<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Knightsbridge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000145</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Longwood Road, Trim, Meath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>046 948 2700</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:gmcdonald@barchester.ie">gmcdonald@barchester.ie</a></td>
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<td>Type of centre:</td>
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<tr>
<td>Registered provider:</td>
<td>HC Developments Unlimited Company</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Fiona Moncur</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Una Fitzgerald</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Vincent Kearns</td>
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<tr>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

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

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

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).
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**

<table>
<thead>
<tr>
<th>From</th>
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<tr>
<td>28 November 2017 08:00</td>
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<tr>
<td>29 November 2017 08:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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**Summary of findings from this inspection**

This report sets out the findings of a two day, unannounced inspection. The inspector's followed up on the action plan from the previous inspection.

During the course of the inspection, the inspector's met with residents, relatives, staff and the management team in the centre. The views of all were listened to, staff practices were observed and documentation maintained was reviewed.

Overall, the inspectors found that care was provided to a good standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management and staff of the centre promoted a person-centered approach to care were striving to improve residents’ outcomes. Residents were well cared for, had good access to health and social care services and expressed satisfaction with the assistance and support they received in the centre. Relative's spoken to were highly complementary of the care.

Management systems were in place within the centre that define the lines of responsibility and accountability. The person in charge responsible for the governance, operational management and administration of services and resources demonstrated sufficient knowledge and an ability to meet regulatory requirements.
The action plan from the last inspection in April 2017 was followed up. Overall, the inspector's were satisfied that actions had been completed. However, one action under Outcome 9 Medication Management relating to the timeframes for medication administration is restated. Major non-compliance was found within Outcome 7 Safeguarding and Safety. The measures in place to protect residents when a suspicion of abuse was reported did not result in appropriate action been taken to minimise any further risk.

The person in charge confirmed that all staff have completed Garda vetting.

The findings are discussed throughout the report and areas for improvement are outlined in the action plan at the end of the 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 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a defined management structure with lines of authority and accountability. The management team within the centre had undergone change in the preceding months and newly appointed staff were in acting positions.

The centre was managed by a suitably qualified and experienced nurse. The person in charge was in position since the last inspection in the centre and held authority, accountability and responsibility for the provision of the service. During the inspection she demonstrated that she had good knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre. Management systems in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored with regard to Safeguarding and Safety requires a full review. Due to the information that was disclosed during the inspection, the inspectors sought reassurance that all appropriate measures will be taken to safeguard residents and protect them from abuse. HIQA was formally communicated with through the notification process the following day, and received the detail of preliminary screening carried out. A full investigation with a follow up report will be forwarded once completed. This finding is actioned under Outcome 7 Safeguarding and Safety.

The centre had an auditing schedule and review system in place to capture statistical information in relation to resident quality outcomes and staffing arrangements. Policies and procedures were in place to guide practice and service provision. An annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017.

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

Findings:
Inspectors found that the policies and procedures were in place to protect residents from harm or suffering abuse but the response from management when allegations, disclosures and suspicions of abuse were reported were not consistently in line with the policy and required a full review. All staff had received training on identifying and responding to elder abuse. The frontline staff who spoke with inspectors displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. There was a policy dated August 2017 in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The inspectors followed up on all reports received since the last inspection and were satisfied that the appropriate steps had been taken and had been investigated. However, during this inspection the inspectors found clear evidence that the policy was not consistently adhered too. The inspectors found evidence that an allegation that was reported to the nursing management was not appropriately managed. The information was not escalated and consequently a safeguarding preliminary screening was not carried out with an appropriate follow up to ensure that all residents were safeguarded.

The centre promoted a restraint free environment. Additional equipment such as low beds, laser alarms and crash mats were available. The restraint register gave clear evidence of a reduction in the number of residents using bedrails. Risk assessments had been completed. Consent for the use of bedrails was in place and kept under review. The documentation reviewed gave clear evidence that safety checks were completed when bed rails were in use.

The centre had a policy on and procedures in place to support staff when working with residents who have responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Staff spoken with adopted a positive, person centered approach towards the management of responsive behaviours that challenge. The inspectors reviewed a sample of files. Staff were familiar with the de-escalation techniques best adopted to manage responsive behaviour. The care plans in place were person centered and guided practice. Inspectors were satisfied that residents were
provided with support that promoted a positive approach to responsive behaviours.

Small amounts of money were managed for some residents at their request. Inspectors were satisfied that this was managed in a safe and transparent way. Frequent checks of the balances were carried out to ensure that they were correct. The centre acts as a pension agent for one resident. The manager confirmed that the residents’ pension was held in their own named account.

**Judgment:**
Non Compliant - Major

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

**Findings:**
There was a centre specific safety statement and a risk management policy that had been most recently reviewed in January 2016. The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the centre which covered for example, risks such as residents' falls, fire safety risks and manual handing risks. There were adequate governance and supervision systems in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed by the person in charge on an on-going basis. Overall the premises appeared safe and there were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors and safe walkways were seen in the outside areas. Inspectors spoke to the facilities manager who outlined the arrangements for maintaining and monitoring health and safety in the centre. These included the health and safety committee meetings which were attended by the general manager, the person in charge, the head of each department such as household and kitchen, facilities manager, CNM and/or staff nurse representatives. This committee met approximately six times a year or more often if required. This meeting also kept the provider representative informed and reviewed health and safety issues including any incidents, accidents or near misses in the centre. This meeting also reviewed procedures and practices including risk management and fire safety in the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. All accidents and incidents were recorded on incident forms, were submitted to the person in charge and provider representative. Inspectors noted that there was evidence of suitable actions in response to individual incidents. For example, from a sample of records of incidents involving residents it was clearly recorded the action taken to support the resident following any untoward event. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any
learning/changes required to prevent reoccurrence. There was also evidence of further actions including reviews of practice, care planning, updated risk assessments and further staff training. However, the hazard identification process required improvement as a number of potential hazards were identified by inspectors that required action including:

- the potential trip hazard of a small step from the sitting room in the Boyne Unit required risk assessing
- the storage of staff coats and bags in an unrestricted store room and in an unrestricted cleaners room required risk assessing
- the absence of any support rails in the communal shower or assisted bathroom room required risk assessing

There were fire policies and procedures that were center-specific. The fire safety plan was viewed by inspectors and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Inspectors noted that here were copies of residents' personal emergency evacuation plan (PEEP's) stored in each unit and at the reception desk to the center. The person in charge outlined how these documents were made readily available to support staff in managing any emergency situation involving a resident in the center. Each staff member spoken to were familiar with residents' PEEP's and the individual evacuation requirements of residents. Inspectors examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been tested in May 2017, the fire alarm was last tested in September 2017 and the emergency lighting was also last tested in September 2017. In addition, there were records of daily/weekly and monthly fire safety checks including fire alarm and emergency lighting and monitoring of fire exits. The facilities manager outlined how fire evacuation drills were most recently recorded on November 13 2017. Fire safety drills were practiced at least eight times a year and all staff were recorded as attending fire safety training and fire evacuation practice drills. All staff including staff working night duty confirmed to by inspectors that they had received such training and attended fire evacuation drills. All staff spoken to demonstrated an appropriate knowledge and understanding of what to do in the event of fire.

Overall the premises, including the communal areas and bedrooms were found to be clean and there was adequate standard of general hygiene at the center. All hand-washing facilities had liquid soap. There were policies in place on infection prevention and control that were recorded as most recently reviewed in September 2016. There was personal protective equipment such as latex gloves and plastic aprons available in designed cupboards. Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. For example, regular training of staff, subtle staff infection control reminder notices and strategically placed hand sanitizer dispensers throughout the premises. Most staff that were interviewed demonstrated adequate knowledge of the correct procedures to be followed. The training matrix indicated that all staff had completed training in hand hygiene and infection prevention and control. However, the cleaning practices as described to inspectors was not adequate to ensure the prevention of cross contamination and required review. In addition, the following infection control issues required attention:

- some cleaning mops were observed to be stored in cleaning buckets which did not
promote effective drying and subsequent prevention of cross contamination
● the practice of storing linen trolleys with soiled linen in communal shower and bath rooms required review to ensure prevention of cross contamination
● the practice of sharing hoist lifting slings with more than one resident required review to ensure prevention of cross contamination.

Care plans reviewed contained a current manual handling assessment which had been completed and these plans referenced the specific equipment required for resident and staff safety. Manual handling practices observed were seen to be in line with current best practice. The training matrix recorded that all staff were trained in manual handling.

Judgment:
Substantially Compliant

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:
There was a written operational policy relating to the ordering, prescribing, storing and administration of medicines to residents. Actions required from the last inspection had been partially addressed. The medication management policy was last reviewed in September 2017. All medications that require crushing are individually prescribed by the doctor. The inspectors reviewed the actual administration times of medication as evidenced from the electronic system. There was evidence that residents’ medications are not always administered to residents within a reasonable timeframe of the prescribed administration time. This non compliance was found on the previous inspection. Inspectors also noted that administration times are at 2100 and 2300. However, inspectors were informed by some staff that the prescribed time 23:00 hours time does not meet with some residents needs, as the resident may have to be woken to take their night time medications. This was discussed at the feedback meeting and a further review is required.

Nursing staff were observed as they administered medications. Residents were unhurried and reminded of the purpose of the medicines administered. The processes in place for the handling and checking of controlled drugs were examined.

Internal audits of medicines management are carried out monthly. Medication errors were reviewed and learning from incidents and reported errors informed improvements to protect residents. In addition, an external provider carries out medicines management audits to ensure compliance with the regulations.
A system was in place for a regular prescription review by the resident’s general practitioner (GP) and pharmacist.

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

Findings:
Residents’ health care needs were met through timely access to medical services and appropriate treatment and therapies. Arrangements were in place to meet the health and nursing needs of residents. Access to a general practitioner (GP) and allied healthcare professionals, including physiotherapy, occupational therapy, dietetic, speech and language, dental, ophthalmology and specialist palliative care services were made available when required.

Residents had good access to allied health care services. The care and services delivered encouraged health promotion and early detection of ill health, which facilitated residents to make healthy living choices. There was evidence within the files that advice from allied healthcare professionals was acted on.

Pre-admission assessments were carried out and recorded for all residents that were admitted. There were processes described to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services. However, from one file reviewed there was no evidence that any information including an updated list of current medications had been sent with the resident to the admitting hospital.

On admission all residents have an assessment of their care needs carried out. Each resident had a personalised holistic care plan prepared within 48 hours of their admission which detailed their needs and choices. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Overall, inspectors found that care plans were person centered. The inspector noted numerous examples within each file reviewed that the care plans were person centered. The detail contained within the care plans evidenced that the staff were knowledgeable
on the specific care needs of residents under their care. The inspectors found clear
evidence that care plans were reviewed and evaluated in partnership with the resident
or relative, at intervals not exceeding four months as per the regulations. The inspectors
spoke with residents who were familiar with care plans. The residents also confirmed
that they were consulted with on any changes that are recommended.

There was evidence that a resident had declined treatment. The potential negative
impact of this decision had been explained by the nursing team and the resident
understood this decision. The resident and families decision was supported and
respected.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Staff spoken to stated that the centre was working to provide as homely an environment
as possible for residents. Since the last inspection improvement was noted in the
changes made to a number of parts of the center such as the opening up of the "Snug"
area which was a relaxing and inviting area. Many residents were seen visiting this area
and enjoying the activities that the activities coordinator facilitated over the course of
the two days. Inspectors noted that efforts had been made to create a more homely and
more interesting environment. For example the addition of soft furnishings, a selection
of book shelves with novels located on corridors, old pictures and clothes on an old
fashioned clothes stand. In addition, the inspectors noted that residents were
couraged to make their bedrooms very personal to their individual taste.

Inspectors noted that the overall ethos of the service upheld the individual rights,
dignity and respect for each resident. For example, the nursing assessment included an
evaluation of the resident's social and emotional wellbeing including suitable activities
assessments. Residents had access to the daily national newspapers, Skype, local
weekly newspapers, magazines, books and several residents were observed enjoying
newspapers. Residents had access to radio, television, and information on local events.
There was music therapy also provided to residents following a suitable assessment and
care plan development. It was evident to inspectors that residents had opportunities to
participate in some activities that were meaningful and purposeful to them and that
suited their needs, interests, and capacities. A range of activities were facilitated, for example, live music sessions, imagination gym and pet therapy. For each resident there was a "Life Story" document completed in each resident's care plans reviewed. These records were instrumental in developing staff knowledge and awareness into the background, preferences and social support needs of residents. These records were completed in consultation with residents and/or their representatives, as appropriate. Inspectors noted that staff were knowledgeable of each resident's life history, hobbies and preferences which also informed the planning of residents' activities. Inspectors noted that there was a positive and friendly atmosphere in the center between residents and staff. This was confirmed by residents and visitors that inspectors spoke with during this inspection.

The centre admits residents with diverse needs inclusive of residents that are young physically disabled. There was clear evidence that the management have assessed the care needs of this diverse group of residents and residents with complex needs. Staff were appropriately skilled and that extra allocated hours are provided to ensure that their specific requests where possible can be accommodated. Young residents are supported to develop and maintain links with the local community and attend local community services. A number of residents regularly went shopping, visited local sporting events, restaurants and occasionally the local pub. Some residents enjoyed frequent visits or outings including the occasional overnight visit away from the center and some residents regularly attended a local day care service.

Residents were facilitated to exercise their civil, political and religious rights. Residents were supported to vote in the center or at their local polling stations. Inspectors observed that residents' choice was respected wherever possible. Aside from the limitations of some parts of the premises, residents retained control over their daily life and were facilitated in terms of times of rising/returning to bed and whether they wished to stay in their room or spend time with others in the sitting rooms. Respect for privacy and dignity was evidenced throughout the inspection. Staff were observed to knock on doors and get permission before entering bedrooms. From speaking to residents it was clear that a number were able to advocate for themselves and/or with the support of their representatives. Inspectors noted that there was an independent advocacy service provided and the contact details of the advocate was placed in a prominent position, near the entrance to the center.

Judgment:
Compliant

**Outcome 18: Suitable Staffing**

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

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

Findings:
The action required from the previous inspection had been completed. Inspectors observed warm and appropriate interactions between staff and residents and observed staff chatting easily with residents. Residents spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to residents. There were systems of communication in place to support staff with providing safe and appropriate care. Inspectors joined handover meetings on both mornings of this inspection and noted good communication to ensure the continuity of care from one shift to the next was provided. Inspectors saw records of regular staff meetings at which operational and staffing issues were discussed. Inspectors saw that staff had available to them copies of the regulations and standards and inspectors found staff to be well informed and knowledgeable regarding their roles and responsibilities. However, following feedback from some residents and some staff in relation to staffing levels the person in charge agreed to review staffing levels to ensure there was sufficient staff to meet the needs of residents at all times.

Inspectors viewed the staff training and education records. One staff member had the lead for staff training and maintaining training records. A detailed overall training matrix was in place and individual records were also recorded in staff files. Mandatory training was in place and training records confirmed that staff had received up to date training in fire safety, safe moving and handling, safeguarding vulnerable persons and training in responsive behaviours. Other training provided included, infection control, falls management, cardio pulmonary resuscitation (CPR) and for nurses' medication management. Staff confirmed that they were facilitated and encouraged to attend training and through their staff appraisals were able to highlight their training needs.

Inspectors reviewed a sample of staff files which included all the information required under Schedule 2 of the Regulations. The provider representative confirmed that all staff and volunteers had been suitably Garda Vetted. Registration details with Bord Altranais agus Cnáimhseachais na hÉireannfor (Irish Nursing Board) for 2017 for nursing staff were seen by inspectors.

Judgment:
Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

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<th>Knightsbridge Nursing Home</th>
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<td>OSV-0000145</td>
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<td>28/11/2017</td>
</tr>
<tr>
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Requirements

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

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

Outcome 07: 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:
Inspectors found that the measures in place to protect residents from harm or suffering abuse and the response from management when allegations, disclosures and suspicions of abuse had been reported required a full review.

1. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
1. The Nursing Management team had immediate education completed regarding escalation of all concerns re safeguarding including verbal and written.
2. Staff forum with staff in Nursing Home to educate re raising concerns and reassurance given that no other safeguarding concerns were raised.
3. Daily clinical governance completed on walk around by management to ensure all safeguarding concerns are reported immediately and escalated if any.
4. Safeguarding social worker scheduled for training with Nursing management in January.
5. Preliminary screening training also carried out immediately with all Nursing Management.

Proposed Timescale: 30/01/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found evidence that an allegation that was reported to the nursing management was not appropriately managed. The information was not escalated and as a direct result a safeguarding preliminary screening was not carried out with an appropriate follow up to ensure that all residents were safeguarded.

2. 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:
1. The Nursing Management team had immediate education completed regarding escalation of all concerns re safeguarding including verbal and written.
2. Staff forum with staff in Nursing Home to educate re raising concerns and reassurance given that no other safeguarding concerns were raised.
3. Daily clinical governance completed on walk around by management to ensure all safeguarding concerns are reported immediately and escalated if any.
4. Safeguarding social worker scheduled for training with Nursing management in January.

Proposed Timescale: 18/12/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified including:
- the potential trip hazard of a small step from the sitting room in the Boyne Unit required risk assessing
- the storage of staff coats and bags in a unrestricted store room and in an unrestricted cleaners room required risk assessing
- the absence of any support rails in the communal shower or assisted bathroom room required risk assessing

3. 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:
- Risk assessment now in place however there is also a plan in place to remove hazard, small ramp being placed in doorway.
- Staff are not permitted to use these areas for storage, staff lockers available and staff to avail of same. Staff educated daily on same
- Risk assessment now in place. Plan is to fit a rail.

Proposed Timescale: 20/01/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
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 including the following identified infection control issues:
- some cleaning mops were observed to be stored in cleaning buckets which did not promote effective drying and subsequent prevention of cross contamination
- the practice of storing linen trolleys with soiled linen in communal shower and bath rooms required review to ensure prevention of cross contamination
- the practice of sharing hoist lifting slings with more than one resident required review to ensure prevention of cross contamination.

4. 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:
1. Staff educated on storage of mop heads, clip system to be put in place to ensure appropriate storage.
2. Staff educated on storage of linen trollies and one area per unit now identified for storage.

3. Cleaning programme in place for all slings, if a resident identified to have an infectious disease a sling is allocated to this person and left in their room. Risk assessment in place.

Proposed Timescale: 20/01/2018

**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:**
The inspectors reviewed the actual administration times of medication as evidenced from the electronic system. There was evidence that residents medications are not always administered to residents within a reasonable timeframe of the prescribed administration time. This action is restated. Inspectors also noted that administration times are at 2100 and 2300. However, inspectors were informed by some staff that the 2300 time does not meet with some residents needs as the resident may have to be woken to take their night time medications. This was discussed at the feedback meeting and a further review is required.

**5. 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:

- A review of administration time’s on-going in the unit to ensure that medications are administered in a timely manner and is person centred. This system was only introduced to ground floor in September and trial rounds had only been in place for 2 weeks. This is under review and will be completed by ADON, staff involved have received further training and are also involved in reviewing procedures.

Proposed Timescale: 20/01/2018

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were processes described to ensure that when residents were admitted,
transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services. In one file reviewed there was no evidence that any information including an updated list of current medications had been sent with the resident to the admitting hospital.

6. Action Required:
Under Regulation 25(1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or elsewhere, to the receiving designated centre, hospital or place.

Please state the actions you have taken or are planning to take:
• Full transfer letter went with resident to hospital however this was not photocopied and kept in file. Staff training re same and management will also audit.
• We plan to move over to Epic for care planning and this will ensure copies of transfer information.

Proposed Timescale: 20/02/2018