<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Kenmare Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000753</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Kenmare, Kerry.</td>
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<tr>
<td>Telephone number:</td>
<td>064 667 9500</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:Kenmare.CNU@hse.ie">Kenmare.CNU@hse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Ber Power</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Breeda Desmond</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 15 December 2015 10:30  To: 15 December 2015 19:30
16 December 2015 08:30  16 December 2015 17:00

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

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<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
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<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This report sets out the findings of an announced inspection and it was the third inspection undertaken by the Authority in the Health Services Executive (HSE) Kenmare Community Nursing Unit. The HSE applied and was granted registration for the ground floor of the unit in June 2013. In October 2015 the provider applied to vary conditions of registration to increase bed capacity. (The registration of Kenmare
Community Nursing Unit will expire 07/06/16.) During this inspection the provider nominee requested to change the purpose of the inspection from an application to vary conditions of registration to an application to renew registration and increase bed capacity from 19 to 41, and this was facilitated. This renewal of registration inspection took place over two days. As part of the inspection the inspector met with residents, relatives, Provider Nominee, Person in Charge, Clinical Nurse Manager (CNM 2), Clinical Development Co-ordinator for the Kerry Community Hospitals and staff members. The inspector observed practices and reviewed governance, clinical and operational documentation to inform this registration renewal application.

The provider nominee and person in charge displayed good knowledge of the standards and regulatory requirements.

The inspector spoke with residents and relatives during the inspection and the collective feedback from residents and relatives was one of satisfaction for the care provided. Family involvement was encouraged through the family forum meetings and residents meetings informed changes to different aspects of life in the centre.

Overall, staff were kind and respectful to residents and demonstrated good knowledge of residents, however, this was not always reflected in care plans examined by the inspector.

Staff levels and skill-mix were adequate to meet the assessed needs of residents. However, it was difficult to determine if all staff had up-to-date mandatory training from the files reviewed.

The premises was clean, bright and appeared well maintained, with adequate space to ensure the freedom, choice, privacy, dignity and autonomy of residents.

A compliant fire safety certificate was evident.

The inspector identified aspects of the service requiring improvement to enhance the areas of good practice evidenced on inspection. These improvements included:

1) a system to review and monitor the quality and safety of care and the quality of life of residents required review to ensure compliance with Regulations
2) administration of medication documentation was not comprehensive
3) maintenance of staff training records
4) malodour in the kitchen (identified on inspection 16/09/14).

The action plan at the end of this report sets out the actions necessary 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.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose (SOP) was reviewed and updated on inspection and was in compliance with the Regulations.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
An annual review of the quality and safety of care and quality of life in consultation with residents and their families to ensure that such care was in accordance with the National Standards was not in compliance with the Regulations. Several audits were completed that considered aspects of safety of care, however, quality of life for residents was not evaluated to determine outcomes for residents regarding their quality of life. For example, food and nutrition, social activities, privacy and dignity audits were completed.
in 2015, however, these were completed by staff without consultation or input from residents to ascertain their perspective. An internal inspection which audited ‘Management Safety and Care’ was completed, where practice was observed, staff were interviewed and policies were reviewed. The report (September 2015) highlighted areas of good practice as well as issues which required action. This report included an action plan with responsibilities assigned for issues to be remedied. These results contributed to the annual review. However, the annual review was not prepared in consultation with residents and relatives, as detailed above.

Examples of clinical audits completed routinely were medication management, clinical risk assessments for residents and equipment. Actions were demonstrated following audits to remedy issues and responsibilities were assigned to appropriate staff.

Minutes of residents meetings were evidenced which demonstrated that meetings were held every two months. Issues were discussed and followed up in subsequent meetings. A recent initiative was the relatives’ forum which has had two meetings to date. The inspector met with three separate relatives and they all gave very positive feedback regarding these meetings. Issues were discussed and relatives found them a source of support as well as a formal forum for bringing items for discussion.

The application to renew the registration of Kenmare Community Nursing Unit included the application to register additional beds and increase capacity from 19 residents to 41 residents. To ensure the suitable, safe and appropriate transition for residents, the Authority requested a programme of admissions to the new beds; in addition, the Authority requested the proposed incremental staffing levels including household staffing, pantry staff, nurse and care staff to ensure the centre is sufficiently resourced to effectively deliver care in accordance with their Statement of Purpose.

**Judgment:**
Non Compliant - Moderate

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**Outcome 03: Information for residents**
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Contracts of care were evidenced for all residents. The contracts detailed fees to be charged and there was no additional fees charged to residents. Contracts of care for residents were signed and dated by either the resident or their next of kin in line with best practice.
A residents’ guide was available for residents and their relatives. Each resident received a copy of the guide on admission.

**Judgment:**
Compliant

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**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 post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. She demonstrated good knowledge and understanding of the Regulations and National Standards to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with her role and responsibilities. There was evidence that the person in charge was commitment to her own continued professional development and had attended many conferences and training sessions. She had implemented a comprehensive training programme for all staff and staff were trained to facilitate in-house training for staff on such topics as adult protection, responsive behaviour and hand hygiene for example.

The person in charge was supported in her role for by the CNM 2 as well as senior staff nurses.

**Judgment:**
Compliant

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

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

### Findings:
The inspector was satisfied that the records required in Schedule 2 (staff files), Regulation 19 (Directory of Residents), Regulation 21 (records set out in Schedule 2, & 4) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Centre-specific policies relating to Schedule 5 (operating policies and procedures) were in place; they were comprehensive and referenced current publications, for example, the HSE policy ‘Safeguarding Vulnerable Persons at Risk of Abuse 2014’. There was a schedule in place for policy update. While all Schedule 5 policies were in place, some were due to expire within in six months and the clinical development co-ordinator reported that these were in the process of being updated. The draft policy on Responsive Behaviour was demonstrated which included an easy guide algorithm for staff to follow. It was developed in line with the new HSE ‘National Dementia Awareness Programme’. The clinical development co-ordinator reported that the policy would be rolled out to staff following completion of the training programme to all staff. She envisaged that this new policy would be in place by February 2016.

Schedule 3 (residents’ records) will be discussed under Outcome 11 Health and Social Care Needs.

### Judgment:
Compliant

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### Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

### Theme:
Governance, Leadership and Management

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

### Findings:
The provider nominee and person in charge were aware of their responsibilities regarding notification to the Authority should the occasion arise. The CNM 2 deputised
for the person in charge. Senior nurses were in place to support the clinical management team also.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

**Findings:**
It was reported to the inspector that staff had completed training in adult protection, however, it was unclear from the training records template if all staff had up-to-date training. Staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if care was untoward. Residents and relatives stated that they could discuss anything with any member of staff and identified the person in charge and the CNM2 by name.

As previously reported, the new policy for Responsive Behaviour will be rolled out in February 2016 following completion of staff training. The inspector formed the view that this change in policy was a potentially positive development, as the current policy was difficult to follow and the inspector had concerns as to how the current policy could inform practice.

The incident forms completed for episodes relating to residents with responsive behaviours demonstrated good insight into assessments of antecedents to the behaviours and positive interventions to prevent or alleviate behaviours, but this information was not evidenced in residents’ care plans or outlined in the current policy.

There was a policy in place for restraint which referred to a bedrail risk assessment and the risk balance tool, however, these were subjective and decisions made were not based on actual risk but perceived risk. The clinical development co-ordinator outlined that these risk tools were being updated as part of the responsive behaviour policy.

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

Findings:
There was a safety statement, a health and safety policy and risk management and incident management policy. Policies were in place for the specific risks listed in the Regulations. Details on the identification, assessment of risks with measures and actions in place to control risks identified were contained within the risk register. The risk register was updated to highlight changes in the status of risks and whether they were closed or not; this was submitted to the Quality and Risk committee on a monthly basis. The emergency plan was available with alternative accommodation detailed, should the need arise.

There was a policy in place for infection prevention and control. Advisory signage for best practice hand washing was displayed over some hand-wash sinks. There were hand hygiene gel/foam dispensers available throughout the centre. Advisory signage for best practice use of hand hygiene gels was displayed and the inspector observed that opportunities for hand hygiene were taken by staff. Staff had completed training in hand hygiene.

Current relevant fire certification for maintenance and servicing was evidenced. Comprehensive fire safety evacuation notices were displayed in prominent positions throughout the centre. A fire safety register was in place for daily, weekly and monthly fire safety checks. The inspector could not determine from the records demonstrated if all staff had completed their mandatory fire training.

It was reported to the inspector that all staff had completed their mandatory training in moving and handling of residents, but this could not be verified in the records available.

A current insurance policy was demonstrated.

A record was maintained of incidents and accidents with appropriate interventions and reporting evidenced. Notifications submitted to the Authority correlated with the accident and incident records.

Residents’ families were responsible for personal laundry. Bed linen was segregated at source and best practice was observed regarding this.

Work-flows described by the chef were in compliance with best practice. Advisory signage indicating designated areas for preparation of different foods to ensure safe food preparation practices and mitigate risk of cross contamination were in place. There
were two designated hand wash sinks available. The previous inspection 16/09/14 identified that there was a significant malodour emanating from the grease traps; while new air conditioning was installed in the kitchen which went some way in reducing the odour, the issue had not been remedied.

**Judgment:**
Substantially Compliant

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### Outcome 09: Medication Management

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

**Findings:**
An over-arching centre-specific medication management policy was in place. It was reported to the inspector that this was being updated to incorporate the new policy regarding ‘Responsive Behaviour’ as well as other current evidence-based best practice guidelines.

Photographic identification was in place for residents as part of their prescription/drug administration record chart to mitigate risk. Controlled drugs were maintained in line with best practice professional guidelines. Medication trolleys were securely maintained. The medication fridge was located in the secure clean utility.

A sample of prescriptions/drug administration records were examined and while nurses usually signed following administration of medication, occasionally administration records were blank.

Medication errors and near misses were recorded and monitored by the CNM 2 to mitigate risk of recurrence. The pharmacist attended the centre on a weekly basis. Medication audits were completed regularly and the attending pharmacist facilitated education sessions for staff on a variety of topics related to medical conditions and their treatments.

**Judgment:**
Substantially 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:
Notifications received by the Authority were reviewed upon submission and prior to the inspection. Notifiable incidents and quarterly returns were timely submitted to the Authority. Records were maintained of incidents occurring in the centre and these were monitored by the person in charge.

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

Findings:
A sample of residents’ assessments and care plans were reviewed. Assessments of daily living forms contained a huge amount of boxes to be ticked, consequently, there was very little space to include person-centred narrative to inform individualised care; invariably, boxes which should have been ticked were inadvertently missed, for example, one resident had cognitive impairment, however, their level of confusion or mental status was not indicated. Occasionally information accrued from the assessments was not included in care plans, for example, one resident was assessed to be at risk of choking, however, while there was a plan of care for swallowing difficulties it did not include the risk of choking. While some care plans had resident-specific information to direct person-centred care, others did not.

Clinical risk assessments such as skin integrity, falls, food and nutrition, oral health and mobility were completed to inform care. Re-assessments were timely completed, however, these updates were recorded on ‘readmission’ assessment forms, in the sample viewed which gave the impression that residents were re-admitted to the centre rather than have their assessments updated. Updates on care and interventions was
documented in a variety of places, for example, the evaluation and progress notes and in care plan updates, however, a daily narrative, as required in Schedule 3 (4) (c) was not evident.

There was a medical officer assigned to Kenmare Community Nursing Unit and the doctor attended the centre on a daily basis. Out-of-hours medical cover was available when necessary. A sample of medical records reviewed demonstrated that resident’s were reviewed on a regular basis. Specialist medical services were also available when required.

Residents had access to the dietician, speech and language therapist, old age psychiatry, geriatrician, general surgeon, physician, dental, optical, chiropody and community palliative care.

**Judgment:**
Non Compliant - Moderate

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### Outcome 12: Safe and Suitable Premises

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

**Theme:**
Effective care and support

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

**Findings:**
The premises was a two-storey building which accommodated an out-patient physiotherapy department, a mental health day service as well as Kenmare Community Nursing Unit. The premises was clean, bright and appeared well maintained, with adequate space to ensure privacy, dignity and autonomy of residents. There was lift and stairs access to the upstairs. Downstairs accommodation, Sheen House, comprised one twin bedroom with en suite facilities and 17 single en suite bedrooms. Within the unit communal space included a quiet sun room, day room and dining room; comfortable seating areas were located along the wide corridors. Within the main foyer of the premises there was a prayer room, family overnight accommodation and family meeting room. Clinical rooms were secured to prevent unauthorised entry. Upstairs accommodation comprised two units; Caha House which was a secure self-contained six-bedded unit with a dining room and a day room and a large foyer with comfortable seating areas; the second unit was Roughty House with accommodation for 16 residents with 14 single en suite bedrooms and one twin en suite bedroom. Additional assisted toilets and bathrooms were available in each unit.
The property was built on an elevated site, consequently, residents upstairs had access to their own secure outdoor space. Caha House (six bedded unit) had a large secure walled garden with walkways and seating. This area was overlooked by an external operator; the provider nominee was aware of this and agreed that the height of the partitioning wall would need to be higher to ensure the privacy of residents. There was a secure garden also in Roughty house with access via the dining room. The unit downstairs, Sheen House, was a rectangular shape and build around a secure garden. Residents also had access to unsecured walkways around the entrance to the building.

The inspector saw evidence of the use of assistive devices, for example, ceiling hoists in bedrooms and bathrooms, wheelchairs, walking aids, clinical monitoring equipment and specialist seating was provided for residents’ use. There was a functioning call-bell system in place.

Closed-circuit television cameras (CCTV) were in public areas. There was a sign to inform residents, staff and visitors that CCTV was in operation. There was a policy in place it to support the use of CCTV.

**Judgment:**
Substantially Compliant

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

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

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

**Findings:**
The complaints procedure was displayed prominently at main reception, as required in the Regulations. The complaints policy was in compliance with the Regulations. The complaints' log was reviewed and complaints were recorded in line with the Regulations. The person in charge monitored complaints and endeavoured to resolve issues as soon as they arose.

**Judgment:**
Compliant

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**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
Theme: Person-centred care and support

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

Findings:
There was a policy in place for end-of-life care and this was in date. The clinical development co-ordinator reported that this policy was being updated to include advance care directive information; this was due to be rolled out in January 2016 following a one-day information workshop for staff.

Spiritual needs were facilitated with Mass held on special occasions; other denominations visited the centre upon request. There was a prayer room for residents located on the ground floor.

Residents had access to consultant palliative care and the hospice services. Staff had completed professional development regarding end of life care, palliative care and specialist syringe-driver. Some residents were receiving palliative care and care practices observed demonstrated that residents were cared for with the utmost respect.

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 policy in place for food and nutrition that included a recognised food and nutrition risk assessment, monitoring and documentation of nutritional status. Catering staff discussed nutritional needs including specialist diets with the inspector and demonstrated their knowledge regarding specialist diets and consistency for residents. Staff had completed training in modified consistency food preparation. Residents’ weights were documented on a monthly basis or more often if their clinical condition warranted; dietary intake was recorded when necessary and residents were prescribed
supplements when their condition necessitated.

Information was relayed by the nurse to kitchen staff on admission of a new resident and following review by the dietician or speech and language therapist with an update of the current status of the residents pertinent to their nutrition. There was a nutritional committee in place to enhance their quality improvement strategy. This committee convened monthly and discussed items such as dietary requirements and fortification of diets. The chef had in-depth knowledge of residents’ likes and dislikes, portion sizes, consistencies, and particular dietary requirements for example, diabetic and renal diets.

Residents had choice at each mealtime and residents spoken with gave positive feedback regarding the quality of their food. The inspector observed breakfast, mid morning, lunch and tea times. Residents requiring assistance with their meals were helped appropriately. Meals were well presented and served in a pleasant atmosphere. Residents had access to fresh water and other fluids throughout the day.

Judgment: Compliant

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

Theme: Person-centred care and support

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

Findings:
The centre operated an open visiting policy which was observed throughout the inspection. Relatives spoken with commended staff on how welcoming they were to visitors. There was fob access to the centre, consequently, all visitors had to ring to gain access to the centre. Minutes from relatives meetings highlighted this and some thought it was a good security measure for residents with cognitive impairment as well as an opportunity to meet and chat with staff, while others thought it was inconvenient for staff to answer the door. Residents did not have a fob to independently leave the centre if they so wished and this was a significant infringement on their right to freedom of movement. This was discussed with the person in charge who outlined that this issue was kept under constant review.

Residents’ meetings every held every two months and minutes from these meetings suggested that feedback was actively sought from residents on an on-going basis on the
services provided to enable them to maximise their independence, make informed decisions and exercise personal autonomy and choice.

The programme of activities included art therapy, music, newspaper reading and exercises. Listening to 'Kerry' radio formed part of the daily activity schedule. However, minutes from several residents’ meetings highlighted that radio coverage was poor in some parts of the centre so residents did not have access to the radio channel of preference. Subsequent meetings identified that an amplifier was requested to remedy this issue, however, poor radio coverage remained an issue to date. Consequently, the activities programme was not adequate to meet the needs of residents.

Judgment:
Non Compliant - Major

Outcome 17: Residents’ clothing and personal property and possessions
Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
There was a centre-specific policy on residents’ personal property and possessions. A record was maintained of residents’ personal property. Residents had access to adequate private storage space of wardrobes, bedside lockers and chests of drawers to enable them to retain control over their possessions and clothing.

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

Findings:
The practice development co-ordinator for the Kerry Community Hospitals supported the person in charge whereby she updated policies procedure and guidelines to ensure they contained current research-based information. She was in the process of upgrading the care planning documentation. The practice development co-ordinator had developed a training needs analysis for all staff and was in the process of collating this information to inform the training programme for 2016. Two nurses had completed the programme of ‘train the trainer’ to facilitate further staff training in-house. The person in charge reported that this was very successful initiative.

The person in charge and CNM2 had completed the preceptor course to facilitate student nurse placement in the centre as part of the nurse degree programme.

Other staff education and training completed in 2015 included end-of-life care, nutrition, food consistencies, food safety, eating drinking and swallowing disorders, specialist clinical equipment, hand hygiene, infection prevention and control, responsive behaviour, fire safety, wound management, communication with people with dementia, roles and responsibilities.

Staff training records were maintained however it was difficult to determine if all staff had completed their mandatory training, as identified previously in this report.

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:

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

<table>
<thead>
<tr>
<th>Centre name</th>
<th>Kenmare Community Nursing Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000753</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>15/12/2015 and 16/12/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26/01/2016</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of the quality and safety of care and quality of life in consultation with residents and their families to ensure that such care was in accordance with the National Standards was not in compliance with the Regulations. Several audits were completed that considered aspects of safety of care, however, quality of life for residents was not evaluated to determine outcomes for residents regarding their quality of life.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **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 Registered Nominee / Person in charge intend to complete an audit on Quality of Life of residents, which will help assess, evaluate and improve the service in order to achieve best outcome. The audit tool has been completed.

**Proposed Timescale:** 15/02/2016

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review and internal inspection were conducted without consultation with residents and relatives.

2. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

**Please state the actions you have taken or are planning to take:**
The annual review will be reviewed in order to include consultation with residents and their relatives
The internal inspection did include a one to one consultation between the Provider Nominee & Risk Manager and residents. This was carried out in the form of a Quality and Safety Walkabout using the toolkit provided by HSE Quality and Patient Safety Directorate, May 2013.

**Proposed Timescale:** 06/02/2016

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure the suitable, safe and appropriate transition for residents, the Authority requested a programme of admissions to the new beds; in addition, the Authority requested the proposed incremental staffing levels including household staffing, pantry staff, nurse and care staff to ensure the centre is sufficiently resourced to effectively deliver care in accordance with their Statement of Purpose.
3. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
A programme of admissions for opening of beds in Roughty House and Caha House to include staffing levels shall be formulated by the Provider Nominee and the Person in Charge. A transition plan is in place for incremental opening of beds as service demands.

Proposed Timescale: Immediate once beds are registered

Proposed Timescale:

<table>
<thead>
<tr>
<th>Outcome 07: Safeguarding and Safety</th>
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</thead>
<tbody>
<tr>
<td>Theme:</td>
</tr>
<tr>
<td>Safe care and support</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a policy in place for restraint which referred to a bedrail risk assessment and the risk balance tool, however, these were subjective and decisions made were not based on actual risk but perceived risk.

4. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The bedrail risk assessment tool is currently being revised (in accordance with the risk balance tool provided in the National policy) to identify actual risks rather than perceived risks.

Proposed Timescale: 17/02/2016

| Theme:                             |
| Safe care and support              |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The current policy regarding responsive behaviour was difficult to follow and the inspector wondered how it could inform best practice. The incident forms completed for episodes relating to residents with responsive behaviours demonstrated good insight into assessments of antecedents to the behaviours and positive interventions to prevent
or alleviate behaviours, but this information was not evidenced in residents’ care plans or outlined in the current policy.

5. **Action Required:**
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
The current policy regarding responsive behaviours is being replaced with a new policy titled ‘Policy for the support of residents with responsive behaviour’. This policy will be rolled out in February 2016 in conjunction with onsite training on the use of ABC charts (for all staff who have not yet attended the National Dementia Awareness Programme which provides education on same). The ABC chart is being introduced to assist the identification of antecedents to responsive behaviour, enabling staff to adapt care practices and/or daily routines to suit the unmet need(s) of the person exhibiting a responsive behaviour. This new policy is also a guidance document to assist the registered nurse when developing (and updating) an individualised person-centred responsive behaviour care plan.

**Proposed Timescale:** 06/03/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was reported to the inspector that staff had completed training in adult protection, however, it was unclear from the records demonstrated if all staff had up-to-date training.

6. **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:**
Person in charge has finalised a training template to demonstrate clearly that staff had up to date training – same to be forwarded to HIQA

**Proposed Timescale:** 06/01/2016

**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 previous inspection 16/09/14 identified that there was a significant malodour emanating from the grease traps; while new air conditioning was installed in the kitchen which went some way in reducing the odour, the issue had not been remedied.

7. 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:
Provider Nominee has notified Maintenance and Estates Department re: the odour from the grease traps. Arrangements have been made for the engineer who oversaw the building of the unit to visit and check the drains and grease traps. Awaiting his visit.

Proposed Timescale: 06/02/2016

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:
A sample of prescriptions/drug administration records were examined and while nurses usually signed following administration of medication, sometimes administration records were blank.

8. 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:
Medication management policy is in place. Person in charge and Community Pharmacist have highlighted to all Staff Nurses, the medication management/policies and procedures in place that comply with legislative and professional regulatory requirements and best practice and their professional responsibility to complete prescription charts without omissions.

Proposed Timescale: 06/01/2016

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:
A sample of residents’ assessments and care plans were reviewed. Assessments of daily living forms contained a huge amount of boxes to be ticked, consequently, there was very little space to include person-centred narrative to inform individualised care; invariably, boxes which should have been ticked were inadvertently missed. Occasionally information accrued from the assessments was not included in care plans. While some care plans had resident-specific information to direct person-centred care, others did not.

9. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
New nursing documentation is being developed to promote person-centred narratives to inform individualised care. The new person-centred nursing documentation will be utilised initially on a trial basis on 9th May 2016 for one month to ensure adequate input and feedback is received from the residents, staff and management. Feedback will be expected by 9th June 2016. Once any identified issues are resolved the final draft will be printed and implemented throughout Kenmare Community Nursing Unit on 4th July 2016. The new nursing documentation will be rolled out in conjunction with on-site education on the completion of same.

Proposed Timescale: 04/07/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While re-assessments were timely completed, these updates were recorded on ‘readmission’ assessment forms, in the sample viewed.

Updates on care and interventions were documented in a variety of places, for example, the evaluation and progress notes and in care plan updates, however, a daily narrative, as required in Schedule 3 (4) (c) was not evident.

10. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Re-admission forms have been removed and daily narratives have been introduced immediately
Proposed Timescale: 06/01/2016

**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 secure garden for Caha House was overlooked by an external operator and the height of the partitioning wall would not ensure the privacy of 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:**
Person in charge is presently in consultation with landscape gardener / maintenance dept in order to provide a solution, to ensure privacy and dignity of residents

Proposed Timescale: 06/04/2016

**Outcome 16: Residents' Rights, Dignity and Consultation**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Listening to ‘Kerry’ radio formed part of the daily activity schedule. However, minutes from several residents’ meetings highlighted that radio coverage was poor in some parts of the centre so residents did not have access to the radio channel of preference. Subsequent meetings identified that an amplifier was requested to remedy this issue, however, poor radio coverage remained an issue to date. Consequently, the activities programme was not adequate to meet the needs of residents.

**12. Action Required:**
Under Regulation 09(3)(c)(ii) you are required to: Ensure that each resident has access to radio, television, newspapers and other media.

**Please state the actions you have taken or are planning to take:**
PAL (Activities assessment) will be completed as part of residents 3 monthly review to determine any change in residents preferences or abilities. Social and Recreation care plan will then be updated accordingly.
The reception for Kerry radio is poor in some bedrooms but residents could listen to it...
in sitting room. This has again been discussed with the maintenance department and electrician and on inspection it is expected that a booster will improve transmission. The Maintenance department are presently working to improve transmission of Kerry radio.

**Proposed Timescale:** 06/02/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents did not have a fob to independently leave the centre if they so wished.

**13. Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
Provider Nominee has discussed the issuing of fobs to residents with the HSE Fire and Safety officer who elicited the following response.
The access control in place provides two functions 1) Prevents unauthorised persons from entering 2) Prevents unauthorised persons from exiting therefore controlling access/egress.

The provision of fobs to patients and relatives was never envisaged as part of the strategy. Allowing this with the present system would compromise its operation. Staff and patient safety in relation to unauthorised access is paramount and staff being aware of who enters the unit is an important feature of the current system. Managing fobs could prove difficult with the current set up. Logging access and egress of patients and relatives could also prove difficult and in the event of an emergency ensuring that staff know who is in and out could pose problems. The current layout/design is reliant on the access control elements to ensure patient safety. Putting an onus on patients to ensure doors are closed properly could also be unmanageable. Access/egress control systems cannot be viewed as a physical restraint particularly when staff can allow/monitor patient’s access and egress. Also residents may pass fobs on to relatives allowing ease of access for relatives and others.

The standards refer to the following which will be difficult to monitor if fobs are given out.

4.8 The resident’s permission is sought before any person enters his/her room
20.3 The resident can receive visitors in private. The resident chooses who he/she sees and does not see and his/her wishes are respected and recorded.
20.4 The person-in-charge ensures that there are no restrictions on visits except when requested to do so by the resident or when the visit or the timing of the visit is deemed to pose a risk.
**Proposed Timescale:**

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