<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>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>32</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-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>
</tr>
</thead>
<tbody>
<tr>
<td>21 January 2015 08:00</td>
<td>21 January 2015 17:30</td>
</tr>
<tr>
<td>22 January 2015 09:00</td>
<td>22 January 2015 13:30</td>
</tr>
</tbody>
</table>

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

| Outcome 02: Governance and Management |
| Outcome 03: Information for residents |
| Outcome 04: Suitable Person in Charge |
| Outcome 05: Documentation to be kept at a designated centre |
| Outcome 07: Safeguarding and Safety |
| Outcome 08: Health and Safety and Risk Management |
| Outcome 09: Medication Management |
| Outcome 11: Health and Social Care Needs |
| Outcome 12: Safe and Suitable Premises |
| Outcome 13: Complaints procedures |
| Outcome 16: Residents’ Rights, Dignity and Consultation |
| Outcome 18: Suitable Staffing |

Summary of findings from this inspection

The provider had applied to the Chief Inspector, to renew registration of the centre and an inspection to inform the decision took place on the 21 and 22 October 2014. At that inspection, inspectors had significant concerns with the overall management of the centre and the fitness of the person in charge. Following that inspection, the provider was required to take immediate action to address concerns regarding the protection of residents and the management of incidents. The provider was also required to attend a meeting in November 2014 with the Health Information and Quality Authority (the Authority) to discuss the significant non-compliances with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The provider assured the Authority improvements were underway to mitigate the issues identified. Following this meeting, the Authority was notified that a new person in charge was appointed in the role. This un-announced inspection was carried out to monitor the centre and to assess ongoing compliance with the Regulations since the last inspection in October 2014.
Overall, inspectors found that significant progress had been made to address the
concerns of inspectors at the previous inspection. The number of incidents and
accidents had reduced and appropriate preventative measures had been put in place.
However, improvement was still required in a number of areas into comply with the
requirements of the Regulations and the National Quality Standards for Residential
Care Settings for Older People in Ireland.

Inspectors met the person nominated on behalf of the provider (the provider) Mr.
Joseph Kenny, the person in charge and a senior director of nursing during the
inspection. They also held a fit person interview with the person in charge.
Inspectors met some of the residents, staff and family. As part of the inspection,
inspectors observed practices and reviewed documentation such as care plans,
accident logs, policies and procedures.

During the inspection, the inspectors identified areas of risk in relation to health and
safety and medication management which the person in charge was required to take
immediate action on. In addition, inspectors had concerns regarding the participation
of the person in charge in relation to clinical governance in the centre, for example,
care planning, aspects of residents' health care needs and the system of auditing.

The physical environment did not meet the needs of all residents with regard to
steps into bedrooms and an accessible outdoor area.

Inspectors found evidence of improved practices in relation to the protection of
residents and in falls management. Improvements had also taken place with regard
to the management of complaints, staff practices around residents, and staff
knowledge of certain key operational policies.

These issues are further discussed in the body of the report and in the Action Plan at
the end of the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Findings:
Inspectors were not satisfied that the management system in place was robust to ensure continuous improvement and the review of the safety and quality of care provided to residents.

Although there were clear governance arrangements in place within the centre and the larger parent organisation and identified lines of authority and accountability, the management of the designated centre required improvement. Since the last inspection, the management structure in the designated centre had changed. These changes had been notified to the Chief Inspector prior to the inspection. However, the new management systems were not effective, and resulted in poor outcomes for residents, as reported in Outcome 8 (Health and Safety and Risk Management), Outcome 9 (Medication Management) and Outcome 11 (Health care needs). This was an issue at the previous inspection, and continued to be an issue at this inspection.

At the previous inspection, it was reported there was a comprehensive system of auditing in the centre. However, since then audits and reviews had not been carried out. While management meetings had taken place, these did not review or pick up on issues identified in the paragraph above. These matters were discussed with the person in charge, who informed inspectors she had not completed audits in the past. She had completed training on the 21 January 2015 and with the support of external support staff would complete new audits of key quality indicators such as care plans.

An annual report of review of the safety and quality of care provided to residents had not yet taken place. The provider was aware of the requirement to prepare a annual report and share same with the residents.

Judgment:
Non Compliant - Major
**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
This outcome was reviewed in the context of the written agreement of the provision of services to residents.

Since the last inspection, the provider had made improvements to the written agreement in place for the provision of services in place for each resident. Inspectors saw a copy of a new agreement. Along with details of the services provided and the fees to be charged to residents, it included an appendix of services that would incur an additional fee. However, the contract had yet to be re-issued to all current residents. Inspectors were informed all residents would receive a new copy of the agreement, which would be issued with immediate effect.

**Judgment:**
Substantially Compliant

---

**Outcome 04: Suitable Person in Charge**

*The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors found the requirements for the role of person in charge were met, with regard to qualifications and experience, although there were some 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. She was new to the role since November 2014. Inspectors acknowledge this change was without notice and with immediate effect. However, improvements were required in relation to clinical governance.
demonstrated by the person in charge which included medication management and care plan documentation. These issues are discussed further under Outcomes 9 and 11.

Inspectors were also concerned that issues raised at the previous inspection such as the implementation of an effective system of audits had not been adequately addressed by the person in charge.

Inspectors held a Fit Person interview with the person in charge during which she demonstrated knowledge in relation to a number of clinical areas and her responsibilities under the Regulations. She was familiar with the residents and their health and social care needs. Inspectors found that she had participated in continued professional development. She had plans to commence a management course in gerontology. The person in charge stated that she maintained her professional development attending in house clinical courses in falls management and as reported before in clinical audit. Inspectors saw documentary evidence that she had attended mandatory training in fire safety, manual handling and the protection of vulnerable adults.

Inspectors were satisfied that there were appropriate deputising arrangements in place and provided by an assistant director of nursing (ADON). The ADON participated fully in the inspection process, was also interviewed, and demonstrated an adequate understanding of her role and responsibilities under the Regulations. However, improvements were identified in relation to clinical governance in the centre as outlined above.

The person in charge was supported in her role by the provider and met with him frequently on an informal and formal basis to discuss management issues. She was also supported by a senior director of nursing who was present throughout the inspection process.

**Judgment:**
Compliant

### Outcome 05: Documentation to be kept at a designated centre

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

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
**Findings:**
Inspectors was satisfied that policies and procedures as required by Schedule 5 were in place and implemented in practice.

The policies and procedures as outlined under Schedule 5 of the Regulations were reviewed. Since the last inspection, the medication management policy had been updated to included additional "as required" (PRN) procedures.

Since the last inspection, an up-to-date record of furniture brought by residents into the centre was completed.

The records required to be kept in respect of staff under Schedule 2 of the Regulations were reviewed. The action from the last inspection was completed, and all staff records were in place as per the requirements of Regulations.

The directory of residents was read by inspectors and all of the information required by Regulations was included. This was an action at the previous inspection and completed.

**Judgment:**
Compliant

---

**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found systems were in place to protect residents from being harmed or suffer from abuse. Appropriate action was taken to respond and act on allegations or suspicions of abuse, with an area of improvement identified.

Inspectors followed up on the actions from the previous inspection, and they had been appropriately addressed. Following the previous inspection the provider was required to take action and retrospectively notify the Authority of all incidents of suspected or alleged abuse that had occurred in the centre. Nine allegations of abuse were subsequently notified in October 2014. In January 2015 the provider submitted an update report on each incident which outlined the action taken and preventative measures put in place. While it was evident that effective action had now been taken, there was no internal report of the investigation completed of each incident. This was discussed with the person in charge and provider during the inspection.
The person in charge was familiar with the arrangements to respond and investigate any reports of alleged or suspected abuse made to her. She described the procedures to protect residents and carry out an investigation. The senior director of nursing would be notified of all incidents of abuse along with the new clinical governance committee established since the last inspection. The committees would oversee and provide guidance to the person in charge following an allegation of suspicion of abuse. The investigation would be overseen and reviewed by this group.

There was a policy on the protection of vulnerable adults, which provided adequate guidance. All staff spoken with were familiar with the types of abuse and the reporting arrangements in place. In addition, records seen confirmed staff had completed training in the prevention of abuse.

Inspectors spoke with a number of residents who reported they felt safe, and were happy with the staff and the care they received in the centre.

Inspectors reviewed the systems in place for safeguarding residents’ money and found evidence of good practice. Improvements had been identified at the previous inspection and were addressed. A robust system of documentation was in place to monitor and record all transactions which were accompanied by two signatures.

Inspectors reviewed the systems in place for the management of behaviours that challenge and restrictive practices in the centre. As reported at the previous inspection, good practices were evident. A low number of residents used restraint, with five residents using bedrails. There was evidence of regular assessment and alternatives were considered, consent was obtained and evidence of consultation in place. An area of improvement in the completion of care plans had been addressed. Inspectors found individual care plans were in place. There were no residents with behaviours that challenged at the time of the inspection. There was access to psychiatric services for a number of residents in the centre, with records of letters of appointments on their files.

**Judgment:**
Non Compliant - Moderate

---

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

_The health and safety of residents, visitors and staff is promoted and protected._

**Theme:**
Safe care and support

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

Some action(s) required from the previous inspection were not satisfactorily implemented.
**Findings:**
Inspectors found there were systems in place to promote the health and safety of residents, staff and visitors. However, improvements were required in the management of risk and adverse events.

There was a risk management policy that had been recently revised and overall it met the requirements of the Regulations. However, it was not fully implemented in practice as area of risk was identified by inspectors. For example, two radiator surfaces in one sitting room and the smoking room were very hot to touch. The radiators each measured approximately 50 degrees celsius and posed a potential scald risk to residents. This was brought to the attention of the person in charge who took immediate action to address the matter. It was later confirmed the radiators would be provided with guards. This had been an action at the previous inspection and was not fully addressed.

There were some systems in place to review risks. The health and safety officer and maintenance person carried out weekly checks. A health and safety committee met every few months and the minutes were read of the last meeting from January 2014. However, there was no evidence that the risk identified above had been discussed or identified before. There was an up-to-date safety statement in place, which incorporated all identified hazards and the controls in place to monitor them.

Inspectors also reviewed records of accidents and incidents. At the previous inspection, a high number of incidents involving residents had occurred, such as falls, bruising and skin tears. Significant improvements had been made since the inspection. Apart from one witnessed fall there had been no falls reported in the centre. In addition, there were no reported injuries such as skin tears and bruising. The person in charge outlined the new measures put in place. The staff rostered into three groups and cared for residents allocated within group. There were 30 minute documented checks completed of all residents, day and night, also confirmed by staff. The residents had a full body check completed daily and any unusual bruising or wounds were formally reported. There was an efficient system in place for the recording of accidents, incidents and near misses. A standard report form would be completed, and reviewed by the person in charge. All incidents would be discussed at the clinical governance meetings. However, improvements continued to be required, for example, the prevention and investigation of medication errors as outlined in Outcome 9.

There was an emergency plan in place, which provided sufficient direction staff. It contained a range of emergency scenarios such as fire, bomb threat and flood. In addition, alternative accommodation and transport contact details were outlined.

The training matrix showed that staff had up-to-date training in moving and handling. Residents’ moving and handling assessments were routinely assessed and instructions for assisting residents to mobilise were available in the care planning documentation which was readily accessible to the appropriate staff.

Inspectors were satisfied that the provider had ensured the fire safety of residents was fully promoted and protected.
Inspectors reviewed the records of fire training for staff that were up to date. Staff were knowledgeable about responding to fires and evacuation procedures. Records showed that fire drills took place on a regular basis, and included details of the learning outcomes achieved.

Records read confirmed emergency exits were inspected by staff on a daily basis to ensure all exit routes were unobstructed. Fire evacuation procedures were displayed throughout the centre.

Inspectors found appropriate fire fighting equipment was provided such as, fire extinguishers and fire alarms. Records read confirmed fire equipment was serviced regularly and in good working order. Records of the alarms and emergency lighting systems confirmed they were serviced on a quarterly basis.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
While this outcome was compliant, inspectors were not satisfied that residents were protected by the centres policies and procedures on medication management. Actions taken are under Outcome 5 and 8.

Inspectors were concerned that medication administration practices in the centre were unsafe. During the review of residents medication prescription and administration sheets, two errors were identified:

- one resident was not administered a weekly medication. While nursing staff had signed as having administered it on the 18.1.15, the resident never received it. This posed a significant risk to this resident, and the person in charge was required to take immediate action. The general practitioner (GP) was informed and appropriate action was subsequently taken to address the matter.

- another resident was administered a medication by nursing staff without a prescription on record.

In addition, there were blank dates when the medication had not been administered. However, the person in charge could not say if the resident was on a regular or an (as
required) PRN medication. Action was taken and a copy of the original prescription was later provided that confirmed it was a PRN medication. It was later changed to a regular medication by the GP.

The procedures carried out above were not in line with nursing professional guidelines or the centre's policy. As a result, at the end of the first day of the inspection, the person in charge was requested to complete a review of a sample of residents medication sheets. The following day, inspectors were informed, all 32 residents medication sheets had been audited, and two errors were identified. These had been investigated and appropriate action had been taken. These matters are discussed under Outcome 11.

A policy on medication management was read by inspectors. However, as reported above it was not implemented by nursing staff in practice.

Staff nurses involved in the administration of medications had undertaken training in medication management practices. While inspectors did not see records of medication audits that were completed by the pharmacy, these had been seen at the previous inspection. However, with the training provided and the system of external audits in place, the errors above were still not picked up by staff.

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 with an area of improvement identified above.

Judgment:
Non Compliant - Major

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Inspectors found residents received care from nursing staff who were familiar with their health care needs. However, improvements were identified in the administration of medication in line with professional guidelines, the documentation of care plans and
aspects of health care such as wound management.

Overall, residents health care needs were met by good standard of nursing care. However, as reported in Outcome 9, inspectors found residents medications were not administered in accordance with professional guidelines. Inspectors also reviewed a sample of care plans were developed to address the identified needs of residents. However, care some plans did not sufficiently guide the care to be delivered. For example, falls care plans did not describe the specific interventions, end-of-life care plans did not outline the residents emotional and religious needs, preferences and wishes and a percutaneous endoscopic gastronomy (PEG) care plan did not outline the feeding regime prescribed by the dietician. This had been an issue at the previous inspection and was not completed. In addition, the layout of some care plans meant the most up-to-date interventions for residents were not clearly displayed, for example wound care plans.

There was evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans. Although it was noted in some records were signed by staff for the resident, with no rationale as to why. 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, recommendations made by allied health professionals were not consistently incorporated into residents' care plans, as outlined above.

There were good practices in the management of wound care. Two residents had wounds on the day of the inspection. A wound assessment was completed and care plan developed. While appropriate measures were in place, the most up to date treatment and dressing regime was not clearly documented, as reported above. Inspectors found residents were regularly assessed for the risk of pressure sores. However, the system of checking pressure relief mattress settings required review, residents individual mattress settings were not recorded.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 12: Safe and Suitable Premises**

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

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
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 meet the requirements of the Regulations, the Authority’s Standards, and the individual and collective needs of the residents. These matters were discussed with the provider and operations manager who was aware of the deficits with the centre. The operations manager explained to inspectors that the centre is engaged in seeking planning permission at the time of the inspection.

The issues are outlined as follows:
- two residents bedrooms were only accessible by steps.
- the light switches in some bedrooms were seen to be difficult to access and did not meet resident’s needs.
- there was inadequate storage space, with hoist and assistive equipment stored in hallways and bathrooms.
- the garden area was not accessible to residents.

There were two three bedded rooms and while 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 for privacy and dignity. The layout of one of these rooms had been altered since the last inspection to better accommodate the needs of residents.

Each bedroom was provided with wash hand basin, a wardrobe and a locker space with lock. Inspectors visited a number of residents in their rooms and they were seen to be personalised and homely.

An internal, smoking area with mechanical ventilation was located on the ground floor. Inspectors noted that this had been risk assessed since the last inspection, and additional protective equipment provided. However, as outlined in Outcome 8, an area of risk was identified in relation to the hot radiator surface. Appropriate action was taken during the inspection.

Inspectors read service reports for hoists, chair lift and lift were in order and this equipment was seen to be kept in 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors were satisfied that the person in charge and provider ensured a proactive approach to the management of complaints. All the actions from the previous inspection were completed.

There was a complaints policy and procedures that met the requirements of the regulations. Inspectors reviewed the complaints procedure, which had been communicated to all residents within the Resident’s Guide and residents committee. It was now prominently displayed within the centre. There was a complaints log which recorded complaints, the actions taken to address complaints and the satisfaction of the complainant as well as a further review for learning outcomes. The log demonstrated that the policy informed practice and that the procedure, when needed, was followed in an efficient and timely manner.

**Judgment:**
Compliant

### Outcome 16: Residents’ Rights, Dignity and Consultation

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

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

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

**Findings:**
This outcome was reviewed in the context of residents' privacy and dignity being respected.

Inspectors found staff routines and care practices appeared to be in a friendly manner that respected residents’ privacy. Staff were observed to interact and engage with the
residents in a professional and patient way. Inspectors observed residents in the sitting areas chatting with staff, who took time to listen and engage. Staff were also overheard talking to residents in a pleasant way. An action from the last inspection was completed, and interactions observed with residents appeared to be with and in their best interests.

**Judgment:**
Compliant

### Outcome 18: Suitable Staffing

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

**Theme:**
Workforce

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

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

**Findings:**

Inspectors found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents.

Staff files were reviewed and found to be satisfactory, and addressed the action from the previous inspection. All staff had completed mandatory training, and there were records of training completed and a training schedule for 2015 was in place.

Inspectors reviewed the planned and actual staff rosters and found that there was an adequate number of staff, with an appropriate qualifications and skills, rostered to reflect the needs of residents. Staffing numbers reflected the layout of the premises, and the care offered in the Statement of Purpose.

While supervision had lapsed since the last inspection the person in charge was aware of the need for supervision procedures to be put in place.

Staff files reviewed were seen to contain all information required by Schedule 2 of the regulations. All nurse’s registration personal identification numbers were seen to be up to date.

Files for volunteers were seen to contain appropriate vetting and role descriptions for each volunteer. This was an action at the previous inspection and was addressed.
Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider's response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killiney Grove Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000051</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/01/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06/02/2015</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with 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 centre.

There was no monitoring and review of the safety and quality of care provided to residents.

---

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:**
We have put the following supports in place to enable the person in charge to demonstrate and ensure appropriate clinical governance of the home.

A new “Clinical Governance & Operations Manager” has been appointed since the inspection to the Group on 2nd February 2015. This person along with the Registered Provider, Advocacy Services Manager and Group Compliance Officer will form the core of the Group Clinical Governance Committee. This committee will meet monthly (“Monthly Group Clinical Governance Meeting”) with the PIC to discuss, minutes from resident and resident family meetings, Clinical Audits, review clinical performance indicators, risks to residents, risks to staff and other risks to the home in particular Health & Safety issues. The committee will ask other managers within the Group to attend this meeting such as the Group HR manager, Group Maintenance Manager when required.

The issues raised and actions identified at the “Monthly Group Clinical Governance Meeting” will be minuted and then communicated by the PIC during the PIC’s “Monthly Nursing Home Clinical Governance Meeting”. This meeting will be attended by the PIC, ADON and a member of the nursing staff.

Furthermore, support and further oversight has been provided with the implementation of a new reporting protocol whereby the PIC must report all incidents in the home to the Group Clinical Governance Committee within 1 working day of the incident occurring, using the Group Incident Accident Form. This new procedure was implemented on 09/01/2015. This new protocol will also facilitate the Group Clinical Governance Committees role in making sure that all incidents are responded to correctly and in a timely fashion by the PIC, and importantly that the PIC takes corrective actions to minimise the risk of such an incident occurring again.

Auditing had been taking place in the home (Care plans were audited to October 2014), but had been suspended for a period until the PIC was trained how to correctly audit. These audits have commenced again in January 2015 and will be reviewed and supervised by the newly appointed Clinical Governance & Operations Manager. These Audits identify the corrective actions required, learning outcomes for staff and improved daily needs identification for residents.

**Proposed Timescale:** 02/02/2015
<table>
<thead>
<tr>
<th>Outcome 03: Information for residents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
</tr>
<tr>
<td>Governance, Leadership and Management</td>
</tr>
</tbody>
</table>

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

The revised written agreement of the provision of care had yet to be issued to residents.

**Action Required:**
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

**Please state the actions you have taken or are planning to take:**
Following our inspection we have reviewed our contract of care and at present it is with legal for final approval. Once approved will be issued to all residents/NOK.

**Proposed Timescale:** 16/03/2015

---

<table>
<thead>
<tr>
<th>Outcome 07: Safeguarding and Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
</tr>
<tr>
<td>Safe care and support</td>
</tr>
</tbody>
</table>

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

Incidents of abuse were appropriately investigated but records were not fully maintained.

**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 new investigation SOP/ Serious Incident Review has been introduced that very clearly ensures that all records of an investigation are maintained and reviewed. A copy of any investigation is also kept with the Clinical Governance and Operations Manager. Support is provided to the PIC by the Clinical Governance and Operations Manager at each stage of the review.

Any investigations that take place will be reviewed at the “Monthly Group Clinical Governance Meeting” and at the “Monthly Nursing Home Clinical Governance Meeting”.

**Proposed Timescale:** 02/02/2015
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:
Areas of risk identified during the inspection were not assessed and monitored for example, hot radiator surfaces.

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

Please state the actions you have taken or are planning to take:
The PIC and Home Maintenance personnel will complete a weekly review of the all the facilities in the home. A check list will be completed and any issues noted will be addressed by the PIC with support from the Group Maintenance Manager and Clinical Governance & Operations Manager. This checklist will be based on the Risk register and safety statement.

Proposed Timescale: 16/02/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management and investigation of adverse events involving residents required improvement.

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:
A new Incident Reporting Protocol was implemented on 09/01/2015, requiring the PIC to communicate all incidents in the home to the Group Clinical Governance committee using the Incident Accident Report form within 1 working day of the incident.

This new protocol will facilitate the Clinical Governance Committee in overseeing the PIC’s response to incidents and ensure where incidents require an investigation, that this is carried out by the PIC as per our policies and procedures. A new SOP/Serious Incident Review has been introduced that very clearly ensures that all management and investigation of adverse events involving residents are correctly and effectively maintained and reviewed. A copy of any serious incident is also kept with the Clinical Governance and Operations Manager. Support is provided to the PIC by the Clinical
Governance and Operations Manager at each stage of the review.

Any investigations that take place will be reviewed at the Clinical Governance monthly review with PIC and at the Corporate clinical governance meeting with the Provider.

Proposed Timescale: 02/02/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medications were not consistently administered by nursing staff in line with the prescription.

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

Please state the actions you have taken or are planning to take:
All Staff Nurses have completed training on Medication Management from our pharmacist on 4th February 2015. The training covered the following : Principles of Medication Management, Medication Policy, Medication round.

All staff nurses have completed the “HSE Land Medication Management” online course.

Since the inspection the PIC has been given training in audit and is now required on a weekly basis, to audit 10 residents medication prescriptions and Kardex forms. The 10 residents selected for this audit are selected at random. Furthermore, the PIC completes a weekly audit of a medication round with a staff nurse on duty. Any non conformances found and corrective actions required are discussed with the Clinical Governance and Operations Manager. The results of these audits will be presented at the Nursing Home Monthly Clinical Governance Meeting.

Proposed Timescale: 06/02/2015
Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not consistently outline the specific interventions to be provided for residents identified needs, as outlined in the report.

Allied health professionals recommendations were not consistently incorporated into care plans.

Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
The PIC will complete a weekly review and audit of 4 residents care plans. The care plans will be reviewed to ensure that each need the resident has, is identified and a detailed care plan on how the need is to be met by care staff is documented and implemented. Each Audit of the care plans will be supervised by the Clinical Governance and Operations Manager and Compliance Officer. This is done to ensure that any corrective actions/learning outcomes are identified and correctly addressed.

To ensure that Allied health professional recommendations are consistently incorporated into the residents care plan a new SOP will be drawn up to guide and support nursing staff to correctly update the residents care plans. The PIC is responsible in ensuring the SOP is followed.

Proposed Timescale: 23/02/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system of consultation of care plans required review.

Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.
**Please state the actions you have taken or are planning to take:**
The PIC will complete a weekly review and audit of 4 residents care plans. The care plans will be reviewed to ensure that each need the resident has, is identified and a detailed care plan on how the need is to be met by care staff is documented and implemented. Following each audit any changes will be reviewed and discussed with the resident and/or NOK. All residents care plans will be reviewed at intervals not exceeding 4 months.

Each Audit of the care plans will be supervised by the Clinical Governance and Operations Manager and Compliance Officer. This is done to ensure that any corrective actions/learning outcomes are identified and correctly addressed.

<table>
<thead>
<tr>
<th>Proposed Timescale: 23/02/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
</tr>
<tr>
<td>Effective care and support</td>
</tr>
</tbody>
</table>

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Medication practices of nursing staff were not consistently carried out in line with professional guidelines.

An area of improvement was required in the prevention of wounds.

**Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnámhseachais.

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff Nurses have completed training on Medication Management from our pharmacist on 4th February 2015. The training covered the following: Principles of Medication Management, Medication Policy, Medication round.</td>
</tr>
<tr>
<td>All staff nurses have completed the “HSE Land Medication Management” online course.</td>
</tr>
<tr>
<td>The PIC completes a weekly audit of resident Medication prescriptions and Kardex’s on a sample of 10 residents. The PIC completes a weekly audit of a medication round with a staff nurse on duty. Any non conformances and corrective actions required are discussed with the Clinical Governance and Operations Manager.</td>
</tr>
<tr>
<td>Nursing and care staff will continue to monitor and record residents skin integrity on a daily basis.</td>
</tr>
<tr>
<td>The PIC will review each resident that requires wound care to ensure that any recommendations/instructions from GP, Tissue Viability Nurse are implemented by nursing and care staff. Nursing staff will document on a daily basis the mattress...</td>
</tr>
</tbody>
</table>
settings for any resident using a pressure relieving mattress.

**Proposed Timescale:** 06/02/2015

### 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:**
Two bedrooms could only be accessed by means of steps.

Light switches were not accessible to residents in a number of 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:**
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.

Light switches were not accessible to residents in all bedrooms.
Our company electrician has carried out a review of all lighting and all light switches are accessible to all residents.

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. 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. New storage areas are now in place for assistive equipment for when not in use.

**Proposed Timescale:** 06/02/2015