

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Killiney Grove Nursing Home
Centre ID:	OSV-0000051
Centre address:	Killiney Hill Road, Killiney, Co. Dublin.
Telephone number:	01 285 1855
Email address:	killiney@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Eclipse Care Limited
Provider Nominee:	Joseph Kenny
Lead inspector:	Deirdre Byrne
Support inspector(s):	Gearoid Harrahill
Type of inspection	Unannounced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	20

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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 02 September 2015 08:00 To: 02 September 2015 17:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection took place to assess ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards of Residential Care Settings for Older People in Ireland 2009. Inspectors also followed up on areas of non compliance identified at the previous inspection which took place on the 21 and 22 January 2015.

In July 2015, the provider notified the Authority of their intention to close Killiney Grove Nursing Home. As required by the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015, the provider had given six months notice of their intention to cease operation. This inspection took place to ensure that the care and welfare of residents during the transition and closure of the centre continued to be met as per the requirements of the Regulations.

As part of this inspection, inspectors met with residents and staff members, observed

practices and reviewed documentation such as care plans, accident logs, policies and procedures. Inspector's found that there were good governance structures in place, and staff interacted with residents in a kind, dignified and respectful manner. The staff were knowledgeable of the health care needs of residents. There was good access to the services of medical care. Inspectors found there were adequate staffing levels and skill mix to meet the assessed needs of residents.

There was good consultation with the residents in relation to the planned closure of the centre. It was evident that their opinion and feedback was listened to and acted. The provider had ensured that each residents was assisted to identify suitable alternative accommodation that met their identified needs. A team had been set up that met on a weekly basis to review each resident individually.

However, a number of improvements were identified, and these related to the premises, provision of fire safety training and staff knowledge of the evacuation procedures. There were improvements required in the documentation of care plans, aspects of health and of policy review. The 10 actions from the previous inspection were reviewed, and four had not been addressed. These and all other matters are outlined in the report and Action plan at the end of the report.

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 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 found there was a clearly defined management structure that outlined the lines of authority and accountability in the centre. However, improvements were identified regarding the on going review of the quality and safety of life of residents. and completion of an annual report as per the Regulations.

The centre is part of a larger parent organisation called Silverstream Healthcare Group. The provider nominee had ensured there were adequate governance arrangements in place. The person in charge who was based full time in centre reported to the management team. There provider along with an operations manager visited the centre on a weekly basis to review the systems in place for closing the service.

Inspectors were informed that clinical operations and strategic review meetings also took place to review the quality and safety in the centre. This was an action from the previous inspection and was partially addressed. These were attended by the person in charge and persons in charge from other designated centres within the group. The minutes of meetings held in April and July 2015 were read and confirmed areas of clinical governance were discussed. However, there were large gaps of up to four months between the meetings and it could not be ascertained what issues were followed up or actioned at these meetings.

There were improved systems in place to monitor the quality and safety of care. This had been an action from the previous inspection and completed. Inspectors reviewed audits of care plans, medication practice and restrictive practices. The person in charge collected a range of key performance indicators each month for example, falls, use of restraint, medication errors, pressure sores and episodes of behaviour that challenge. A detailed analysis was carried out and there was evidence of analysis of the information and trending of the data. This information was reviewed at the clinical governance

meetings. However, as reported above there had only been two meetings and it was not clear what overall improvement or change had been brought about by the audits.

The provider had not developed an annual report on the overall review of the safety and quality of care of residents. Inspectors discussed this with the person in charge who were informed that the report was in progress.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Inspectors were satisfied that residents admissions and discharges were in line with the centres policies and procedures and Statement of Purpose.

The residents had a contract of care in place, which was agreed upon admission and signed, dated and witnessed. This addresses an action required from a previous inspection. The contracts reviewed by inspectors outlined the services, terms and conditions of the care provided by the centre, along with the fees charged on a weekly basis. There was a list of services that incurred an extra fee to be paid separately by the residents.

The centre was in the process of closing down as reported in the summary. 20 residents had been discharged and moved to other centres. At the time of the inspection 16 residents were living in the centre. There were plans to discharge the remaining residents in a carefully planned way. This is discussed under outcome 11 in more detail.

There continued to be a number of admissions to the centre continued for short-term stay and respite care. There were no more longterm admissions to the centre.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the centre was managed by a suitably qualified and experienced person with accountability and responsibility for the service.

The person in charge was a registered nurse who had the relevant length of experience required by the Regulations. She demonstrated adequate knowledge of the Regulations, and was aware of her requirements therein. The person in charge held regular meetings with staff, while the minutes of one meeting were read by inspectors and outlined a range of issues discussed, there were no minutes of other meetings available. Therefore it could not be ascertained how issues had been addressed or followed up. See outcome 2 (governance). Inspectors found the person in charge was familiar with the residents' health and social care needs, and was observed interacting with resident's during the inspection.

The person in charge participated in ongoing professional development by attending courses on a range of topics. She had was in the process of completing an online course in management and completed training in mandatory areas.

There were satisfactory deputising arrangements with the person in charge supported in her role by an assistant director of nursing (ADON).

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors found the records, policies and procedures required by the Regulations were in place. An area of improvement was identified in relation to the review of policies and procedures.

All records reviewed as part of the inspection were maintained in a manner to ensure accuracy and ease of retrieval. A sample of policies and procedures required by Regulations were reviewed, and generally the policies were up-to-date and guided practice. However, some improvements were required. For example, the policy on the protection of vulnerable adults would not fully guide practice as outlined (see outcome 7 for more details), the restraint policy did not reflect the national policy "Towards a Restraint Free Environment". In addition, the medication management policy was not fully implemented in practices by staff (see outcome 9).

Judgment:

Substantially 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 were satisfied that systems were in place to protect residents being harmed or suffering abuse, there were measures in place to ensure a positive approach to behaviours that challenge and restrictive practices were in accordance with the Regulations.

The centre was guided by policies on the protection of vulnerable adults in place. Although the policies required updating to reflect the National Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse". This is discussed under outcome 5.

There was regular staff training in the protection of vulnerable adults. Records read confirmed staff completed training. A small number of staff required refresher training, and dates had been scheduled for this. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. She was aware of the requirement to notify any such allegation to the Authority. While no allegations of abuse had been notified prior to the inspection the person in charge outlined the procedures that would be followed as per the policy. She is aware of the requirement to complete a report if an investigation was carried out. This had been an action at the previous inspection. A number of residents said that they felt safe and secure in the centre, and attributed it to the staff who worked in the centre.

The systems in place for safeguarding residents' money were reviewed during this inspection. Inspectors were satisfied that the procedures in place were satisfactory and a sample of residents monies were counted and reflected the balances on record.

Inspectors read a policy on the management of behaviours that challenged and overall it guided staff practice. A sample of files of residents who presented with behaviours that challenged was reviewed. Care plans were developed to support staff. There was access to psychiatry of older age if required as outlined by the person in charge.

A policy on the use of restraint guided staff, however, it did not incorporate or reflect the Department of Health National policy "Towards of Restraint Free Environment". This is discussed under outcome 5. It was evident that the policy on the use restrictive practices was implemented in practice. A small number of restrictive practices were used were in the form of bedrails and chemical restraint. For example, only three residents of the 16 residents required bedrails

The person in charge and provider ensured the least restrictive form of restraint was used, and a range of alternatives were considered before its used. There was evidence of consultation with residents and their representatives prior to a decision being made. There was regular review of the use restrictive practices, and risk assessments were completed every three months and maintained on residents files. Each resident had a care plan developed and half hourly monitoring checks were carried out. The use of alternatives was encouraged and "low low" beds were available.

Judgment:
Compliant

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

Findings:

Inspectors found the provider had ensured there were systems in place to protect and promote the health and safety of residents, visitors and staff. An area of improvement regarding the staff knowledge and training in fire evacuation procedures was required. The action from the previous inspection was completed.

There were suitable arrangements in place for the prevention and spread of fire in the centre. An area of improvement identified in relation to training. Inspectors spoke to staff who were familiar with the fire evacuation procedures. However, two members of staff had not received fire safety training in the last twelve months, including a nurse in charge of the night shift. Before the close of inspection, the person in charge had scheduled a fire training workshop for the following day to amend these gaps. Inspectors also read records of fire drills for 2015. While the records described the drills it was noted these were theoretical and a factual drill involving staff had yet to take place. This was discussed by the person in charge, who was aware of the legal requirement to complete at least two drills per year.

There were fire orders displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits unobstructed. There were regular fire safety checks which included fire exits. The centre kept a detailed fire folder which kept record of all daily, weekly, monthly and annual checks and tests including fire alarms, emergency routes and fire equipment.

There was personal emergency evacuation plan on file for each resident. The plan included information such as the residents dependency levels and, assessed mobility, level of support and assistance.

A safety statement was seen by inspectors. There were health and safety policies as required by Regulations. A risk management policy was in place and it met the requirements of the Regulations. An area of risk regarding the temperature of radiator was addressed and covers were now provided.

Risks were identified, evaluated and had controls in place for mitigation. There was a detailed risk register for all elements of the centre, including hazards relating to the general premises, the outdoor areas, kitchen, use of equipment, bathrooms and showering, administration of needle medication, staffing levels, and waste management. All of these risks were evaluated by impact and likelihood, and any actions or follow-up notes for learning were documented. Inspectors also read record of regular water temperature checks, flushing of infrequently used outlets, and analyses of water for potential risk of infectious diseases such as e.coli and legionella.

The centre employed fulltime maintenance staff and a log was kept of repairs and maintenance within the centre, including that of work on fire doors and emergency lighting. There was a health and safety committee that meet regularly and minutes read by inspectors confirmed issues and updates were discussed around hazards, incidents and staff training in the centre..

There were arrangements in place to manage adverse events involving residents. There

was evidence of learning and improvement to prevent these incidents from happening again. For example, the management of falls, with evidence of prevention of falls and serious injuries in the centre.

Inspectors saw residents were encouraged to be as mobile as best as possible, and were seen being escorted around the centre. A physiotherapy department was located in the centre. Residents spoke about the exercise classes in the physiotherapy unit and how they encouraged to walk and keep active. Staff were observed following best practice in the movement of residents who required assistance. There was safe floor covering and handrails throughout the centre. There was regular training provided to staff in the movement and handling of residents.

An emergency plan was in place which gave instruction to staff on procedures in the event of an emergency and evacuation. The plan refers to the roles of staff members, emergency contacts, guidance on using equipment to assist in transporting residents, and the order of priority of resident evacuation based on needs and location relative to the emergency point.

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:

Inspectors found the designated centres' had policies and procedures for medication management, and overall this outcome was compliant. An area of improvement regarding the implementation of the policy in relation to faxed prescriptions was identified. All other actions from the previous inspection had been addressed.

A comprehensive medication management policy was seen by inspectors. Inspectors read completed prescription and administration records and overall they were in line with best practice guidelines. However, an area of improvement was identified. For example, a faxed prescriptions was not signed by a general practitioner within 72 hours of receipt in the centre. This procedure was not in line with nursing professional guidelines or the centres policy. This was discussed with the person in charge during the inspection who assured inspectors action would be taken to address it. This had been an action at the previous inspection and was not fully addressed. This is discussed under outcome 5.

There was written evidence that residents medications were reviewed every three-months reviews. There were regular audits of the medication and prescription sheets along with staff practices, although the issue above had not been picked up by the audits.

Since the last inspection, the number of medication errors had reduced with only two errors occurring since them. Inspectors read reports of medication errors that had occurred, which also included details of the investigation carried, actions that were taken and evidence of sharing of information with staff for learning purposes.

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 them to be correct.

Inspectors read records that confirmed all staff nurses involved in the administration of medications had undertaken training updates in best practice.

Judgment:

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:

Inspectors were satisfied a record of all incidents occurring in the designated centre were maintained and notified where required to the Chief Inspector.

A record was maintained of all incidents and accidents occurring the centre. The person in charge ensured that where required incidents were notified to the Authority within three working days. The centre had also submitted quarterly notifications of incidents as required by the regulations.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Inspectors found residents were regularly assessed for a range of health care needs with care plans developed where a risk was identified. However, the documentation of care plans and consultation with residents required improvement. In addition, an aspect of the management of residents nutritional needs required review. The actions from the previous inspections were not fully addressed.

Inspectors reviewed three residents' care plans were during the inspection. There were care plans developed for residents identified needs. However, the care plan for a resident with a percutaneous endoscopic gastronomy tube (PEG) did not inform practice. For example, it did not include the dieticians most up-to-date recommendations in relation to the feeding regime. This was discussed with nursing staff who were familiar with the resident's health care needs and described the resident's most up-to-date feeding regime. The person in charge took prompt action and a revised care plan was later shown to inspectors that reflected the residents correct feeding regime. Inspectors saw that care plans were in place for residents whose files were reviewed and kept up to date. However, there was lack of documented evidence that the residents or their families were consulted with.

In addition, the management of residents nutritional needs with the PEG tube required review. While there were regular monthly weights carried out and residents nutritional needs were regularly assessed, the needs of resident with the PEG tube required improvement. As outlined above the care plan did not guide practice or incorporate the most up-to-date dietician's recommendations. While an oral care assessment was completed and risks were identified, there was no oral care plan developed for the resident. There was no evidence that the resident had been reviewed or seen by a dentist in terms of their oral care.

The recording of each residents treatment and daily care required improvement. A daily record was to be maintained by health care assistants to confirm when a resident has been assisted with showers, baths, toileting, skin care and eating. However, inspectors found these were not consistently recorded with many with gaps for most residents. This was discussed with nursing staff who said it was their role to ensure the records were complete, but could not explain why the records were blank.

There were good practices in the management of falls and the arrangements in place for wound care. There were regular review of residents' health care needs using evidence based assessments tools. These were completed every three months or more frequently if required. Where an identified need arose, care plans were developed. The staff were knowledgeable of residents care needs. There was evidence of referral to the relevant health professionals.

There was regular access the services of general practitioner and there was evidence of regular review of residents' medical needs. The residents had a choice of retaining their own GP. There were appropriate arrangements were in place for on call out of hours and at weekends.

There was evidence of access and referrals to allied health professional services such as physiotherapy, occupational therapy, dietician, speech and language therapy, optometry and dental. Where recommendations were made by these professionals. An area of improvement in relation to access to dental services is outlined above.

As reported earlier the provider had notified the Authority of their intention to close the centre. It was anticipated that the provider would cease operation by the February 2015. A transition team had been established that oversaw the management of each residents discharge from the centre. The team was headed by the provider and met weekly to review each resident and identify suitable alternative accommodation that met their assessed needs. At the time of the inspection 20 residents had been safely discharged to other designated centres for older persons. There were 16 residents remaining in the centre. The person in charge along with the transition team was in the process of identifying alternative accommodation for remaining residents. Inspectors reviewed documentation that outlined the discharges to date and planned discharges.

Inspectors were informed that residents and their families could meet the provider at the weekly meetings. Records read confirmed families were facilitated to visit any new accommodation also. The person in charge stated she visited residents in their new homes after they had settled in.

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:

The centre is set in a suburban part of Dublin, with views over the Irish Sea. It is set on its own grounds with parking around the front. Inspectors found aspects of the design and layout of the building did not fully meet the requirements of the Regulations. The issues outlined in the previous inspection had not been fully addressed. The on-going deficits in the centre are as follows:

- two residents bedrooms were only accessible by steps,
- the ensuite toilet in one residents bedroom is 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,
- the garden area was not accessible to residents.

The centre is a large, three story house set on its own grounds. There is are a number of communal sitting areas where residents may sit during the day, including private areas to have a quiet chat or alone time. The building was in a clean condition, well maintained, and nicely decorated. A conservatory accessed through the living room was a designated smoking area for residents.

The fixtures and furnishings in bedrooms and shared areas are appropriate for the residents needs. The premises were well-maintained with suitable heating, lighting and ventilation.

Inspectors visited a number of bedrooms, some were vacated and empty. The empty bedrooms were used to store equipment in the centre. The lack of storage space for equipment had been an issue in previous inspections. The majority of bedrooms in the centre were single occupancy. There is sufficient space for residents have a locker by their bed, and a large wardrobe to store clothes. There was space for residents to have chair and personal belongings. Where bedrooms were shared by residents, these rooms were large enough for residents to provide their own furniture, belongings and any necessary equipment. There were screens between provided between the beds for privacy. A call bell was provided by each residents bed and they were in good working order.

There was appropriate assistive equipment provided to promote residents independence and comfort. Inspectors found hoists, wheelchair were provided for residents.

There was a lift servicing all three floors, and a chair lift on a set of steps on one of the floors. Inspector saw handrails were provided along all corridors. There were a suitable

number of bathrooms and shower facilities provided along with an accessible bath. There were grab rails in all of these rooms which were adapted for for wheelchairs or low mobility users.

Inspectors followed up on the conditions attached to the registration of the centre specifically regarding two bedrooms accessible only by steps into them and one bedroom with steps into an ensuite toilet. Inspectors were informed a resident in a wheelchair was presently residing in the room with steps leading into the ensuite. Inspectors discussed the issue of the steps leading to the en suite bathroom with the person in charge who assured inspectors that the matter had been discussed with the resident and their family, and that they were happy for that resident to remain in the preferred bedroom and use the next nearest bathroom. Inspectors met the resident who confirmed she was happy to be in the room.

Judgment:

Non Compliant - Moderate

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that residents were consulted with and participated in the organisation of the centre. Residents privacy and dignity was maintained including receiving visitors in private.

Inspectors found residents were consulted with and their feedback was sought. There was a monthly residents meeting in the centre. The minutes of the meetings read confirmed a range of issues were raised for example, the residents were updated by staff on the planned closure, any residents who have moved and information on upcoming events. Where issues raised required action there was a record of the follow up information outlining the action take to date. A number of residents told inspectors they attended the meetings and how they enjoyed attending them.

The residents and their families could also meet with the provider at the weekly transition team meeting in the centre. At the meeting any concerns or in relation to the closure could be discussed. Inspectors read records that confirmed families were

updated provided with information to assist them in the discharge of their loved one. Residents who spoke to inspectors told them they were aware of the planned closure and the move. Some reported that they were sad to leave the centre.

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.

The provider and person in charge ensured residents continued to have opportunities to participate in meaningful activities in line with their interests and preferences. A health care assistant (HCA) was employed to facilitate activities. The HCA outlined to inspectors the weekly programme of activities that she displayed in the centre. The programme included exercise classes, painting, poetry, reading and music. In addition a number of external professionals facilitated karaoke classes, dog therapy and SONAS (a therapeutic programme done to music for residents with communication difficulties). Some could attend a weekly fine dining session. An annual BBQ took place on the grounds of the centre, with food and music provided. There was a wide range of outings with trips to museum's, the national concert hall, the zoo, the botanic gardens, cinema, theatre and musicals to name but a few.

Inspectors saw a beautifully laid out photo album that outlined the many events, outings and activities that had taken in 2015. A similar album had been completed for 2014 and 2013.

Judgment:
Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that there was a sufficient number of staff with the skill mix and experience to meet the needs of the centre.

The staffing levels took into account the layout of the building and the assessed needs of the residents, with appropriate supervision arrangements in place. For example, healthcare assistants were designated to residents on each floor reporting to nursing staff. Inspectors found continuity of staffing levels and skill mix despite the planned closure. There was a roster that was planned each week and based on the changing requirements of the centre and its residents.

Inspectors reviewed a matrix of each member of staff and the training they had attended. All staff had completed up-to-date training in mandatory areas for example, elder abuse, manual handling. There were gaps identified in fire safety training which is discussed to in Outcome 8. There was other training provided to staff to meet the resident's needs. For example, nurses were trained in CPR and in the use of Automated External Defibrillators (AEDs). The majority of staff had additional training in the assessment of residents nutritional needs and dysphagia.

There was a policy on recruitment of staff that was in line with the requirements of the Regulations. Inspectors reviewed a sample of personnel files for nurses and healthcare assistants and were satisfied that this recruitment policy was being adhered to, and the files contained all the documentation required by Schedule 2 of the Regulations. For example, references, An Garda Siochana vetting and nursing registration details.

There was a policy on volunteers working in the centre, and written agreements with work experience programmes. Inspectors were satisfied that procedures were being followed to give assurance that anyone working in the centre had An Garda Siochana vetting.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Killiney Grove Nursing Home
Centre ID:	OSV-0000051
Date of inspection:	02/09/2015
Date of response:	02/10/2015

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 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 systems in place for reviewing the safety and quality of care required review.

1. 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.

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

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

A Compliance and Quality Audit of residents care plans ,Medication Audit, Complaints review, Incident/Accident review and Residents/Relative review takes place monthly. This involves both an internal review/audit by the DON and an external review /audit from the Corporate Clinical Governance Team. The Clinical Governance and Operations Manager and DON meet monthly to discuss the findings of the review/audit and set corrective actions and learning outcomes.

The outcomes identified in the care plan audit are to be actioned in the residents care plan to ensure an improved delivery of care. The DON/PIC will work with the nursing staff in reviewing the care plans and updating them as per the findings of the audit. These findings are communicated to staff locally in the home at the Home Clinical review meetings. The actions from these meetings are included where necessary in the twice daily handover that occurs with the care staff (Nursing and care assistants). Any changes made to practice and the residents care plan are to be discussed with the resident and/or their NOK. The residents /NOK is then invited to sign off the care plan but if they do not wish to, the Staff nurse will document that the discussion and review has taken place. The Group Resident Advocate meets with residents on a monthly basis and Relatives on a 3 monthly basis and will ensure that each resident's wishes are followed up and documented into their care plans.

The outcomes identified in the Medication Audit are reviewed by the DON/PIC and where indicated with the pharmacist and residents GP. The DON/PIC will ensure all actions are completed within 1 month. The action plan and learning outcomes are then reviewed by the Clinical Governance and Operations Manager on a monthly basis with the DON/PIC.

A review of all Incident/Accidents takes place every 4 weeks. The learning outcomes are based on the trends identified and this has resulted in changes to policies and practices around Management of Falls, Medication Management, Risk management. These are reviewed with the DON/PIC on a monthly basis and communicated to staff by the DON/PIC.

Complaints are reviewed on a monthly basis with the DON/PIC and Clinical Governance and Operations Manager. They are reviewed to ensure that our policy is followed and that the complainant is satisfied with the outcome of the investigation.

The last review meeting with the DON/PIC and Clinical Governance and Operations Manager to review all of the above Audits took place 29th September 2015. Actions have been set and will be reviewed again on the 27th October 2015.

All of the above Audits, actions required, learning outcomes were reviewed at the last Corporate Clinical Governance Team review meeting on the 30th September 2015. This team is made up of Provider, Clinical Governance and Operations Manager, Compliance, Risk and Quality Manager, Resident Advocate and Clinical Administrator. These review meetings take place monthly.

Proposed Timescale: 02/10/2015

Theme:

Governance, Leadership and Management

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

There was no annual review of the quality and safety of the service provided to residents in the centre.

2. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

The Annual review commenced in January 2015, and is made up of Monthly Reports titled "Monthly Led Monitoring review of Home". The monthly report consist of the findings/Actions required/Learning outcomes achieved of all of the Audits, incidents/accident reports and Complaints. Each week a Weekly report are compiled by the DON/PIC. This report records the admissions, discharges/deaths, Bed Occupancy, Training, Complaints, HIQA notifications.

The Training Matrix report is collated every month and training is arranges following review. The annual home Business plan, compiled each November, includes Quality Improvement plans for the next calendar year.

These reports will be collated each January going forward and issued to each Home following an annual review meeting with the Provider and Head Office Support team including the Clinical Governance Team.

Proposed Timescale: 31/01/2016

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:

The policies on protection and restraint required review to reflect the most recent national policy.

3. Action Required:

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

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

Our policy on protection of Residents will be reviewed and updated to reflect the National Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse".

Our policy on Restraint will be reviewed and updated to reflect best practice guidelines and will reflect the National policy, "Towards a Restraint free environment".

Proposed Timescale: 31/10/2015

Theme:

Governance, Leadership and Management

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

The medication management policy was not fully implemented in practice by nursing staff.

4. Action Required:

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

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

All nursing staff completed "HSELAND" Medication Management training on 18th September 2015. Training in Medication Management for Nurses to be delivered by the pharmacist and to take place on the 6th and 7th October 2015. All medication Management training to be completed by 7th October 2015. To ensure learning is derived from this training the DON/PIC will complete monthly internal Medication round drug Audits. The Clinical Governance and Operations Manager will review these audits on a monthly basis to ensure that the learning is being put into practice.

Proposed Timescale: 27/10/2015

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:

Some staff were not familiar with the fire evacuation procedures for the centre.

5. Action Required:

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

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

All staff have completed training in Evacuation procedures in the event of Fire on the 16th September 2015. This training is reviewed by the DON/PIC at the weekly Fire Drill that takes place in the home. This drill reviews how staff will react to the sounding of the Fire alarm and how they would evacuate the residents safely. The results of this drill are recorded and kept by the DON/PIC. Any issues raised are brought to the attention of the Provider through the Group Head of Maintenance and Premises. As all staff rotate between day duty and night duty, all staff can be observed to ensure that learning is derived from the training received.

Proposed Timescale: 27/10/2015

Theme:

Safe care and support

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

Not all staff had up to date fire safety training.

6. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

All staff completed Fire training on the 16th September this training included, training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. To ensure learning is derived from the training weekly Fire Drills take place with staff lead by the DON/PIC.

Proposed Timescale: 27/10/2015

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:

The percutaneous endoscopic gastronomy care plan for one resident did not guide practice.

7. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

The care plan has been fully reviewed and now details PEG feeding care plan.

Proposed Timescale: 16/09/2015

Theme:

Effective care and support

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

There was lack of evidence that residents or their families were consulted with regarding their care plan.

8. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

Any changes made to practice and the residents care plan are to be discussed with the resident and/or their NOK. The residents /NOK is then invited to sign off on the care plan but if they do not wish to, the Staff nurse will document that the a discussion and review has taken place. The Group Resident Advocate meets with residents on a monthly basis and Relatives on a 3 monthly basis and will ensure that each resident's wishes are followed up and documented into their care plans.

Proposed Timescale: 27/10/2015

Theme:

Effective care and support

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

The management of residents nutritional required improvement in terms of residents with PEG tubes.

9. Action Required:

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

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

Training to be delivered in best practice for care for a resident with a "PEG TUBE". This training will be delivered to all nursing staff and care assistants on the 20th October 2015 . The training will detail how care is to be delivered and The Policy on Enteral Feeding will be updated to reflect the training delivered.

Proposed Timescale: 27/10/2015

Theme:

Effective care and support

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

Residents were not provided with access to dental services as outlined in the inspection report.

10. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

The DON/PIC will ensure that each resident can access a dentist in the local area. To date we have been able to secure a mobile dental service to visit in the home for residents that due to their medical /nursing condition are unable to travel to the Dentist. Any treatment required will be followed up and documented in the care plan and as per our SOP Management of Allied Health professional Visits: Rev 2.

Proposed Timescale: 01/10/2015

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:

Aspects of the design and layout of the centre do not meet the requirements of the Regulations:

- two bedrooms only accessible by steps,
- an ensuite toilet in one bedroom accessible by steps,
- the light switches in some bedrooms not accessible,
- there was inadequate storage space,

-the garden area was not accessible to residents.

11. 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:

Our statement of purpose reflects the dependency levels and specific care needs that can be met in the following rooms :

Bedroom 2 is a single private room ensuite on the ground floor, (13sq meters). This bedroom can only accommodate a resident that is fully mobile and does not require assistance to mobilise as there is a step at the passage way leading to the bedroom. If a residents condition changes from the above an alternative room will be offered to meet the residents needs.

Bedroom 3 is a single private room ensuite on the ground floor, (10.3 sq meters). This bedroom can only accommodate a resident that is fully mobile and does not require assistance to mobilise as there is one step up to the ensuite bathroom. If a residents condition changes from the above an alternative room will be offered to meet the residents needs.

Bedroom 22 is a single private room ensuite on the second floor,(13.8 sq meters). This bedroom can only accommodate a resident that is fully mobile and does not require assistance to mobilise as there are two steps down to enter the bedroom. If a residents condition changes from the above an alternative room will be offered to meet the residents needs.

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: 16/02/2016