Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Kilrush Nursing Home
Centre ID:	OSV-0000452
Centre address:	Kilimer Road, Kilrush, Clare.
Telephone number:	065 906 2686
Email address:	managerkilrush@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Services
Provider Nominee:	Pat Shanahan
Lead inspector:	Mary Costelloe
Support inspector(s):	John Greaney
Type of inspection	Unannounced
Number of residents on the date of inspection:	43
Number of vacancies on the date of inspection:	2

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 October 2016 09:30	17 October 2016 17:30
18 October 2016 09:00	18 October 2016 16:30

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 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a monitoring inspection, which took place to monitor ongoing regulatory compliance of the centre. This monitoring inspection was un-announced and took place over two days.

As part of the inspection the inspectors met with residents, relatives, the person in charge and staff. The inspectors observed practices and reviewed documentation such as care plans, medical records, health and safety records, incident logs, complaints logs, policies and procedures and staff files.

On the days of inspection, the inspectors were satisfied that the nursing and healthcare needs of residents were being met. Nursing documentation was generally found to be of a high standard. The person in charge and staff demonstrated a comprehensive knowledge of residents' needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. The

inspectors observed staff interacting with residents in a respectful and friendly manner. Residents were observed to be relaxed and happy in the company of staff. Residents spoke highly of staff and stated that they were happy and felt safe living in the centre.

The inspectors observed sufficient staffing and skill-mix on duty during the inspection.

The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day.

Issues in relation medicines management identified at the last inspection had largely been addressed.

Improvements were required to maintaining effective oversight of cleaning and infection control, ensuring policies were up to date and implemented in the centre, ensuring that appropriate and suitable bed linen was in use, ensuring all staff and persons who provided services to residents had satisfactory Garda Síochána vetting in place, ensuring all staff files contained the required documentation, ensuring notification to the Chief Inspector of allegations of abuse, management of those allegations and complaints management.

All areas for improvement are contained in the action plan at the end of this 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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors were satisfied that the systems were in place to monitor the quality of care and experience of residents, however, improvements were required to maintaining oversight of all departments.

The inspectors were satisfied that there was a full-time person in charge with the appropriate experience and qualifications for the role. Deputising arrangements were in place in the absence of the person in charge. There was an on-call out of hours system in place.

The provider had established a clear management structure, and the roles of managers and staff were set out and understood.

There were systems in place to monitor the quality of care and included the experience of the residents and relatives.
There was a planned audit schedule in place. The inspectors were shown recent audits in relation to incidents and falls, medication management and infection control.

Monthly governance meetings were held at which key performance indicators such as resident profile, clinical documentation, clinical risk, health and safety, audits, complaints and staffing issues were reviewed and action plans were developed to address areas for improvement.

An annual review of the quality and safety of care had been completed in March 2016. Audits in relation to hygiene and infection control, catering, health and safety, medication management, human resources, care standards, clinical documentation as well as complaints, feedback from residents committee meetings and relatives satisfaction surveys had been used to inform the review.

Residents' committee meetings continued to be held on a regular basis and were facilitated by the activities coordinator. Minutes of meetings were recorded. Issues discussed included catering and food, activities and nursing care. There was evidence that issues raised by residents had been acted upon. Residents had recently visited the local walled gardens as a day trip following a suggestion at the residents meetings.

There was evidence that residents and relatives were consulted with in relation to review of residents care pans.

Improvements were required to maintaining effective oversight of cleaning and infection control, ensuring policies were up to date and implemented in the centre, ensuring that appropriate and suitable bed linen was in use, ensuring all staff and persons who provided services to residents had satisfactory Garda Síochána vetting in place, ensuring all staff files contained the required documentation, ensuring notification to the Chief Inspector of allegations of abuse, management of those allegations and complaints management.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was a registered nurse with the required experience in the area of nursing older people and worked full-time in the centre. He was in the role since April 2015 and normally worked Monday to Friday. He was on call out-of-hours and at weekends. A clinical nurse manager (CNM) deputised in the absence of the person in charge and supervised the delivery of care.

The person in charge continued to engage in on-going professional development and recent education and training completed included, a four day training course on healthcare associated infection prevention, a leadership course and a management development programme, as well as attendance at the in-house training programme.

The inspectors observed that the person in charge was well known to staff, residents and relatives. Residents and staff told inspectors that he encouraged them to raise issues of concern and felt that they were listened to.

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:
The inspectors were shown records of some medication errors and were informed that while other errors had occurred, records could not be found and therefore were not available on the day of inspection.

While schedule 5 policies were available and systems were in place to review and update policies, inspectors noted that some of the policies had not been updated by the review date indicated. The provider informed inspectors at the feedback meeting held at the end of the inspection that all policies had been recently updated and were available to download on the computerised system. The updated versions of some policies had not been made available to staff. Staff had not signed as having read and understood updated versions of the policies.

Gaps were noted in the curriculum vitas of some staff members, therefore a full employment history together with a satisfactory history of any gaps in employment was not always available.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
While the provider and person in charge had taken some measures to safeguard residents from being harmed and from suffering abuse, inspectors found that the provider had not ensured that all persons who were employed in the centre and persons who provided services to residents on a regular and on-going basis had Garda Síochána vetting in place. This was brought to the attention of the person in charge who undertook to address the issue as a priority. The operations manger confirmed that these staff members would no longer be rosterd on duty until such time as satisfactory Garda Síochána vetting was in place. This is discussed further under Outcome 18: Staffing. Inspectors found that a number of complaints concerning allegations of unsatisfactory staff interactions were recorded in the complaints book and some had not been notified to HIQA as allegations of abuse. These allegations had not been managed in line with the safeguarding policies and best practice. These matters have since been formally notified to HIQA and an investigation is currently taking place into the most recent incident.

The inspectors reviewed the comprehensive policies on protection of residents from abuse, responding to allegations of abuse and management of whistle-blowing. Staff spoken to confirmed that they had received training in relation to the prevention and detection of elder abuse and were knowledgeable regarding their responsibilities in this area. Training records reviewed indicated that most staff had received this training, however, four recently recruited staff had not yet received training. The person in charge informed inspectors that training was planned over the coming weeks.

The inspectors reviewed the policy and systems in place for the protection of residents' accounts and personal property. Inspectors were satisfied that safe, accountable and transparent systems were in place for the management and safeguarding of residents' finances and other valuables.

Inspectors reviewed the policies on behaviour management and restraint use. The policy on behaviours that challenged outlined clear guidance and directions to staff as to how they should respond and strategies for dealing with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The policy on restraint provided clear guidance for staff and was based on the national policy. Staff confirmed that they continued to promote a restraint free environment. There were two bed rails and one lap belt in use at the time of inspection.

The inspectors reviewed a sample of residents' files with bed rails in use and presenting with responsive behaviour. There was evidence of completed risk assessments, care plans and safety checks completed for use of bedrails. The inspectors noted that detailed, individualised responsive behaviour care plans were in place and ABC charts were being used to record episodes of responsive behaviour. Many staff had attended training on understanding and managing behaviours that challenged. Staff spoken with were knowledgeable regarding triggers and strategies used to deescalate situations.

There was evidence of access to and referral to psychogeriatric services. Some residents were prescribed psychotropic medications on an 'as needed' basis and inspectors noted that these were usually only administered as a last resort when other strategies outlined in care plans had not been successful.

The inspectors observed staff interacting with residents in a respectful and friendly manner. Residents were observed to be relaxed and happy in the company of staff. Residents spoke highly of staff and stated that they were happy and felt safe living in the centre.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The provider had systems in place to protect the health and safety of residents, staff and visitors, however, improvements were required to some aspects of infection control including cleaning of communal and staff areas, to updating of the risk register and to providing mandatory training to all staff in fire safety, manual handling and infection control.

There was a recently updated health and safety statement available. The risk management policy was comprehensive and included reference to the risks specifically mentioned in the regulations. The person in charge outlined to inspectors that the risk register was due to be updated and recorded on the computerised system. The risk register available at the time of inspection was not clearly updated and it was not always clear if risks identified had been acted upon or not. A risk identified in March 2015 had not been addressed, this risk had been recently reviewed but no details or updates were included in the register.

There was a comprehensive recently updated emergency plan in place which included clear guidance for staff in the event of a wide range of emergencies including the arrangements should it be necessary to evacuate the building. There was personal emergency evaluation plan (PEEP) documented for each resident.

Training records reviewed indicated that most staff members had up-to-date training in moving and handling. A number of recently recruited staff did not have up to date manual handling training, the person in charge advised that this training was planned. An inspector observed an instance of poor manual handling practices in the main day

room while a resident was being transferred by two staff members from a wheelchair to the armchair. This was brought to the attention of senior nursing staff. This is included in an action under Outcome 18: Staffing.

The inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in March 2016 and the fire alarm was serviced on a quarterly basis. The fire alarm was last serviced in September 2016. Systems were in place for daily, weekly and monthly fire safety checks and these checks were recorded. Fire safety training took place annually and included evacuation procedures and use of fire equipment. Training records reviewed indicated that most staff had received up-to-date formal fire safety training. New staff members were given fire safety training as part of their induction and formal training was planned for recently recruited staff in November 2016. Records were maintained of regular fire drills, details of what worked well, future learning and actions were documented.

Handrails were provided to all circulation areas and grab rails were provided in all toilets and bathrooms. Call-bell facilities were provided in all rooms. Safe floor covering was provided throughout the building.

There was an infection control and prevention policy in place. Hand sanitising dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in their use. However, the inspectors noted that some communal areas such as the main corridors, staff toilet areas, smoking and hairdressing rooms were not visibly clean on the first day of inspection. Inspectors spoke with cleaning staff who were knowledgeable regarding infection control procedures, colour coding and use of cleaning chemicals. Staff confirmed that they had received training in infection control and hand washing techniques. Cleaning staff spoken with told the inspector that it was difficult to clean all areas of the centre thoroughly in the allocated time. This issue was discussed with the person in charge who agreed that additional cleaning hours were required and that he had discussed this with the operations manager. The inspectors noted that 24% of those surveyed in a recent relative questionnaire rated hygiene as fair or poor. Inspectors observed that staff uniforms were not stored in accordance with best practice in infection control. Some soiled uniforms were observed on the floor of the staff changing rooms while others were hanging in contact with outdoor clothing.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

implemented.

Findings:
The inspectors found that substantial improvements had taken place to address medicines management issues included in the last inspection report. Inspectors generally found evidence of good medicines management practices and sufficient policies and procedures to support and guide practice, however, some improvements were required to recording of medication stock, checks on receipt from the pharmacy and to the recording of administration of p.r.n. medicines 'as required' medications.(a medicine given as the need arises).

An inspector spoke with nursing staff on duty regarding medicines management issues. They demonstrated competence and knowledge when outlining procedures and practices on medicines management.

Medicines requiring strict controls were appropriately stored and managed. Secure refrigerated storage was provided for medicines that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis.

The inspector reviewed a sample of medicine prescribing/administration sheets. All medicines were regularly reviewed by the general practitioners (GP). All medicines were individually prescribed. The inspector reviewed prescription and administration records and observed that they were generally completed in accordance with best practice guidelines. However, the inspector noted that some p.r.n. medicines prescribed were documented as administered in the nursing notes but had not been signed as administered in the administration and prescription chart. Furthermore the dose administered was not always recorded.

Medicines were delivered in monitored dose units and nursing staff informed the inspector that these were checked by the night staff to verify that what was delivered corresponded with prescription records, however, there were no systems in place to record these checks. Systems were in place to record medicines errors and staff were familiar with them. The inspector was shown records of some medicine errors and was informed that while others had occurred, records could not be found on the day of inspection. Inspectors noted that some errors had resulted due to discrepancies between the prescription and medicines in the monitored dosage units.

Systems were in place for the return of out of date and unused medicines to the pharmacy.

Nursing staff confirmed that they had good support from the pharmacist who also provided ongoing training and advice to staff. Regular medicine management audits were carried out by the pharmacist and person in charge. Recent medicine management audits were reviewed and indicated good compliance.

Judgment:
Non Compliant - Moderate

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 found that a number of complaints concerning allegations of unsatisfactory staff interactions were recorded in the complaints book and some had not been notified to HIQA as allegations of abuse. These allegations have since been notified to HIQA.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
The inspectors found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

All residents had access to general practitioner (GP) services. There was an out-of-hours GP service available. The inspectors reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. Chiropody and optical services were also provided. The inspectors reviewed

residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes.

The inspectors reviewed a number of residents' files including the files of residents with wounds, restraint measures in place, presenting with responsive behaviour, at high risk of falls, with specific medical issues and nutritionally at risk. See Outcome 7: Safeguarding and safety in relation to the management of restraint and responsive behaviour.

Comprehensive up-to-date nursing assessments were in place for all residents. A range of up-to-date risk assessments were completed for residents including risk of developing pressure ulcers, falls risk, nutritional assessment, dependency and mobility.

Nursing documentation was generally found to be of a high standard. Care plans guided care and were regularly reviewed. Care plans were informative, individualised and person centered. There was evidence of relative and resident involvement in the review of care plans.

The inspectors were satisfied that wounds were being well managed. There were adequate up-to-date wound assessments, photographs and wound care plans in place.

The inspectors were satisfied that weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed regularly. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspectors confirmed this to be the case. Care plans in place were found to be person centered and very comprehensive. Nutritional supplements were administered as prescribed.

The inspectors reviewed the files of residents who had recently fallen and noted that the falls risk assessments and care plans had been updated following each fall. The physiotherapist visited the centre on a weekly basis and carried out post-falls assessments. Low-low beds, crash mats, chair and bed sensor alarms and hip protectors were in use for some residents. The inspectors noted that the day rooms were supervised by a member of staff at all times.

Staff continued to provide meaningful and interesting activities for residents. There was a full-time activities coordinator employed. The weekly activities schedule was displayed. The inspector observed residents enjoying a variety of activities during the inspection including fit for life exercise programme, word quiz, dog therapy and arts and crafts. Many of the residents actively took part and residents informed the inspectors that they enjoyed the variety of activities taking place. The activities coordinator told inspectors that during the summer months activities included gardening and day trips to areas of local interest. Local school children visited regularly and local musicians visited. A detailed 'Key to me' was documented in each residents file which clearly outlined residents likes and dislikes, hobbies, interests and preferred daily routines. Records were maintained of each residents participation in activities. There was a range of daily and local newspapers delivered to the centre and many residents enjoyed reading the

newspapers. The activities coordinator spent time visiting and spending 1:1 time with residents who preferred to stay in their bedrooms. Residents spoken with confirmed that this took place. Residents had recently visited the local walled gardens, local museum and some had attended the local fair.

Judgment:
Compliant

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 centre was two storey in design, purpose built and suited its intended purpose. Some parts of the building were not maintained in a clean condition. This had already been discussed under Outcome 8: Health and safety and risk management while other areas required repair and maintenance. Inspectors noted that the quality of some bed linen in use was poor.

There was a variety of communal day spaces on both floors including day rooms, dining room, smoking room, quiet room, visitors' room, oratory and seating provided in the front entrance area. The communal areas had a variety of comfortable furnishings and were domestic in nature.

Bedroom accommodation met residents' needs for comfort and privacy. There was adequate numbers of assisted toilets, bath and shower rooms. Assisted toilets were located beside the day rooms. There was a nurse call-bell system in place.
Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. Some residents spoken to stated that they liked their bedrooms.

Residents had access to an enclosed garden area, which was paved and had raised flower beds. Some seating benches were provided.

There was appropriate assistive equipment provided to meet the needs of residents, including hi-low beds, hoists, specialised mattresses and transit wheelchairs. There was a lift provided between floors. The inspector viewed the maintenance and servicing

contracts and found that equipment was regularly serviced.

Inspectors noted that the building was secure. The front external door had a key coded security system in place. All external doors were fitted to the fire alarm and CCTV cameras were installed at the external door exit areas to ensure additional safety.

The inspectors noted that some parts of the building required further maintenance such as:
- the floor sealer around the toilet located on the ground floor beside the entrance to the dining room was blackened
- the light to the entrance lobby to this toilet was not working
- the toilet seat to the ladies staff toilet was broken
- the hot water tap to the hand washing sink on the first floor corridor was defective
- there was no light in the toilet located on the first floor beside the day room.

Inspectors noted that some bed sheets in use were very worn, some were found to be thread bare. When this was brought to the attention of the person in charge, he advised that new bed sheets had been acquired; however, inspectors noted many of the worn sheets on beds and on the clean bed linen trolley.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
The inspectors found that the management team had a positive attitude to receiving complaints however, the management and documentation of complaints required improvement.

There was a complaints policy in place dated October 2012, while it included details of the complaints officer and appeals process, it was outside of its review date. The complaints procedure was displayed in the front entrance lobby area along with a comment/suggestion box however, the majority of residents did not have access to this area. This was brought to the attention of the person in charge on the first day of the inspection. The complaints procedure was prominently displayed in the hallway beside the main dayroom on the second day of inspection.

The inspectors reviewed the complaints log, details of which were recorded on the computerised system. There was one open complaint at the time of inspection. Inspectors reviewed some of the closed complaints logged and noted that details of investigations carried out were not always clearly documented in line with the regulations and the centres own complaints policy.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
On the day of inspection, inspectors noted sufficient staff on duty to meet the needs of residents, however, the hours allocated to cleaning staff required review. There were two nurses including a clinical nurse manager (CNM) and six care assistants on duty during the morning time, two nurses and five care assistants on duty in the afternoon, two nurses and six care assistants on duty in the evening and two nurses and two care assistants on duty at night time. The person in charge was normally also on duty during the day time. There was a full-time activities coordinator employed Monday to Friday. Inspectors reviewed the staff rotas and noted that these staffing levels were the norm.

Cleaning staff spoken with told the inspector that it was difficult to clean all areas of the centre thoroughly in the allocated time. This issue was discussed with the person in charge who agreed that additional cleaning hours were required and that he had discussed this with the operations manager.

Nursing registration numbers were available for all staff nurses.

Inspectors reviewed the recently updated comprehensive recruitment policy, however, the policy was not always fully implemented in practice. Inspectors reviewed a sample of staff files and noted that satisfactory Garda Síochána vetting was not in place for all staff. This was already discussed and included in an action under Outcome 7: Safeguarding and safety.

Gaps were noted in the curriculum vitas of some staff members, therefore a full employment history together with a satisfactory history of any gaps in employment was not always available. This action is included under Outcome 5: Documentation to be kept at the designated centre.

The management team continued to provide on-going training to staff. Training records indicated that staff had attended recent training in relation to understanding and managing challenging behaviour, dementia care, infection prevention and control and medication management.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary Costelloe
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Kilrush Nursing Home
Centre ID:	OSV-0000452
Date of inspection:	17/10/2016
Date of response:	14/11/2016

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:
Improvements were required to maintaining effective oversight of cleaning and infection control, ensuring policies were up to date and implemented in the centre, ensuring that appropriate and suitable bed linen was in use, ensuring all staff and persons who provided services to residents had satisfactory Garda Síochána vetting in place, ensuring all staff files contained the required documentation, ensuring notification to the Chief Inspector of allegations of abuse, management of those

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

allegations and complaints management.

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.

Please state the actions you have taken or are planning to take:
• A deep clean of the home has been completed and more effective controls are in place for enhanced monitoring and oversight of standards of cleanliness and infection control.
• An additional 2 hrs per day cleaning hours have been added to the Housekeeping Department to ensure hygiene standards are maintained.
• All policies that pertain to cleaning and infection control have been updated and made available to staff for review and signing.
• Additional Bed Linen has been purchased and is in use.
• There is documentary evidence of completed Garda Vetting on all staff files.
• The Chief Inspector has been notified retrospectively of all recent allegations of abuse which were managed as complaints.

Proposed Timescale: Completed 08/11/16

Proposed Timescale: 08/11/2016

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 updated versions of some policies were not available to staff in the centre.

2. Action Required:
Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

Please state the actions you have taken or are planning to take:
• The updated versions of policies are now available to staff in the centre.

Proposed Timescale: Completed 20/10/16

Proposed Timescale: 20/10/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Gaps were noted in the curriculum vitas of some staff members, therefore a full employment history together with a satisfactory history of any gaps in employment was not always available.

3. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
• One staff member with gaps identified in his CV was updated and forwarded to the Inspector on the second day of the inspection. The remaining CV with gaps has now been updated with a full employment history explaining gaps and is available for review.

Proposed Timescale: Completed 08/11/16

Proposed Timescale: 08/11/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records relating to all medication errors were not available at the time of inspection.

4. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
• Records relating to medication errors have now been located and are now available for inspection by the Chief Inspector. The PIC will ensure that all medication incidents are reported, recorded, investigated and corrective action taken where required.

Proposed Timescale: Completed 19/10/16

Proposed Timescale: 19/10/2016

Outcome 07: Safeguarding and Safety
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Four recently recruited staff had not yet received training in safeguarding of residents. **5. 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:** • All four recently recruited staff have now completed training on safeguarding of residents. Proposed Timescale: Completed 09/11/16
Proposed Timescale: 09/11/2016
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The provider had not ensured that all persons who were employed by the centre and persons who provided services to residents on a regular and on-going basis had Garda Síochána vetting in place. **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:** • All persons who are employed by the Centre and provide services to Residents now have Garda Síochána vetting in place. • All staff are trained in the detection, prevention and response to allegations or suspicions of abuse. Proposed Timescale: Completed 08/11/16
Proposed Timescale: 08/11/2016
Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of complaints concerning allegations of unsatisfactory staff interactions were recorded in the complaints book. These allegations had not been managed and investigated in line with the safeguarding policies and best practice.

7. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
• All complaints concerning allegations of unsatisfactory staff interactions have now been fully and thoroughly investigated. Notifications have been made retrospectively to the Chief Inspector and an internal investigation report has been submitted to the Inspector in relation to the most recent allegation of unsatisfactory staff interaction.

Proposed Timescale: Completed 25/10/16

Proposed Timescale: 25/10/2016

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 following respect:
The risk register available at the time of inspection was not clearly updated and it was not always clear if risks identified had been acted upon or not. A risk identified in March 2015 had not been addressed, this risk had been recently reviewed but no details or update were included.

8. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
• The risk register has now been reviewed and updated and corrective actions have been made to address the risk identified in March 2015
• A new lock has been fitted to a storage cupboard in the first floor Kitchenette to ensure that electrical appliances and cleaning chemicals can be safely stored when the Kitchenette is left unattended.
• Work has been scheduled for to fit a mag lock with key pad to the Kitchenette doors as an additional safety measure to ensure residents can gain entry to the Kitchenette, only when supervised.

Proposed Timescale: 25/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some communal areas such as the main corridors, staff toilet areas, smoking and hairdressing rooms were not clean on the first day of inspection. Staff uniforms were not stored in accordance with best practice in infection control, soiled uniforms were observed on the floor of the staff changing rooms while others were hanging in contact with outdoor clothing.

9. 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:
• A deep clean of the home has been completed and enhance cleaning and monitoring of these areas is now in place
• Staff Uniforms are now stored in accordance with best practice in infection control.
• The procedures for monitoring standards for the prevention and control of healthcare associated infection will be reviewed to ensure that they are in accordance with national standards and the guidelines published by the Authority.

Proposed Timescale: 30/11/2016

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:
Some medications prescribed on a PRN 'as required' basis were documented as administered in the nursing notes but had not been signed in the administration and prescription chart and the dose administered was not always recorded.

Medications were delivered in monitored dose units and nursing staff informed the inspector that these were checked by the night staff to verify that what was delivered corresponded with prescription records but there were no systems in place to record these checks. Inspectors noted that some medication errors had resulted due to discrepancies in the monitored dosage units.

10. 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:
• Incidents where PRN medication was recorded as given in the progress notes but not signed in the Residents administration and prescription chart have been addressed with the relevant Nurse who made this documentation error. The importance of charting the dose administered for PRN medications has been addressed with all Registered Staff.
• A checking system is now in place to ensure that medications delivered to the Centre corresponds with Residents' prescription records

Proposed Timescale: Completed 24/10/16

Proposed Timescale: 24/10/2016

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:
Inspectors found that a number of complaints concerning allegations of unsatisfactory staff interactions were recorded in the complaints book and some had not been notified to HIQA as allegations of abuse.

11. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
• All allegations concerning unsatisfactory staff interactions which were recorded in the complaints log have been notified retrospectively as allegations of Abuse to the Chief Inspector.

Proposed Timescale: Completed 21/10/16

Proposed Timescale: 21/10/2016

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:
Some parts of the building required repair and maintenance such as
- The floor sealer around the toilet located on the ground floor beside the entrance to the dining room was blackened
- the light to the entrance lobby to this toilet was not working
- the toilet seat to the ladies staff toilet was broken
- the hot water tap to the hand washing sink on the first floor corridor was defective
- there was no light in the toilet located on the first floor beside the day room.

Some bed sheets in use were very worn, some were noted to be thread bare.

12. 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:
• All of the above repairs and maintenance have been completed, including replacement of worn sheets with new linen.

Proposed Timescale: Completed 25/10/16

Proposed Timescale: 25/10/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Details of investigations carried out as a result of complaints were not always clearly recorded.

13. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:
• All complaint investigations have been reviewed, fully investigated, appropriately actioned and clearly documented.

Proposed Timescale: Completed 21/10/16

Proposed Timescale: 21/10/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of recently recruited staff did not have up to date manual handling training. An inspector observed an instance of poor manual handling practices in the main day room while a resident was being transferred by two staff members from a wheelchair to the armchair.

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

Please state the actions you have taken or are planning to take:
• All recently recruited staff are scheduled to complete their manual handling training on Thursday November 17th 2016

Proposed Timescale: Completed 17/11/16

Proposed Timescale: 17/11/2016