<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killure Bridge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000242</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Airport Road, Waterford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>051 870 055</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@killurebridge.com">info@killurebridge.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Killure Bridge Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Kenneth Walsh &amp; David Hyland</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents</td>
<td>78</td>
</tr>
<tr>
<td>Number of vacancies</td>
<td>1</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
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: 22 September 2015 09:55  
To: 22 September 2015 14:50

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

This report sets out the findings of a one day single outcome announced inspection of Killure Bridge Nursing that was undertaken on the 22 September 2015. The Authority had received a concern in relation to safeguarding and the protection of vulnerable adults in the centre. The Authority also received a notification from the centre of alleged elder abuse which was related to the concern received. However there was a delay in this notification being sent to the Authority as the person in charge classed the incident as challenging behaviour and not as an allegation of abuse. A provider led inquiry was requested from the centre on the 26 June 2015, which was received by the Authority on 02 July 2015 and included the required evidential documentation. Following review the inspector requested further information and requested on going up dates from the centre which were received in a timely fashion.

The inspector conducted a single outcome inspection to look at safeguarding practices in the centre. During this inspection the inspector met and interviewed residents, the providers, the person in charge, the clinical nurse manager, the psychiatric liaison nurse, nurses and care staff. The inspector reviewed documentation which included policies and procedures, resident’s records and plans of care, minutes of staff meetings, training records, incidents, allegations and investigations and other relevant documentation.

Residents interviewed reported to feeling very safe and happy in the centre, they told the inspector that if they had any concerns or worries they would go to the person in charge and staff and said that issues were dealt with immediately. The inspector saw that safeguarding measures had been put in place to ensure the safety of residents in the centre. There was evidence of ongoing monitoring and review of plans of care. There was evidence of full involvement of the psychiatric services for
review of residents care and to provide advice and support to staff. The psychiatric services have also committed to providing training to staff in the management of psychiatric conditions and behaviours that challenge and this training is to be provided in October 2015.

Staff interviewed reported that although there had been allegations of abuse they were satisfied that no physical abuse had taken place and that all actions and measures were put in place by the person in charge to ensure that all residents were safeguarded at all times from all forms of abuse including inappropriate conversations. They stated they had no concerns for residents safety but would report immediately if they had and demonstrated their knowledge of the centres policy and procedures in relation to safeguarding. Training records confirmed that staff had up to date training in safeguarding of residents.

Overall the inspector found that the person in charge, provider and staff demonstrated a commitment to care delivery and continuous improvement with comprehensive auditing of the service and care resulting in improvements for residents. They had adequate knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. They demonstrated the awareness of the requirement to notify all allegations of abuse to the authority and assured the inspector they would do so immediately in the future.
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
As outlined in the introduction the Authority received a concern in relation to safeguarding and the protection of vulnerable adults in the centre. The inspector conducted a review of the centre safeguarding practices and their management of behaviours that challenge.

Policies and procedures were in place for the prevention, detection and response to abuse and the person in charge had recently developed a policy on intimacy and sexual relationships which was rolled out to all staff in a training session.

The inspector was satisfied that robust measures were put in place to ensure that residents were protected from abuse. All staff had up-to-date training in safeguarding and positive behaviour support and demonstrated to the inspectors their awareness of what to do if there was an allegation of abuse. The inspector saw that any allegations of abuse in the past had been acted on immediately, investigated fully and appropriate action taken. Notifications were sent to the chief inspector as required by legislation with the exception of this notification that was not notified within the appropriate time frame and this is actioned under outcome 10.

The person in charge informed the inspector that she is the designated person to deal with any allegations of abuse. She also had contacted the HSE social worker responsible for elder abuse who was on leave but the person acting up for her came to the nursing home and conducted an investigation into the allegations of abuse. Residents interviewed by the inspector reported feeling very safe and happy in the centre, they told the inspector that if they had any concerns or worries they would go to the person in charge and staff and were confident that issues were dealt with immediately. They told the inspector there had been no further inappropriate conversations and said staff were always vigilant. The inspector saw that safeguarding measures had been put in place to ensure the safety of residents in the centre.
There was a policy on challenging behaviour and the inspectors saw that staff had received training on dealing with behaviours that challenge. From a selection of care plans viewed by the inspector it was noted that behavioural interventions records gave clear directions to staff on how best to prevent or appropriately respond to behaviours that challenge. For residents who were admitted through the psychiatric services there was evidence of regular review by the psychiatrist and discussion at Multidisciplinary team meetings. There was a psychiatric liaison nurse who visited a number of residents on a weekly basis and was available for advice and support. The psychiatric team had committed to provide education and training for staff in the centre around psychiatric conditions, treatments and management of behaviours. The inspector saw evidence of this commitment and training was scheduled for October 2015.

**Judgment:**
Compliant

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**Outcome 10: Notification of Incidents**

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

**Theme:**
Safe care and support

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

**Findings:**
An allegation of abuse was not notified to the authority within the required time frame as outlined in the regulations.

**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:

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

Centre name: Killure Bridge Nursing Home
Centre ID: OSV-0000242
Date of inspection: 22/09/2015
Date of response: 30/09/2015

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 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 abuse was not notified to the authority within the required time frame as outlined in the regulations

1. 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.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
All notifications will be submitted to the Authority within the 72 hours in future

Proposed Timescale: 30/09/2015