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:	Kilminchy Lodge Nursing Home
Centre ID:	OSV-0000052
Centre address:	Kilminchy, Portlaoise, Portlaoise, Laois.
Telephone number:	057 866 3600
Email address:	kilminchylodgenh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Kilminchy Lodge Nursing Home Limited
Provider Nominee:	Florence McCarthy
Lead inspector:	Sheila Doyle
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	2

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 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 compliance with specific outcomes as part of a thematic inspection. 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:
21 March 2017 10:00	21 March 2017 18:00
22 March 2017 09:00	22 March 2017 16:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant

Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and the inspector's rating for each outcome.

The inspector met with residents, relatives, and staff members during the inspection. The journey of a number of residents with dementia was tracked. Care practices and interactions between staff and residents who had dementia were observed and scored using a validated observation tool. Documentation such as care plans, medical records and staff training records were also reviewed.

Kilminchy Lodge Nursing Home is a purpose-built single-storey centre, which provides residential care for 52 people. Approximately 16% of residents have been diagnosed with dementia. There is no specific dementia unit in the centre.

The overall atmosphere was homely and comfortable. There were appropriate staff numbers and skill mix to meet the assessed needs of residents. Improvement was required to ensure that staff files contained all documents specified in the regulations. Staff were offered a range of training opportunities including a range of dementia specific training courses.

Safe and appropriate levels of supervision were in place to maintain residents' safety. There were policies and procedures in place around safeguarding residents from abuse. Some improvements was required relating to the assessment of residents who, due to their conditions, had episodes of responsive behaviour. Improvement was also required to ensure that appropriate care plans were in place to address residents' assessed needs. One aspect of medication management required review.

While the results from the observations were encouraging, additional work is required to ensure that the majority of staff interactions with residents promote positive connective care. Improvement was required to ensure that all residents had opportunities to participate in activities in accordance with their interests and capacities.

In order to ensure the design and layout of the premises will promote the dignity, well being and independence of residents with dementia the provider needs to complete some actions in relation to the premises.

These are discussed further in the report and included in the action plan at the end.

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
The inspector was satisfied that each resident's wellbeing and welfare was maintained by an acceptable standard of nursing care and appropriate medical and allied health care. However the arrangements to meet each resident's assessed needs were not consistently set out in an individual care plan. Some improvement was also required to medication management practices.

Improvement was required around the storage arrangements for medications that required strict controls. The inspector checked the stock balance of a sample of these medications. Although the balances were correct, unsafe practices were observed. The practice was that the controlled drugs were supplied for individual residents with the resident's name on the label and box. However the inspector noted that in some cases the medications had been removed from the boxes that they were supplied in and put into other boxes with similar medication increasing thereby increasing the risk of error.

Otherwise the inspector saw evidence of safe medication management practices. The inspector reviewed a sample of administration and prescription records and noted that they were in line with national guidelines. Improvement required from the previous inspection relating to medications to be administered as and when required had been completed.

Pharmacy services were also available for advice, support and training.

The inspector reviewed some clinical issues such as wound management practices and saw that although recent improvements had occurred, further improvement was required. Wound assessment and treatment charts were in place and residents had access to the services of a tissue viability nurse. However the inspector saw in one case that although the resident required wound care there was no care plan in place to inform practice.

The inspector saw that the recommendations of the dietician or speech and language therapist (SALT) were not consistently incorporated into the care plans or practices. For

example the inspector saw that a resident was recently reviewed by SALT and a specific diet was recommended. However the care plan had not been updated to reflect this change.

The inspector found several examples of these types of inadequate documentation. In relation to some residents with dementia, there were no specific care plans in place to support a consistent approach to the care and management of the residents. These issues were discussed in detail with the provider nominee and person in charge at the feedback meeting.

Samples of clinical documentation including nursing and medical records were reviewed which indicated that all recent admissions to the centre were assessed prior to admission. The pre-admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident. There was documented evidence that residents and their families, where appropriate, were involved in the care planning process.

Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available on referral including speech and language therapy (SALT) and occupational therapy (OT) services. Physiotherapy services were available on site. Chiropody, dental and optical services were also provided. The inspector reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes.

The inspector was satisfied that residents' nutritional needs were met. Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weights were also recorded on a regular basis.

The inspector noted ongoing improvements in the choice and presentation of meals. The inspector saw that the chef regularly carried out a survey speaking to each resident and asking what changes they would like to see to the menu. These suggestions were then incorporated into the menu cycle. The inspector observed the dining experience and saw that improvements had occurred since the previous inspection. Tables were nicely laid, condiments were available and adequate staff were now in the dining room to assist residents who required it. This was an action required from the previous inspection.

Residents told the inspector that they now had baking sessions and they were looking forward to doing some Easter baking.

The inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided. The inspector found that there were care practices and facilities in place so that residents received end-of-life care in a way that met their individual needs and wishes. Previous initiatives undertaken continued. Having reviewed a sample of care plans the inspector was satisfied that each resident or their relative had been given the opportunity to outline their wishes regarding end of life. The person in charge stated that the centre received advice and support from the local palliative care team.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
The inspector found that although measures were in place to protect residents from being harmed or abused, improvement was required around the management of responsive behaviours.

Because of their medical conditions, some residents had episodes of 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 inspector saw however that assessments had not been completed and therefore possible triggers and appropriate interventions were not recorded in their care plans. A detailed policy was in place but was not being implemented.

The inspector saw however that staff approached residents with responsive behaviour in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. The inspector noted that training had been provided for staff and additional training was scheduled for the coming months. Support and advice were available to staff from the psychiatry of later life services.

Staff had received training on identifying and responding to elder abuse. There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. Additional training was scheduled for the coming months.

Improvements were noted around the use of restraint and usage was now lower than at previous inspections. Staff had attended specific training. The inspector noted that appropriate risk assessments had been undertaken and regular safety checks were completed when bedrails or lap belts were in use. There was documented evidence that alternatives had been tried prior to the use of restraint as required by the centre's policy. Staff spoken with confirmed the various strategies that had been tried. Additional equipment such as low level beds, sensor alarms and crash mats had also been purchased to reduce the need for bedrails.

The provider was an appointed agent for some residents who were unable to manage their financial affairs. The provider nominee was aware of his obligations as an

appointed person and he discussed plans underway to change the current system to provide additional safeguards to residents. The inspector reviewed the current system and saw that all deposits and withdrawals were documented and balances checked were correct.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
The inspector was satisfied that residents were consulted on the organisation of the centre, and that their privacy and dignity was respected. However, the inspector saw that sometimes the activities did not reflect the capacities and interests of each individual resident.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia. The observations took place in the day room and the dining room. Observations of the quality of interactions between residents and staff for selected periods of time indicated that the majority of interactions reflected task orientated care while 26% indicated neutral care.

The inspector noted that while the activity coordinator was delivering care to a resident on a one to one basis, many other residents were unoccupied and many were sleeping. This was discussed with the provider and person in charge following the inspection.

Despite this the inspector saw that the activity coordinator was committed to meeting the needs of the residents. She discussed plans to improve the activity programme and to attend additional training which was already scheduled for the coming months.

Residents' civil and religious rights were respected. Residents confirmed that they had been offered the opportunity to vote at election time. In-house polling was available. Religious services were celebrated on a regular basis and residents told the inspector how grateful they were for this. Each resident had a section in their care plan that set out their religious or spiritual preferences.

There was a residents' committee in operation. Issues discussed included activities and menu choices. Satisfaction surveys had also recently been completed and the results were currently being analysed to inform improvements.

Independent advocacy services were available to residents.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The complaints of each resident including residents with dementia, his or her family, advocate or representative and visitors were listened to and acted upon and there was an effective appeals procedure.

There was a complaints policy in place which met the regulatory requirements. The inspector reviewed the complaints log and found it contained details of the complaints made, the outcome of complaints and whether the complainants were satisfied with the outcomes.

The procedure was on display in the front hall.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector was satisfied that, at the time of inspection, there were appropriate staff numbers and skill mix to meet the assessed needs of residents taking into account the size and layout of the centre. All staff were supervised on an appropriate basis. Improvement was required to staff files.

The inspector reviewed a sample of staff files and found that some did not hold all the relevant documents as required by Schedule 2 of the regulations. For example, details and documentary evidence of relevant training was not consistently included.

Garda Vetting was in place for all staff. An actual and planned roster was maintained in the centre with any changes clearly indicated. The inspector reviewed the roster which reflected the staff on duty. Systems were in place to provide relief cover for planned and unplanned leave. Up to date registration numbers were in place for nursing staff.

There was an induction programme in place for new staff. Appraisals also took place regularly. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included training in dementia care, infection control and managing responsive behaviours. The inspector saw that additional training was planned for the coming months.

The inspector was satisfied that on the day of the inspection, there were appropriate staff numbers and skill mix to meet the assessed needs of residents including residents with a dementia. The inspector noted that additional staff were now rostered at various times during the day to provide additional supervision for residents. This was an action required from the previous inspection and the person in charge confirmed that she continually monitors the staffing levels.

Several volunteers attended the centre and provided very valuable social activities and services which the residents said they thoroughly enjoyed and appreciated. These had been vetted appropriate to their role. Their roles and responsibilities were set out in writing as required by the regulations.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Kilminchy Lodge Nursing home is a single storey building consisting of 44 single rooms, 36 of which have en suite facilities. Some of the en suite facilities are shared between two rooms. In addition there are 4 twin rooms, three of which have en suite toilet and wash hand basin facilities. Adequate screening was available in the shared rooms. Call bells were provided in all bedrooms and communal areas.

Some of the bedrooms were comfortable and had bright, fresh curtains and bed linen. However improvement was required in some rooms to ensure that were personalised to suit the residents. The inspector noted that some but not all had clocks to assist with orientation.

There was a large comfortably furnished day room to the front of the building. In

addition there was a separate lounge area midway down one wing.

The dining room was large and had another seating area at one side. Other areas included a smoking room, the front reception area, and staff office. The laundry was located in an adjacent building.

The corridors were wide, had grab rails, were clutter free and allowed residents plenty of space to walk around inside. Bedrooms were located on either side of the corridors which appeared to be dark because doors and floor coverings were dark.

The inspector noted that directional signage to assist residents with dementia, was minimal. The person in charge discussed plans to improve on this. The inspector noted that toilet doors had been painted a bright colour.

All areas were well maintained. Appropriate assistive equipment such as hoists, seating, specialised beds and mattresses was provided to meet residents' needs.

The inspector found that a high level of cleanliness and hygiene was maintained throughout the building. Staff spoken with were knowledgeable as regards infection control measures and the safe use and storage of cleaning chemicals and disinfectant agents.

Adequate arrangements were in place for the disposal of general and clinical waste. Ample parking was available at the front of the building.

There was an enclosed garden area off the dining room. This however was not freely accessible and was in need of some repair to ensure it was safe and accessible for residents. There were also other grounds around the building that residents did not have access to.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	Kilminchy Lodge Nursing Home
Centre ID:	OSV-0000052
Date of inspection:	21/03/2017
Date of response:	30/03/2017

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no specific care plans in place to support a consistent approach to the care and management of residents with dementia.

Although a resident required wound care, there was no care plan in place to inform practice.

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

Please state the actions you have taken or are planning to take:
The Dementia specific care-plans are currently being put in place as per recommendations. Resident requiring wound care plan, had same put in place and put forward to be seen by inspector before end of inspection.

Proposed Timescale: Remaining Dementia specific care plans corrections will be completed by Friday April 7th 2017.

Proposed Timescale: 07/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recommendations of the dietician or speech and language therapist (SALT) were not consistently incorporated into the care plans or practices.

2. 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:
The Nutrition care plan of a resident who had been reviewed by SALT had new recommendations and this was not documented in the care plan as it should have been but was documented in the review notes and narrative notes instead. This was amended immediately by staff nurse. All staff nurses have been informed re proper documentation of any changes into the appropriate care plan rather than only documenting in review notes.

Proposed Timescale: 22/03/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate arrangements were not in place for the storage of medications that required strict controls.

3. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or

supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
PIC has sourced key for medication fridge . The Practice of removing a butrans patch which may be last one in box and adding it to another box has been discontinued. The PIC has spoken to all staff nurses with regard to this practice and this is not to happen again. The residents who are on Butrans patch will now have their individual box placed in its own zip locked plastic pocket with the proper identification.

Proposed Timescale: 22/03/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Possible triggers and appropriate interventions to manage responsive behaviours were not recorded in care plans.

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

Please state the actions you have taken or are planning to take:
The appropriate interventions to manage responsive behaviours are being documented in ABC charts and kept with narrative notes but not recorded in the individual resident care plan. This practice is currently being checked in all care plans and appropriate documentation entered in the care plan for challenging behaviours.
In addition to this PIC will arrange to send staff nurses on training in preparation and documentation of specific care plans for older persons.

Proposed Timescale: 27/04/2017

Outcome 03: 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:
The activity programme did not meet the needs of the residents.

5. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to

participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The PIC has met with activity co- ordinator in relation to an urgent need to implement a more robust activity programme. Residents meeting is planned in order to involve them in what changes they would like to see, e.g. A second room to be organised so that residents with different or specific needs can be facilitated, also if favourable to Residents to introduce a variety of group activities at the one time in the main day room giving all residents something to take part in.

Proposed Timescale: Residents meeting proposed for Thursday 6th April 2017. Following on with introduction of changes decided on to commence on Monday 10th April 2017.

Proposed Timescale: 10/04/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff files did not have all the relevant documents as required by Schedule 2 of the regulations. For example details and documentary evidence of relevant training was not consistently included.

6. 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:
Staff involved have been spoken to and given the time frame of two weeks to provide missing documentation

Proposed Timescale: 13/04/2017

Outcome 06: 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 enclosed garden area was not freely accessible and was in need of some repair to ensure it was safe and accessible for residents.

7. 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:
Maintenance department had already been informed of this necessary work. Centre just waiting on work to commence

Proposed Timescale: 01/05/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that bedrooms were personalised to suit the residents.

Corridors appeared to be dark because doors and floor coverings were dark.

Directional signage to assist residents with dementia, was minimal.

8. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
PIC met with a representative from (Dementia related company) on 28th April 17 to get advice and costings on suitable signage and colours for dementia residents with a view to making changes.
Personalisation of Residents Rooms on Agenda for Residents Meeting on 6th April 17

Proposed Timescale: To commence 10th April based on decisions made by Residents.

Proposed Timescale: 10/04/2017