Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centres for Older People

Name of designated centre:	Kilminchy Lodge Nursing Home
Name of provider:	Kilminchy Lodge Nursing Home Limited
Address of centre:	Kilminchy, Portlaoise, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	20 and 21 March 2018
Centre ID:	OSV-0000052
Fieldwork ID:	MON-0020946

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This is a single-storey purpose built centre. Kilminchy Lodge Nursing Home is staffed by qualified nursing and care staff at all times and caters for residents whose dependency levels range from low to maximum. It accommodates both female and male residents over the age of 18 years with a wide range of care needs. This centre can accommodate up to 52 residents. It has 44 single rooms, 36 of which have en-suite facilities. Some of the en-suite facilities are shared between two bedrooms. In addition, there are four twin rooms, three of which have en-suite toilet and wash-hand basin facilities. Adequate screening is available in the shared rooms. Call bells are provided in all bedrooms and communal areas. Additional toilets and shower rooms are wheelchair accessible.
There is a large living room where many of the daily activities take place. The purpose-built kitchen is adjacent to the large dining area with ample natural lighting which leads to a secure outdoor area. An additional sitting room is also available.
The centre is situated in a busy town and is serviced by nearby restaurants/pubs/libraries/ pharmacies/ GP surgeries etc.

The following information outlines some additional data of this centre.

Current registration end date:	31/01/2019
Number of residents on the date of inspection:	51

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information and information submitted by the provider or person in charge since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk to staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre.
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarize our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
20 March 2018	10:00hrs to 17:30hrs	Sheila Doyle	Lead
21 March 2018	09:00hrs to 14:30hrs	Sheila Doyle	Lead

Views of people who use the service

Residents gave generally positive feedback about the service they were receiving.

Residents said that they would talk to staff if they had any concerns. They knew who to approach if they had a complaint and felt it would be addressed.

Residents said they were consulted with, on a daily basis, and regular residents' meetings were facilitated. Throughout the inspection, residents were seen to be treated with dignity and respect and their wishes were respected.

All residents reported satisfaction with the food and said choices were offered at meal times. Some residents said it was like being in a hotel. They described staff as kind and caring and that everyone does their best for you.

Capacity and capability

Overall, a good service was being provided to the residents, but some improvements were needed to ensure that recruitment practices were in line with the regulations, and the policy in place.

The inspector saw that staff files were incomplete. This was identified as a non-compliance at previous inspections but had not been addressed within the agreed timescale. Four files were reviewed, and none contained all the required information under Schedule 2 of the regulations.

The person in charge was a registered nurse, worked full-time in the centre and had the required experience in nursing older people. The inspector interacted with the person in charge throughout the inspection process and was satisfied that she was effectively engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector found that a robust governance structure was in place. There was evidence of effective leadership and management which resulted in a positive impact on the care and support for residents. There was a clearly defined organisational structure.

The person in charge assured the inspector that Garda Síochána (police) vetting was in place for all staff.

Following a review of the staff rosters, residents' care records including dependency needs, and feedback from residents, the inspector was satisfied that there were

sufficient staff on duty to meet residents' needs.

Since the previous inspection, there had been an increased emphasis on staff training and the majority of staff had received mandatory training. However on reviewing the training records, the inspector was unable to determine if all staff had received training on safeguarding vulnerable adults or infection control. This non-compliance is included under the section on quality and safety.

The inspector found that the quality of care, and experience of residents was monitored, and reviewed on an ongoing basis. The inspector saw that the annual review of the quality and safety of care was completed. It was noted that this was presented in a resident-friendly format. In addition, an auditing schedule was in place, and the inspector saw that this included detailed action plans when required.

There were no volunteers currently in the centre, but the person in charge was aware of the regulatory requirements for volunteers.

Regulation 14: Persons in charge

The person in charge is a registered nurse and has the required experience in nursing older people.

She continues to attend clinical courses such as medication management and dementia care.

During the inspection she demonstrated her knowledge of the regulations and the standards and outlined plans in place to further improve the service. The person in charge was observed frequently meeting with residents, visitors and staff throughout the days of inspection and it was obvious that she was well known to all.

Judgment: Compliant

Regulation 15: Staffing

At the time of inspection, there were appropriate staff numbers and skill-mix to meet the assessed needs of residents and the safe delivery of services.

Judgment: Compliant

Regulation 16: Training and staff development

Since the previous inspection, there had been an increased emphasis on staff training and the majority of staff had received mandatory training. However on reviewing the training records, the inspector was unable to determine if all staff had received training on safeguarding vulnerable adults or infection control. This non-compliance is included under the section on quality and safety.

Judgment: Compliant

Regulation 21: Records

Four of four staff files reviewed did not meet the requirements of the regulations. Gaps included lack of two references, lack of a reference from a recent employer, lack of documentary evidence of qualifications and incomplete employment history.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had put in place a clear management structure and management systems to ensure the service was provided in line with the statement of purpose.

Judgment: Compliant

Regulation 30: Volunteers

There were no volunteers in the centre at the time of inspection, but the person in charge was aware of the regulatory requirements when necessary.

Judgment: Compliant

Quality and safety

Overall, the findings showed that on the day of inspection, the residential centre was providing good quality care and support although some gaps were noted in the

training records.

It was noted that visitors were welcomed in the centre, and encouraged to participate in the residents' lives. Visitors spoken with confirmed this to the inspector. Visiting was unrestricted during waking hours. A lounge area was available for residents to receive visitors in private.

Noted improvements in the quality and safety of care included the arrangements in place to ensure each resident's assessed needs were consistently set out in an individual care plan. This had been identified as a non-compliance at the last inspection. Care plans were based on comprehensive assessments informed by input from the residents or their relatives. In addition, the inspector reviewed the management of clinical issues such as wound care and dementia care and found that improvements had occurred. Detailed assessment and treatment plans were in place.

The inspector was satisfied that, when needed, residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Detailed assessment and treatment plans were in place. Some staff had attended training and additional training was planned. Support and advice were available from the psychiatric services.

In addition, the inspector found that the overall use of restraint remained low and additional equipment such as low beds had been purchased to provide less restrictive alternatives. Detailed assessments were completed, adequate guidance was outlined in care plans, and safety checks were carried out when restraint was in use. Care plans reviewed now outlined the care to be provided when bedrails were in use, including how often safety checks should be completed to safeguard residents. The inspector saw that these checks were carried out in line with the care plan and the policy in place.

Although there were systems in place to safeguard residents, the inspector could not find evidence that all staff had received training in relation to the detection, and prevention of, and response to abuse, as required by the regulations. The inspector did note that some relevant training was already planned. The person in charge confirmed that the remaining staff will attend this training. Staff spoken with were clear on the procedure to follow should there be an allegation of abuse.

The provider had clear processes in place to protect residents' finances. Residents had the option of retaining a small amount of cash for safekeeping within the centre. Countersigned receipts were maintained for withdrawals and deposits.

The provider acted as a pension agent for a number of residents, and arrangements were in place to afford adequate protection and access to these finances.

The rights and diversity of each resident was respected and safeguarded. Ongoing training was in place on the provision of person-centred care.

Examples of this included assisting residents to develop and maintain personal relationships and links with the community. In addition, the inspector saw that residents had access to advocacy services and safeguarding services if needed.

The inspector found that each resident was offered a choice of appropriate recreational and stimulating activities within the centre. This had been identified as a non-compliance at the previous inspection. 'A key to me' and life stories were completed for residents as appropriate. This enabled staff to formulate a relevant activity programme. Residents showed the inspector the Easter cards they were currently making. It was also noted that many residents went out home or out locally with their relatives. The person in charge told the inspector that she was monitoring the activity programme on an ongoing basis, and speaking with residents, to ensure that it was sufficient to meet their needs.

Residents were facilitated to exercise their civil, political, and religious rights in accordance with their wishes.

The residential service was homely and provided adequate physical space to meet each resident's assessed needs. The inspector noted improvements to the premises since the last inspection. This included some directional signage, and the use of contrasting colours to aid orientation. While the premises was homely and comfortable for residents, some improvements were required to ensure that the decor is in keeping with the statement of purpose and meets residents' needs for privacy. Some residents said that they would like to be able to lock their bedroom door, however, this facility was not available. Other improvements required related to, but not limited to:

- broken tiles and discoloured grouting in some bathrooms and toilets
- inadequate storage for equipment
- damaged areas on walls and skirting boards
- some bedroom doors in need of redecoration
- inadequate ventilation in the sluice room
- inadequate staff facilities.

These were discussed with the provider at the feedback meeting. The inspector acknowledged that an extensive refurbishment plan is in place but some interim work will need to be completed.

The centre maintained a risk management policy and risk register which detailed and set control measures to mitigate risks identified in the centre. The risk management policy was in accordance with legislation.

The inspector found that some improvement was required to infection control procedures. It was noted that the majority of staff had not attended specific training or updating on the national standards. In addition, the inspector saw that some surfaces in the sluice room were uneven with sections of sealant missing which prevented adequate cleaning of this high risk area.

It was noted that hand hygiene gels were located around the centre and the

inspector saw staff and relatives using them.

The fire safety register and associated records were maintained, and precautions against the risk of fire were in place. The inspector saw that personal emergency evacuation plans (PEEPs) were developed for all residents to ensure that safe evacuation was possible if needed. Fire drills were carried out on a regular basis. The inspector saw that a night time drill was carried out at the time of inspection.

There were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. However, the inspector found that, in some cases, nursing staff were administering medication to residents in crushed form although it had not been specifically indicated on the prescription.

Otherwise the inspector found evidence of safe medicines management. Improvement required from the previous inspection relating to the custody and storage of medication that required strict controls had been addressed. Audits of medication management were ongoing, and there was evidence of input from the pharmacy services.

Regulation 11: Visits

It was noted that visitors were welcomed in the centre, and encouraged to participate in the residents' lives.

Judgment: Compliant

Regulation 17: Premises

The inspector noted improvements to the premises since the last inspection. This included some directional signage, and the use of contrasting colours to aid orientation. While the premises was homely and comfortable for residents, some improvements were required to ensure that the decor is in keeping with the statement of purpose and meets residents' needs for privacy.

Judgment: Not compliant

Regulation 26: Risk management

The centre maintained a risk management policy and risk register which detailed and set control measures to mitigate risks identified in the centre. The risk management policy was in accordance with legislation. Evidence was seen of risk assessments being completed, updated and reviewed. These included the specific risks relating to abuse, unexplained absence of a resident, accidental injury, self-harm and aggression and violence as required by regulation.

Judgment: Compliant

Regulation 27: Infection control

The inspector found that some improvement was required to infection control procedures. It was noted that the majority of staff had not attended specific training or updating on the national standards. In addition, the inspector saw that some surfaces in the sluice room were uneven with sections of sealant missing which prevented adequate cleaning of this high risk area.

It was noted that hand hygiene gels were located around the centre, and the inspector saw staff and relatives using them.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Precautions against the risk of fire were in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. However, the inspector found that, in some cases, nursing staff were administering medication to residents in crushed form although it had not been specifically indicated on the prescription.

Otherwise, the inspector found evidence of safe medicines management.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans were based on comprehensive assessments informed by input from the residents or their relatives. Improvements required from the previous inspection had been addressed.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Support and advice was available from the psychiatric services.

Staff had up-to-date knowledge and skills to respond to and manage responsive behaviours.

Judgment: Compliant

Regulation 8: Protection

Although there were systems in place to safeguard residents, the inspector could not find evidence that all staff had received training in relation to the detection, and prevention of, and response to abuse, as required by the regulations.

The provider had clear processes in place to protect residents' finances.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights and diversity of each resident was respected and safeguarded. Examples of this included assisting residents to develop and maintain personal relationships and links with the community. In addition, the inspector saw that residents had access to advocacy services and safeguarding services if needed. The inspector found that each resident was offered a choice of appropriate recreational and

stimulating activities within the centre. This was monitored on an ongoing basis.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kilminchy Lodge Nursing Home OSV-0000052

Inspection ID: MON-0020946

Date of inspection: 20/03/2018 and 21/03/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The PIC is currently checking all staff files to ensure that they do have accurate documentation, which is relevant to the individual employee and includes the necessary records relevant to the individual's roles and responsibilities. Staff files that are not compliant with the regulations will have the necessary absent documents obtained and securely filed in line with the requirements set out in the regulations This will be completed by April 20th. We have put a plan in place that the admin person will do monthly checks on all staff files to ensure that all necessary documents are obtained. The PIC will oversee that there are safe systems in place to ensure safe and effective recruitment practices going forward.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The provider is in the process of planning a 25-bedroomed extension at rear of building which will be incorporated into current building, and a detailed refurbishment of our existing 52 rooms will also be completed to provide all rooms with a separate en-suite. The living environment will be much more stimulating and enjoyable for our residents and their families. All of our residents will be involved in the decision-making process and will be kept up to date as the plan progresses. Meantime areas in main bathrooms ill have repairs completed with regard to tiling. The doors on some rooms will be refurbished to enhance their appearance. Residents will be helped to have a sense of • more ownership of their personal space e.g. some of our residents have asked to have their rooms re painted. We will ensure that colour schemes are appropriate to enhance their sense of belonging and enjoyment. Provider already has plan to re-place the kitchen floor covering and replacement of necessary equipment. Plan is also in place to do renovations on current staff room to provide proper facilities for a staff room facility for staff meal breaks as currently meals have to be taken in the residents' dining room. Maintenance will commence immediately with regard to applying new sealant to the	

washing area (Stainless steel) in the sluice rooms in order to bring these facilities in compliance with infection prevention and control guidelines.
Time frame for immediate upgrading and repair work will be approx. 8 weeks. We will set a goal for Monday June 11th.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The PIC will put in place an effective dissemination of information on infection control. This will involve all staff being asked to look at the current best practice DVD of infection control. This will commence on Thursday 28th March 18.
The remaining staff who have to receive their training from the HSE infection control clinical nurse specialist will be allocated to do so in early May with dates proposed for May 8th, 11th and 16th.
he PIC and CNM will put in place a continuous quality improvement plan for regular performance development of all staff in striving to create a person-centered approach to the prevention and control HCAI'S
We will put in place an in-house infection control committee. Time frame to put all this in place is by end of May 2018.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
PIC has met with Nursing Staff in relation to omission of CRUSH documentation from a Resident's Mars chart who was receiving crushed medication. Staff are all reminded again of their duty to ensure they practice the 10 rights of medication management at all times and a poster of the 10 rights is on each trolley within their view. Staff have been reminded that they must follow appropriate medicines management practices and have responsibility to ensure that at all times medicines are administered s prescribed by resident's doctor, and approved by the Pharmacist.
CNM will be asked to do regular medication competency drug rounds. The incorrect documentation on resident's file was corrected immediately by the dispensing Pharmacist and all staff informed.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
PIC has provided members of staff who have not completed the in-house training on safeguarding with the specific training video and those staff members have completed viewing of the video today Wednesday March 28th.
Training will be provided to all staff again in June/July of 2018 so as to have complete compliance in mandatory training every 2 years as set out in our company Policy. The PIC is confident that care staff and Nursing are all very confident in recognizing and reporting any concerns they might have with regard to any risk to a resident.

AII new staff are supervised. Care staff are always reminded that restraint can only be used in line with evidence-based practice and following a very detailed risk assessment by the multi-disciplinary team.
Safeguarding of all our residents is monitored on an on-going basis by Person in Charge.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	01 June 2018
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Orange	20 April 2018
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Substantially Compliant	Yellow	30 April 2018

	infections published by the Authority are implemented by staff.			
Regulation 29(5)	The person in charge shall 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.	Substantially Compliant	Yellow	21 April 2018
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	28 April 2018