the hilly gardens are unsafe for our residents and that even the provision of sloped pathways to access the only level section at the bottom of the site would provide an unnecessary risk in terms of trips and falls, manual handling in terms of pushing wheelchairs up the gradient and also a risk in terms of supervision of the area. The alternative provisions of terraces and patios on the level grounds have met our residents needs as safe areas to access outdoors.

Since this issue was raised at our last inspection we have made these areas safer with the provision of newly installed higher balustrading on the sun terrace and a bright red coloured steel protective handrail at the front of the home to the patio area nestled mid way up the avenue. New furniture and gazebos have also been installed in this area. We have also provided raised beds for the Gardening Club to raise their own plants and herbs during the summer. We also provided a Café-styled enclosed area to the side which has proven very popular with residents and relatives and has been busy all year.

There was inadequate storage for assistive equipment. We are currently undertaking a review of our facility to look at an alternative plan for storage of assistive equipment. Review date by November 14th.

There is a planning application currently lodged with Dun Laoghaire/Rathdown to extend and remodel Killiney Grove Nursing Home to remove any multi occupancy bedrooms and provide new single en suite bedrooms.

All potential residents will have a full pre admission assessment completed and will only be accepted into multi occupancy rooms if their needs can be met there in that...
environment. (Review date November 14th)

**Proposed Timescale:** 30/06/2015

<table>
<thead>
<tr>
<th><strong>Outcome 13: Complaints procedures</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
</tr>
<tr>
<td>Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The complaints procedure was not prominently displayed in the centre.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in 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>The complaints policy is displayed at reception as you enter the home.</td>
</tr>
</tbody>
</table>

**Proposed Timescale:** 19/11/2014

| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** |
| There was inconsistent evidence of the outcome of complaints and whether residents were satisfied. |
| **Action Required:** |
| Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied. |
| **Please state the actions you have taken or are planning to take:** |
| The policy on Management of Complaints is to be updated and will include a detailed procedure for staff to follow in relation to the management of complaints made. A new complaints reporting structure and format will be introduced that will assist staff in reviewing and confirming that residents are satisfied with the outcome following the investigation of a complaint made. Learning outcomes will be established for staff and this will improve the overall management of complaints in the home. The person in charge to inform the Corporate Clinical Governance Group of any reports of any Complaints. Details of the complaint will be reviewed and within 24hrs a member
of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.

All care staff will receive training in Responding to complaints.

Proposed Timescale: 12/01/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not promptly informed of the outcome of their complaint.

Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
The policy on Management of Complaints is to be updated and will include a detailed procedure for staff to follow in relation to the management of complaints made.

A new complaints reporting structure and format will be introduced that will assist staff in reviewing and confirming that residents are satisfied with the outcome following the investigation of a complaint made. Learning outcomes will be established for staff and this will improve the overall management of complaints in the home.

The person in charge to inform the Corporate Clinical Governance Group of any reports of any Complaints. Details of the complaint will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.

All care staff will receive training in Responding to complaints.

Proposed Timescale: 12/01/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents have reported their being fear of raising complaints against staff.

Action Required:
Under Regulation 34(4) you are required to: Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.
Please state the actions you have taken or are planning to take:
Residents will continue to have their monthly meetings where they have always raised any issues or concerns with the resident advocate. Going forward the resident advocate will inform the person in charge and a member of the Corporate Clinical Governance committee of any issues or concerns or complaints made. Residents will be informed of this change and this will ensure a transparency that was lacking and this will bring reassurance to the residents that all issues raised will not result in them being adversely affected.

The policy on Management of Complaints is to be updated and will include a detailed procedure for staff to follow in relation to the management of complaints made.

A new complaints reporting structure and format will be introduced that will assist staff in reviewing and confirming that residents are satisfied with the outcome following the investigation of a complaint made. Learning outcomes will be established for staff and this will improve the overall management of complaints in the home.

The person in charge to inform the Corporate Clinical Governance Group of any reports of any Complaints. Details of the complaint will be reviewed and within 24hrs a member of the committee will aid the person in charge in the investigating, notifying and resolving of any issues noted.

All care staff will receive training in Responding to complaints.

Proposed Timescale: 12/01/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practices carried out by staff may compromise residents dignity and privacy.

Action Required:
Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

Please state the actions you have taken or are planning to take:
Training to be given to all staff working within the nursing home on Code of Conduct and communication. This is to ensure that the nursing home has regard to the sex, religious persuasion, racial origin, culture and linguistic background and ability of all our residents, this will ensure our residents dignity and privacy.

Proposed Timescale: 12/01/2015
<table>
<thead>
<tr>
<th>Theme:</th>
<th>Suitable Staffing</th>
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<tbody>
<tr>
<td><strong>Outcome 18: Suitable Staffing</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Theme:</strong></td>
<td>Workforce</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Staff required additional training in the prevention of falls.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>Falls Management will be aided by the policy on Falls Management that is to be updated and will include a detailed procedure for staff to follow in relation to the management of falls for residents. A new Fall reporting structure and format will be introduced that will assist staff in reviewing and establishing learning outcomes for staff and this will improve the overall management of falls in the home. All care staff will receive training in Falls Management and reducing Risk.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>12/01/2015</td>
</tr>
<tr>
<td>Theme:</td>
<td>Workforce</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>The roles and responsibilities of volunteers were not clearly outlined in a written agreement.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>Our policy on Volunteers will be updated to clearly define their roles and responsibilities.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>12/01/2015</td>
</tr>
</tbody>
</table>