Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Kilcara House Nursing Home
Centre ID:	OSV-0000241
Centre address:	Kilcara, Duagh, Listowel, Kerry.
Telephone number:	068 45 377
Email address:	Kilcarahouse@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mertonfield Limited
Provider Nominee:	Noel Kneafsey
Lead inspector:	Mary O'Mahony
Support inspector(s):	Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	8

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, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 January 2015 08:15	20 January 2015 16:30

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

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 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was the sixth inspection of Kilcara Nursing Home by the Health Information and Quality Authority's (HIQA or the Authority) Regulation Directorate. Previous inspection reports can be viewed on the Authority's website www. hiqa. ie: centre no.0241. This was an unannounced inspection which was triggered by unsolicited information received by the Authority. On the day of inspection there were eight vacancies in the centre. As part of the inspection process inspectors met with residents, the provider, the nurse manager, staff nurses, care staff, household staff, and visitors. The person in charge met the inspectors on arrival but had to leave the centre during the morning and was therefore not available to discuss the information received by the Authority. This was discussed in the feedback meeting at the end of the day which was attended by the provider, the nurse manager and the night staff nurse. Inspectors observed practices and reviewed documentation such as care plans, medical records, training records, complaints log as well as the required policies. A number of staff files were checked for compliance with Regulations. The findings of the inspection are set out under 12 outcome statements. These outcomes are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National

Quality Standards for Residential Care Settings for Older People in Ireland.

All the actions required from the previous inspection had not been attended to, nevertheless, inspectors viewed a number of improvements. The inspectors found the premises, fittings and equipment were of a good standard although some improvements were required in the area of maintaining a safe environment and infection control processes throughout the centre.

According to the roster seen by inspectors the person in charge worked as a member of staff on three mornings a week. There was evidence of individual resident's needs being assessed and during the inspection. Staff were seen to support residents with their meals and care needs where necessary. The manager on duty informed inspectors that community and family involvement were encouraged in the centre. There was a varied activities programme seen on the notice board.

Some actions were required to comply 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. These involved risk management, medication management, safeguarding and safety, care planning, infection control, complaints, nutrition, end of life care, and records to be kept in the centre.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was an experienced nurse manager and was seen by inspectors to be rostered on duty three mornings per week. Staff, residents and relatives all identified the person in charge as the person with the overall authority and responsibility for the delivery of care. She was supported in her role by the nurse manager who was knowledgeable of the Regulations and Standards when spoken with by inspectors. Inspectors did not have an opportunity to speak with the person in charge as she left the centre shortly after the arrival of inspectors, before they could apprise her fully of the purpose of the inspection.

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

Findings:
This outcome was addressed only in so far as it pertains to the records required to be kept under Schedule 3 of the Regulations part 4 (c). This finding related to updated records of staff signatures and was explained under outcome 11; Health and social care needs.

Judgment:
Non Compliant - Moderate

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 viewed the training records for the prevention of elder abuse. A staff member told inspectors that she had not done centre specific training in the prevention of elder abuse. This was confirmed in the training records seen. Inspectors spoke with other members of staff who demonstrated an awareness of what to do if an allegation of abuse was made to them. One resident, who was immobile, said that she felt that her complaints were not listened to and she informed inspectors of allegation of physical altercations with another resident. This allegation of peer abuse was discussed with the provider and the nurse manager at the feedback meeting at the end of the inspection who acknowledged that these residents were not compatible and staff were aware of these altercations. The nurse manager agreed to provide this resident with the option of a single room which she had requested from inspectors when she stating to inspectors that she was "afraid". The resident also stated that she would like to have access to an advocate. This occasion of alleged "peer abuse" had not been notified to the Authority in line with Regulations. This risk to residents had not been assessed and controls had not been put in place. Nevertheless the required notification was made to the chief inspector following the inspection.

Staff with whom inspectors spoke had not been afforded training in the understanding of behaviours which challenge, which was relevant to caring for residents in the centre.

Inspectors found that the centre had not maintained a log of any restraints in use in the centre in line with Schedule 3 (g) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2013.

Judgment:
Non Compliant - Major

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:
Clinical risk assessments were viewed by inspectors in the residents' care plans. These included fall risk assessment, nutritional assessments, skin assessments, social involvement, continence, moving and handling and restraint.

Inspectors viewed the centre-specific health and safety statement which was reviewed in 2014. Risk assessments were viewed in this statement which identified hazards for residents, staff and visitors. It dealt with risks in the environment and set out actions and controls to manage these. There was evidence that improvements had been made. A secure gate had been installed at the top of the narrow stairs and this was controlled on both sides with a key pad lock. The lift had been risk assessed and serviced and staff accompanied residents when using the lift.

An audit of health and safety issues was undertaken in all areas recently and inspectors saw records of these audits. However, the audit seen for the previous month had not highlighted the fact that bulbs were blown in two of the 'running man' fire exit signs and that a radiator cover was broken.

There was a risk assessment policy in place however, this did not address the risks specified under Regulation 26 (c) (i) to (v) and did not outline the controls in place to manage these risks. Inspectors viewed a risk register with evidence that risk assessment was on going. However, there were other risks that were unidentified throughout the centre and these required controls to be put in place. For example, risk of injury from the radiator cover which was broken with sharp edges exposed, dirty laundry stored on a clean linen trolley and the risk of residents' privacy and dignity being compromised in three bedded rooms, had not been assessed.

Inspectors noted that following the last inspection the windows in what was called the "new wing" had restrictors fitted. However, in line with findings in the previous inspection the treatment room door was unlocked when checked on three occasions during the inspection. There was an open "sharps" container of used syringes and needles on the floor and other items which needed to be kept secure. The provider undertook to place this container in a locked cupboard. Inspectors noted that a store cupboard for wound dressings was also unlocked and there was a large scissors on the

shelf. A store room for hoists, chairs and other equipment was also unlocked and all these areas were seen to have been fitted with key-pad locks, one of which was broken and others which had been disabled. Inspectors also noticed that unlabelled shampoo and shower gels were being shared by residents and this was confirmed by staff, who were helping residents with their morning showers.

The fire policies and procedures viewed by inspectors were centre-specific. The fire safety plan was viewed by inspectors and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Fire maps indicating escape routes were clearly displayed. Fire equipment training and fire evacuation training was provided. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of a fire. The inspector examined the fire safety register with details of all services carried out which showed that fire fighting, fire safety equipment and fire alarms had been serviced as required and this was next due in May 2015. Fire alarm checks and automatic fire door release checks were carried out weekly and there was a daily fire door checking system. However, inspectors noted that one fire door in the laundry room was held open with containers of cleaning equipment. There was an emergency plan for the centre and inspectors were informed that the nearby home of the provider and the local resource centre could be used to provide accommodation for residents, in the event that an evacuation was necessary. Inspectors saw that this was formalised and outlined in the emergency plan.

As regards infection control and hygienic practices, hand sanitisers and hand washing facilities were in place throughout the centre. Inspectors observed some staff carrying out best practice in infection control, with regular hand washing and appropriate use of personal protective equipment such as gloves and aprons. However, inspectors observed that some staff took off the gloves they were wearing for care provision, when they were called to the handover report and they were seen to put them into their uniform pockets, without hand washing, following removal of gloves. This was discussed with the provider and the nurse manager at the feedback meeting. Inspectors also noted that a bag of used laundry was placed on top of the clean linen trolley. In a clean linen store cupboard inspectors noticed that a clean hoist sling was lying on the ground near to a white plastic hazardous item. This was brought to the notice of the night staff nurse. The person in charge informed inspectors that residents did not have individual slings provided which would prevent cross infection, nevertheless, she said that residents were assessed individually for their hoist sling as regards size and suitability.

The provider had contracts in place for the regular servicing of all equipment in the centre and inspectors viewed these records for hoists, wheelchairs, and electric beds.

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

Findings:
The medication trolley was secure and the medication keys were held by the nurse in charge. Medications were stored and disposed of appropriately in line with An Bord Altranais (ABA) agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). The centre had a policy on medication management which was viewed by inspectors.

Even though most prescriptions viewed outlined the maximum dose in 24 hours of PRN (when necessary) medication, inspectors noted that not all prescription sheets stated this. Examples seen were a prescription for an analgesic and another example seen concerned a number of sedative drugs for one resident. A recording error was noted for one medication where the nurse administering the medication the previous day had not signed that a drug had been administered. This was pointed out to the nurse administering the medication on the day of inspection. Not all medication errors were being recorded as required by the Regulations, as this error had not been noticed by staff.

Residents' photographs were available in the medication file to enable staff to identify the residents prior to administration of medications. However, there were photographs missing from some residents' files. These photographs were made available while the inspection was in progress. A local pharmacist provided the medication management system and was available on a daily basis. The pharmacist also undertook annual audits of the medication processes. Inspectors saw evidence that the General Practitioner (GP) carried out a regular review of medications. There was a system in place to review and audit medication practices.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
The inspectors saw that most notifications to the Authority were forwarded within the

required timeframes. These notifications were viewed prior to and during the inspection and inspectors were satisfied with the actions taken and medical care provided. However as outlined under outcome 7 a notification of an allegation of peer abuse had not been made to the Authority.

As outlined in the introduction to the report the Authority had been in receipt of unsolicited information on four occasions in 2014, this concerned staff shortages, staff being under work pressure, residents being treated with disrespect and lone staff using the hoist for residents who were of maximum dependency level. These were alleged to have occurred before, during and after this monitoring event. These were discussed with the nurse manager and the provider in the context of the responsive regulatory monitoring event on that day.

There was an incident and accident log maintained for both residents and staff. The person in charge had notified the Authority of incidents and accidents in line with the requirements under Regulation 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:
There was evidence that residents' health care needs were met through timely access to the GP service. Residents were facilitated to retain their own GP and most of residents were under the care of one GP who visited the centre regularly. Medications in a sample of files seen were reviewed by the GP at least every three months and sooner if required. Inspectors were able to verify this by viewing the medication administration sheets and the medical notes. Staff indicated to the inspectors that the service provided was prompt and responsive. There was access to an out-of-hours doctor service also. While inspectors were on the premises the GP attended the centre to assess two residents.

Care plans were individualised and risk assessment tools were used to inform best

practice and assess the residents' needs. A daily nursing note was present and there was evidence that residents were involved in the planning of their care. The nurse manager informed inspectors that resident could access personal information if requested.

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

However, in the sample of care plans viewed by the inspectors not all were updated as required by legislation or as required by the changing needs of the residents. One at risk resident, who had a body mass index (BMI) of 16, had a malnutrition universal screening (MUST) score of 2, which was last recorded in his care plan as assessed on 19/10/14. The policy on Nutrition in the centre stated that all at risk residents should have their MUST score assessed on a monthly basis. Inspectors found that this had not been done on two occasions in the sample of files reviewed. Inspectors noted that an essential test for blood clotting, the international normalised ratio (INR) had not been taken three monthly, in line with the doctor's recommendations for one resident. The blood test had been recorded in the resident's care plan as last taken on 08/04/14. Nevertheless, evidence was sent on to the Authority following the inspection that a blood test was taken in January 2015. Inspectors noted that resident who had been assessed as, at high risk of falls and had recently fallen, did not have his falls risk assessment completed since 19/09/14.

Inspectors saw that some initial care plans required updating due to the passage of time since they were first carried out. For example, where care plans were reassessed four monthly a staff member's signature was present on the seizure management care plan of one resident on 17 occasions. This indicated to inspectors that the original care plan was in place for a couple of years. The staff signature sheet on some care plans had not been updated since 28/10/12. New staff had been employed, since this date, and were making entries in the care plan using their initials, without a corresponding signature sheet. This would have enabled inspectors to verify which staff member had created the record. This was not in compliance with best practice guidelines from An Bord Altranais agus Cnaimhseachais na hEireann, 'Recording Clinical Practice Guidance for Nurses' 2002, section 7.4. This was addressed under outcome 5: Documentation to be kept at a designated centre.

The centre had a staff member employed as an activity co-ordinator and residents advocate. On the day of inspection, inspectors noted that this person was involved in residents' personal care throughout the morning and she was also seen attending to the laundry needs of residents. The activity programme outlined the availability of bingo, music sessions, social outings, hairdressing, arts and crafts, newspaper reading and also individualised activities. However, these were not seen to be facilitated during the inspection. Nevertheless, inspectors viewed photographs of the residents which

indicated involvement with staff and local school children with as well as photographs of Christmas and family celebrations.

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

Findings:
The nursing home was a two-storey building that was purpose built in 1994 and had a lift and back stairs to the top floor. It provided long term residential care and respite care for up to 35 residents. At the time of inspection six residents had a diagnosis of dementia. There were seven empty beds on the day of inspection.

Bedroom accommodation consisted of 17 single rooms with en suites, six twin rooms, three of which have en suites and two three-bedded rooms which had adjoining shared bathrooms. The provider was asked to risk assess the three bedded rooms to ensure that residents' privacy and dignity was maintained at all times. Inspectors observed that the curtains used to screen the beds in these rooms were in good repair. These were seen to be utilised when care was being delivered. The bedrooms which did not have en suite facilities had a wash-hand basin in the room. One of the three bedded rooms was occupied by three female residents and one of these asked inspectors if she could be accommodated in a single room, due to lack of privacy and her fear of other residents. The nurse manager informed inspectors that she would attend to this request as she had available empty rooms at that time. Inspectors noted that the three bedded rooms did not provide adequate space for residents to carry out activities in private and to meet relatives in private, as required under Schedule 6 (3) (f) and (g). All residents in these three bedded rooms were not compatible, as revealed to inspectors.

On the ground floor there was one shared toilet and wash-hand basin and one assisted bathroom with bath, toilet and wash-hand basin. On the first floor there was one communal bathroom which had a bath and shower area. There was also a separate communal toilet and wash-hand basin. Each resident had an individual locker and wardrobe and in the communal bathrooms each resident had an individual bathroom cabinet for their belongings. Inspectors saw call bells and individual lights over each bed.

Inspectors found that there was adequate private and communal space in the centre. The communal living space for residents was on the ground floor and consisted of two dining rooms, a conservatory, two sitting rooms, a small prayer room and an indoor smoking room. Outdoor space consisted of surrounding concrete paths and a secure accessible patio area to which residents had free access. To the front of the building there was a parking area for staff and relatives. The gardens were maintained in good order and there was an enclosed patio area which residents used when the weather permitted.

Staff changing facilities were seen and staff had adequate storage facilities for personal belongings. Hoist, wheelchairs, walking frames, electric beds and electric mattresses were available for use depending on the assessed needs of residents. Inspectors viewed the service records where appropriate. The premises was noted to be warm and bright. Appropriate signage was in evidence. The dining room was nicely painted and the centre was kept clean and in good repair. Failings such as, the broken radiator cover, the 'running man' signs which were not working and the fire door which was held open were addressed under outcome eight: Health and safety and risk management. Inspectors saw evidence of a cleaning schedule for all areas. There was a separate kitchen with sufficient cooking facilities and equipment. This was located in the centre of the home and was easily accessible to staff, serving meals to the residents.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

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

Residents told inspectors that they knew who to complain to. Staff were aware of the complaints procedure. Relatives' questionnaire results also revealed their knowledge of the facility to complain if not happy with the service.

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

At the previous re-registration inspection the provider undertook to get a new complaints book as the current book was too small to record sufficient information, in a layout that would make the information more accessible. However, the inspectors noted that this had not been attended to. The complaints were recorded in narrative, subjective form and inspectors noted that the residents' comments were recorded. However, the satisfaction or not of the complainant was not recorded, as required by Regulations.

Judgment:
Non Compliant - Moderate

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

Inspectors spoke to residents who used the prayer room in the centre. There was a weekly communion service available.

There was evidence that staff had received training on end of life care.

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

At dinner and tea time residents dined in the conservatory and adjoining dining room. Residents requiring help with meals were support by staff members, in the conservatory area. The tables were decorated with flowers and appropriate cutlery. Residents expressed satisfaction with the food and the menu choice. Residents had their choice respected as to where they would like to dine but the majority came to the dining room. Mealtimes were seen to be sociable occasions. However, residents' choices were not always documented and when inspectors asked to see evidence of choices offered they were shown various slips of paper which were often undated. In addition, staff informed inspectors that mealtimes can be rushed at times due to staff shortages and that staff were sometimes seen to stand over residents when helping them to eat. Prior to inspection, inspectors had received an unsolicited receipt of information confirming this.

Inspectors saw the home made food on offer and viewed the menu cycle which was varied and appeared to offer choice throughout the month. Communication between the kitchen staff and the nursing staff was apparent on inspection.

Judgment:
Non Compliant - Moderate

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

implemented.

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

Inspectors viewed staff training records and staff demonstrated relevant knowledge of the areas of training received. One staff member did not have updated training in relation to the moving and handling of residents and this staff member did not have fire training or elder abuse training done. There was evidence in the roster that a staff nurse was on duty at all times in the centre except for one Wednesday afternoon. The nurse manager said that this was an omission from the roster and the night nurse informed inspectors that she had been asked to do that shift. Inspectors viewed up-to-date registration details with the relevant professional body for nursing staff. The person in charge lives adjacent to the centre and the nurse manager stated that she would attend the nursing home when required.

Inspectors reviewed a sample of records that were required to be maintained in staff files, as set out in Schedule 2 of the Regulations. In the sample of files checked, inspectors noted that the required Garda vetting clearance was not in place for one staff nurse who was working in the centre since 5 May 2014. A gap in employment records had not been accounted for also, as required by the Regulations.

Inspectors spoke to the person in charge about the fact that there were only two staff on duty after 10 or 11 pm it is a two storey building and 12 of the residents in the centre were listed as having high and maximum dependency level. The night nurse and the nurse manager assured inspectors that there were continuous checks on residents throughout the night. In addition, initially the night nurse informed inspectors that she had two carers on duty with her at night. This was later corrected by staff and inspectors saw that one carer goes off duty at either 10pm or 11 pm. Inspectors spoke with a number of staff individually about their view of the staffing levels on day and night shift. Some staff said that they were very rushed and one resident said that she felt that staff did not have time to listen to her or converse socially. Following the inspection a member of staff informed inspectors that they were under pressure to attend to all the care needs of residents because of the limited staffing levels. Staff appraisal forms which were not seen on inspection, were sent on to the Authority retrospectively.

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:

Mary O'Mahony
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[1]

Centre name:	Kilcara House Nursing Home
Centre ID:	OSV-0000241
Date of inspection:	20/01/2015
Date of response:	29/04/2015

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A current list of staff signatures was not maintained in the centre in line with best practice guidelines from the professional body for nursing staff. The staff signature sheet on some care plans had not been updated since 28/10/12. New staff had been employed since this date and were making entries in the care plan using their initials without a corresponding signature sheet. This would have enabled inspectors to verify which staff member had created the record. This was not in compliance with best

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

practice guidelines from An Bord Altranais agus Cnaimhseachais na hEireann, 'Recording Clinical Practice Guidance for Nurses' 2002, section 7.4.

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:
All care plans are kept in a closed cabinet with a specific nurse's signature sheet attached. All new nurses will sign sheet.

Proposed Timescale: 29/04/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had been afforded access to training that would provide updated knowledge and skills in the management and understanding of behaviours which were challenging.

Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Training course on Challenging behaviour has been booked. All staff have to attend.

Proposed Timescale: 31/05/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff in the centre were not trained in the centre's policy and response to allegations 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:
Training course on Elder Abuse and how to respond to allegations of abuse has been

booked. All staff have to attend.

Proposed Timescale: 31/05/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of peer abuse had not been investigated or reported to the Chief Inspector in line with Regulations. The provider failed to act to safeguard a resident where it was acknowledged by staff that residents were heard to be shouting at each other on occasions.

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:
The allegation of peer abuse has now been dealt with. The two residents who were involved in the alleged peer abuse have now been placed in separate rooms.

Proposed Timescale: 29/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not taken all reasonable measures to protect residents from all forms of abuse for example, peer abuse.

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 management/staff did not class general disagreements amongst residents as peer abuse. As a result from the allegation of peer abuse each resident is now provided with a risk assessment to help highlight any forms of abuse.

Proposed Timescale: 29/04/2015

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 include the measure and actions in place to control 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:
Our risk management policy now includes the measures and actions to help control abuse.

Proposed Timescale: 30/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy set out in Schedule 5 did not include the measures and actions in place to control the unexplained absence of any resident.

Action Required:
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.

Please state the actions you have taken or are planning to take:
Our risk management policy now includes the measures and actions to control the unexplained absence of a resident.

Proposed Timescale: 30/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy set out in Schedule 5 did not include the measures and actions in place to control accidental injury to residents, visitors or staff.

Action Required:
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.

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

Our risk management policy now includes the measures and actions to control accidental injury to residents, visitors or staff.

Proposed Timescale: 31/05/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy set out in Schedule 5 did not include the measures and actions in place to control aggression and violence.

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:
Our risk management policy now includes the measures and actions to control aggression and violence.

Proposed Timescale: 31/05/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy set out in Schedule 5 did not include the measures and actions in place to control self-harm as required in Regulation 26 (c) (v).

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:
Our risk management policy now includes the measures and actions to control self-harm as required in regulation 26.

Proposed Timescale: 31/05/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that all risks in the centre had been assessed and that

controls had been put in place for these. Examples of this were:
-clean items on the ground near a high risk item in the clean linen cupboard
-a broken radiator cover
-a fire door held open
-fire escape 'running man' signs with bulbs blown
-peer abuse
-accessible sharps bucket
-unlocked storage areas
-shared washing and shaving requirements
-lack of proper protocol when removing gloves
-management of soiled laundry

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:
Risk management policy has again been updated and relevant information put in place.
Radiator cover has now been fixed.
Everybody has been re-informed of the importance of keeping fire doors closed.
Fire escape ''running man" signs are now been reviewed by electrician.
The alleged peer abuse now been dealt with.
Sharps bucket is now kept within a locked container.
All staff have again been re-informed about importance of keeping storage areas locked.
All residents are now provided with individual personal hygiene bags in their lockers.
Staff have been re-informed about the importance of Infection control. In house training has been scheduled.
Staff have been re-informed of the importance of Infection control re soiled laundry.

Proposed Timescale: 29/04/2015 Monitoring on a daily basis

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.
These failings included:
-lack of appropriate and effective hand washing procedures
-poor procedure to deal with dirty laundry
- failure to ensure that clean items are kept off the floor in the linen store near to hazardous items
-'sharps' container of used needles and syringes stored on the floor of the unlocked treatment room
-shared hoist slings

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

Please state the actions you have taken or are planning to take:
Staff have been re-informed about the importance of Infection control. In house training has been scheduled.
Staff have been re-informed of the importance of Infection control re soiled laundry.
All staff have again been re-informed about importance of keeping storage areas locked and sharps bucket is now kept within a locked container.
Residents now have individual hoist slings.

Proposed Timescale: 29/04/2015

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:
Inspectors were not able to ascertain if one resident had medication as prescribed on 19 Jan 2015 as the nurse had not signed the administration chart.
Photographs were not present on all residents' files to enable identification of the resident prior to the administration of medication

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 nurses are to review Medication management policy.
Photo ID has been provided for all new residents.

Proposed Timescale: 30/06/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
-The maximum dose of PRN (when necessary) medications were not outlined for some medications.
Inspectors noted that one file reviewed contained a number of sedative medications prescribed in this way and this had not been reviewed as required by the Regulations and in line with the centre's policy. Inspectors noted that this practice did not ensure

that medicinal products were administered safely, in accordance with the directions of the prescriber and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.
-Advice from the pharmacist re the maximum dose of the medications had not been sought.

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 charts are been reviewed by GP's and maximum dose of PRN included. Most charts did already have maximum PRN doses included.

Proposed Timescale: 31/07/2015

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:
An allegation of possible peer abuse had not been notified to the Authority in line with Regulations.

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 allegation of possible peer abuse had not been notified to authorities as
1. Management/staff did not class general disagreements as peer abuse.
2. The resident involved did not forward their concerns to management/staff or advocate.

To help highlight/ prevent any form of abuse each resident is now provided with an individual Risk Assessment which is to be completed on a 3 monthly basis.

Proposed Timescale: 31/10/2015

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:
Not all the care plans were updated in line with regulations and with the changing needs of residents;
For example:
-One at risk resident, who had a body mass index (BMI) of 16, had a malnutrition universal screening (MUST) score of 2, which was last recorded in his care plan as assessed on 19/10/14.
-The policy on Nutrition in the centre stated that all at risk residents should have their MUST score assessed on a monthly basis. Inspectors found that this had not been done on two occasions in the sample of files reviewed.
-A resident who had been assessed as, at high risk of falls and had recently fallen, had his risk of falling last assessed on 19/09/14.
-Where care plans were required to be reassessed four monthly, a staff member's signature was present on the same seizure management care plan of one resident on 17 occasions.

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:
All care plans are updated 3 monthly/PRN. All nurses are aware and are responsible for their own individual Care plans.
A meeting has been held with all nurses with regard to updating Care plans.

Proposed Timescale: 29/04/2015

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:
The three bedroomed rooms did not provide adequate space for residents to carry out activities in private and to meet relatives in private as required under Schedule 6 (3) (f) and (g).
All residents in these three bedroomed rooms were not compatible as revealed to inspectors.

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:

Privacy, dignity and respect a major components of our ethos. If a resident/family request more privacy a visitors room is also available.
It is not possible for all residents to be compatible, but when/if an issue /concern arises staff and management will deal with same.

Proposed Timescale: 29/04/2015

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The satisfaction or otherwise of the complainant was not recorded in the complaints book.

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:
Our complaints procedure has been reviewed and satisfaction of the complainant is now recorded in the complaints book.

Proposed Timescale: 29/04/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the complainant had been made aware of the results of the complaint and the right to appeal the outcome if not satisfied.

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 complainant is informed of the outcome of the complaint.

Proposed Timescale: 29/04/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
There was no evidence in the complaints book that measures required for improvement in response to a complaint had been put in place.

Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
Our complaints procedure has been reviewed and measures required for improvement in response to a complaint, has been put in place.

Proposed Timescale: 29/04/2015

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff informed inspectors that mealtimes can be rushed at times due to staff shortages and that staff sometimes stand over residents when helping them to eat. This was not in accordance with best practice guidelines for assisting residents with meals. Prior to this inspection, inspectors had received an unsolicited receipt of information confirming this.

Action Required:
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
The issue with regard to staff shortages has been reviewed by management. Adequate numbers of staff are available to assist residents with their needs.

Proposed Timescale: 29/04/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence on inspection that all residents were offered choice of meals at dinner and tea time. Records seen were mostly undated and did not contain a list which seemed to include all residents.

Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
Choice has always been offered to each resident but may have been documented inappropriately, our menu record keeping has been reviewed and updated.

Proposed Timescale: 31/05/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had been afforded updated or mandatory training for example, two staff member said that their manual handling training was out of date and another staff member had not done the mandatory fire training and centre specific abuse prevention training.

Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
All staff have had up to date Manual Handling Training.
Fire training /Specific Elder abuse prevention and Challenging Behaviour training has now been booked for all staff.

Proposed Timescale: 31/08/2015