Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Kenmare Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Kenmare, Kerry
Type of inspection:	Unannounced
Date of inspection:	03 December 2020
Centre ID:	OSV-0000753
Fieldwork ID:	MON-0029917

About the designated centre

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

Kenmare Community Nursing Unit is located on the outskirts of the town of Kenmare. It is registered to accommodate a maximum of 41 residents. It is a two-storey building with lift and stairs access to the upstairs accommodation. It is set out in three units: Sheen House located on the ground floor with 19 residents; Roughty House can accommodate 16 residents and Caha House is a six bedded dementia specific unit, both on the first floor. Residents' accommodation comprises 37 single and two twin bedrooms with en suite shower and toilet facilities. The palliative care family room is adjacent to the palliative care suite bedroom; the family room has a comfortable seating, kitchenette and en suite shower and toilet facilities. Additional assisted bath and toilet facilities are located throughout. Each unit has a dining room, sitting room and quiet rooms for residents to enjoy. Additional seating areas are located in the large foyer and along corridors for residents to rest and look out at the mountains, garden and courtyards. The enclosed gardens and courtyards both upstairs and on the ground floor provide secure walkways, seating and shrubbery for residents leisure and enjoyment. Other resident facilities include a prayer room for quiet reflection, visitors room, physiotherapy gym, occupational therapy room, and hair dressers salon. The community physiotherapist, monthly surgical outreach clinic from University Hospital Kerry, mental health day services are accommodated on site and residents have access to these facilities. The service provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided, mainly to older adults.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information 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 with 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 summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

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
Thursday 3 December 2020	10:00hrs to 17:45hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

The overall feedback from residents was that staff generally promoted a person-centred approach to care and were found to be very kind and caring. The inspector met with several residents on the day of the inspection and spoke in more detail with four residents.

The inspector arrived to the centre unannounced in the morning and staff guided the inspector through the infection prevention and control (IP&C) measures necessary on entering the designated centre. These processes were comprehensive and included a signing in process, hand hygiene, face covering, and temperature check. Following an opening meeting, the person in charge facilitated a tour of the premises. The centre was set out in three different units, Sheen House on the ground floor, and Roughty and Caha Houses on the first floor. The reception area contained communal spaces including a beautiful prayer room, seating areas, visitors toilet, lifts and stairway to the first floor. Resident bedroom accommodation was mainly provided in single occupancy en-suite bedrooms with a small number of twins rooms. At the time of the inspection these were all single occupancy. Many bedrooms were seen to be personalised and homely with furnishings, art work, photographs and soft furnishing brought from home. A number of residents who spoke with the inspector told them they were very proud of their bedrooms and loved the privacy it provided them. One resident told inspectors she liked to stay in her room and enjoyed looking out at the view from her window. The inspectors saw that some of the windows were low-set and residents could see out of them easily when seated in a chair. Some had views of well-kept external courtyards with new murals painted on the walls to brighten the view, others had mountains and countryside scenery.

Each of the three units were self-contained with day rooms, dining rooms, pantry and seating areas. Day rooms and dining rooms were decorated with items of domestic furniture such as dressers with decorative chinaware and comfortable seating to provide a homely environment for the residents to enjoy. The rooms contained tables set to accommodate socially distanced dining. However during the inspection, the inspector saw just four residents in the dining room down stairs and the remainder were seen to eat their meals in their bedrooms. Some residents told the inspectors this was by choice.

Two residents were observed in the day room during the day. Residents reported that staff facilitated social interaction and activities with them. Documentation available in long-stay residents bedrooms showed that staff engaged in socialisation and activities such as hand and face massage, art and crafts, reminiscence and chat. The inspector saw and residents confirmed that staff assisted residents to keep up their appearance. It was reported that newspaper reading was facilitated each morning in the day room and residents enjoyed that.

The inspector saw two residents freely walking around the centre and saw that

access to the external court yards was unrestricted from a number of areas of the centre. The courtyards were well maintained and lovely colourful seating areas and colourful vegetation was seen. The day of the inspection was wet and cold; residents said they spent time outside in the good weather. Residents described the COVID-19 pandemic precautions as difficult but were grateful for mobile phones, skype and technology which they said helped them stay in contact with their families and the local community. The centre was gifted an i-pad and the inspector saw this was set up in the day room on Sheen House for residents; live sessions were being streamed from the local secondary school with activities such as music, singing and exercises and residents said they enjoyed this very much.

Residents spoken with were very complimentary about the staff. They said they were very grateful to the staff who worked so hard to keep the centre safe. The inspector saw positive interactions between residents and staff and it was obvious staff knew residents well and vice versa. Residents told the inspector that the current visitor restrictions were difficult but understood the necessity of the restrictions associated with visiting and were very grateful to the staff who cared so well for them.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Kenmare Community Nursing Unit (KCNU) was a residential care setting operated by the Health Services Executive (HSE). It was part of the HSE campus located in a quiet setting on the outskirts of Kenmare town. The governance structure comprised the general manager who was the registered provider representative (RPR) and the person in charge reported to the RPR. The assistant director of nursing deputised for the person in charge when necessary. On site they were supported by administration, care, catering and household staff. Off site, the service was supported by the clinical development co-ordinator, quality and safety advisor and human resources.

The centre was registered to accommodate 41 residents. At the time of inspection, 28 beds were opened; 19 downstairs in Sheen House; nine (of 16 beds) upstairs in Roughy House; Caha House with six beds remained closed. The bed allocation for the service comprised 12 long-stay, one palliative care, two respite and 26 community support convalescence beds. At the time of inspection, bed occupancy was 12 long-stay residents and nine short-stay residents (16 residents downstairs and four upstairs).

The inspector recognised that these were challenging times for residents, their

families and for staff. She acknowledged the work and ongoing commitment by the service to ensure the safety and well-being of residents, staff and visitors regarding COVID-19 pandemic and the related stresses.

The inspector followed up on issues identified on the previous inspection. On this inspection, improvements were noted in the areas such as oversight of quality improvement, care plan documentation, the complaints process including consultation with residents.

The person in charge had completed the self assessment regarding COVID-19 preparedness in September 2020 which included additional information to show actions being taken to demonstrate how they were working towards meeting the standard statements under each theme. For example, an infection control lead was in place as well as a COVID induction and PPE lead, and health and safety lead; another member of staff was identified as the family liaison person to ensure families were kept up-to-date of the COVID-19 status in the centre. Letters were regularly sent to families updating them with COVID-19 information.

There were systems in place for the prevention and early detection of COVID-19 in the centre. Residents were monitored for any change on their condition and staff had their temperature checked twice daily. There was serial testing of staff for COVID-19 and residents were tested when symptoms indicated that a test was required. The COVID-19 contingency plan was updated in October 2020 following a review of the service regarding governance arrangements, staffing considerations, IP&C and end-of-life care. Additional risks were identified and the risk register was updated to reflect these.

Quality and Patient Safety meetings were facilitated by the general manager on a monthly basis and these were attended by the persons in charge of the CH04 area and the quality and safety advisor; additional attendees were present at these meetings if required such as the fire officer, if there was a fire safety matter. Issues discussed included audit results, incidents, accidents, complaints, falls for example as part of the oversight of service provision. Minutes of local health and safety meetings were reviewed and these showed ongoing review of the service with actions taken to improve COVID-19 precautions. For example, the establishment of additional entry points to the centre with the associated HPSC precautions. The risk register was examined and showed general risks as well as risks associated with the impact of COVID-19 on the service, residents, staff and visitors. Regular COVID-19 meetings were facilitated that included information sharing of current HPSC guidance and implementation in practice. The COVID-19 preparedness plan showed sequential deputising arrangements in place should the person in charge or other members of the management team be unable to work, with responsibilities and duties in the event of a COVID-19 outbreak. Staff were allocated to work in separate teams to minimise contacts with the residents and other staff members and enable contact tracing.

The person in charge reported that a new system called ViClarity was implemented earlier in the year to facilitated clinical governance. The clinical development co-ordinator had oversight of the audit programme for the Kerry CHO area and

scheduled monthly audits to be completed to monitor the quality and safety of care delivered to residents. The system allowed for additional audits to be completed following incidents and accidents. Previously, the person in charge completed the audits, but additional staff had received training in auditing and were now involved with monitoring the service too. Audits showed that responsibility for improvements were assigned to different staff for actioning with reviews of items such as medication management, care planning, infection prevention and control, and the management of restraint.

The annual report for 2019 reviewed the activities and achievements of 2019 and also identified areas for improvement. For example, they identified improvement necessary with the activities programme and one staff member had completed training relating to activities; they introduced a safety pause to highlight awareness of areas of risk; safeguarding officers were appointed as part of resident protection. Satisfaction surveys were completed for short-stay residents upon their discharge, however, routine satisfaction surveys were not undertaken for long-stay residents. While quality of care was audited, areas relating to quality of life were not routinely assessed. For example, a review of residents meetings showed that one meeting was held in 2020 in September, however, this had not been highlighted in the quality review meetings.

During the inspection, staffing levels and skill-mix were sufficient to meet the assessed needs of residents. A review of staffing rosters showed there were a minimum of 3 nurses were on duty during the day and two nurses at night, with a regular pattern of rostered care staff. During the week there was generally the person in charge, deputy person in charge in addition to the nursing numbers on duty. Cleaning staff were provided by an external agency and a household supervisor was available. There was no activities person employed in the centre; activities were seen to be the responsibility of all care staff and staff were allocated to the activities programme. It was reported to the inspector that this was a daily allocation, however, it was not identified on the duty roster or the display notice board which indicated roles and responsibilities of staff on duty. Nonetheless, the person in charge had introduced a 'staff identity' programme for staff to highlight their strengths, experience and qualifications and to promote best practice. From this, leads were established for infection control, health and safety, and an activities lead was proposed which would enable and ensure a structured and consistent activities programme for residents.

Training was scheduled on an ongoing basis. COVID-19 related training included hand hygiene, personal protective equipment (PPE) training, donning and doffing, and infection prevention and control. Additional training included train the trainer regarding hand hygiene, manual handling, flu vaccination (4 staff), serial testing screening (all nurses) and supra-pubic catheterisation. Some staff had completed the CEOL (Compassionate End-of-Life) programme and more staff were awaiting to complete this. Nonetheless, while staff had access and were familiar with the National Standards, copies of the Health Act and regulations made thereunder were not available.

The medication management documentation was the standard HSE record which

comprised the resident's prescription and three-month administration record. A sample of these were examined which included records of a resident receiving respite care. The original prescription for this resident was dated July 2018. The resident was admitted to the centre on several occasions and the medication chart was used repeatedly. While some medications appeared to be discontinued with a line drawn through them, they were not signed or dated to indicate when they were discontinued. The repeated use of a medication administration chart had potential for medication errors or near-miss episodes. The medication management policy required updating regarding policy information on time-lines associated with medication administration records and the associated prescriptions. Gaps in administration records were seen so it could not be assured whether residents received their medication in line with their current prescription.

There was significant improvement noted in the complaints process. The complaints policy was clearly displayed at the entrance to the centre. There was a robust complaints management system in place with evidence of complaints recorded, investigation into the complaint, actions taken and the satisfaction of the complainant with the outcome. Oversight of complaints was signed off by the person in charge and included lessons learnt and improvements to practices following on from complaints. Residents who spoke with the inspector were aware of the complaints procedure and reported feeling safe and confirmed high satisfaction with the services.

Regulation 14: Persons in charge

The person in charge was full time and had the necessary experience as required in the regulations. She facilitated the inspection in an open manner and demonstrated good knowledge regarding her role and responsibility. She was articulate regarding governance and management of the service and quality improvement initiatives required to enhance the service. She had previously completed the LEO management programme and Managing Health and Safety in the Healthcare Setting programme. She committed to undertaking a post graduate qualification in management in line with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 15: Staffing

The number and skill mix was appropriate to the size and lay out of the centre and the assessed needs of residents as assessed in accordance with regulation 5.

Judgment: Compliant

Regulation 16: Training and staff development

Access to the Health Act and Regulations made thereunder were not available to staff.

Judgment: Substantially compliant

Regulation 21: Records

Gaps in medication administration records were seen so it could not be assured whether residents received their medication in line with their current prescription.

Occasionally, medications were not discontinued in line with professional guidelines; while a line was drawn through them, they were not signed or dated.

Judgment: Not compliant

Regulation 23: Governance and management

As part of the annual review, satisfaction surveys were completed for short-stay residents upon their discharge, however, routine satisfaction surveys were not undertaken for long-stay residents to obtain their feedback on the service they received. While quality of care was audited, areas relating to quality of life were not always assessed. For example, a review of residents' meetings showed that one meeting was held in 2020 in September, however, this had not been highlighted in the quality review meetings.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was being updated at the time of inspection to include the following:

- current registration details
- whole-time equivalent staffing complement
- current organisational structure

- current complaints officer
- deputising arrangements for the person in charge
- details of the person responsible for the pre-admission assessment of residents to the centre to ensure that the service could cater for their assessed needs
- floor plans to be updated to include access to courtyard from dining room and new access in the palliative care suite.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications were submitted to the Chief Inspector in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

Significant improvement was noted in the complaints process. Complaints were comprehensively recorded, investigated and followed up by the person in charge including meeting with the complainant to ensure they were happy with the outcome and resolution. Residents who spoke with the inspector said they could raise issues and reported feeling safe.

Judgment: Compliant

Regulation 4: Written policies and procedures

The medication management policy did not comprehensively inform staff of the management of documentation associated with residents receiving respite care.

Judgment: Substantially compliant

Quality and safety

In general, the inspector observed that the care and support given to residents was

respectful, relaxed and unhurried; and staff were kind, and were familiar with residents preferences and choices and facilitated these in a friendly manner.

Significant improvement was noted regarding residents' care planning documentation which was found to be comprehensive, personalised and very person-centered. Residents' assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. They were regularly reviewed and updated following assessments and recommendations by allied health professionals. Therapeutic recreational activities records were maintained in bedrooms of residents receiving long-stay care and not for short-stay occupancy. These included activities such as chair exercises, face and hand massage, reflexology, art and hair styling. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to COVID-19 guidelines. They provided a holistic picture of the resident and their individual needs, wishes and preferences. Transfer information was available in line with regulatory requirements. Care plans regarding end-of-life care had been updated based on resident's expressed wishes with clear pathways in place for treatment, should the need arise. Advanced care plans were in place for all residents and the inspectors noted that there had been discussions regarding potential care options, including decisions made regarding COVID-19 for residents or their representative, when appropriate. There was a prayer room in the centre that was available for residents and relatives should they wish to have a quiet area for reflection or prayer. The chaplin attended the centre on a weekly basis and mass was streamed live to bedrooms and day rooms for residents. Other religious preferences were also facilitated.

The inspector were satisfied that the health care needs of residents were well met. The medical officer attended the centre three times a week at a minimum and was contactable by phone as required. The medical officer had access to residents records via HealthOne IT system to enable timely updates and continuity of service for residents. The community physiotherapist was on-site and residents had timely access to this service. Access to allied health was evidenced by regular reviews by the occupational therapist, podiatry, tissue viability, dietician, speech and language, as required. The community pharmacist attended the centre on a monthly basis to provide expertise, review prescriptions and stock in the centre. An anti-microbial audit completed in October 2020 demonstrated positive results and good compliance.

In relation to COVID-19, policies were updated in accordance with the Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units. There was evidence of consultation with public health regarding COVID-19 guidance and current HPSC literature was available to support the service. All nurses were trained in COVID-19 swab testing, two staff were identified as the IP&C lead for the centre and one staff member was the PPE lead. Routine staff swabbing was facilitated on a fortnightly basis and the person in charge reported that there was a 100% uptake by staff for testing. There was active monitoring of residents for signs and symptoms as evidenced in residents care

plans.

Staff were observed to abide by best practice hand hygiene. Laundry was segregated at source and other precautions in place for infected laundry included the use of alginate bags, and clinical waste procedures were seen to be robust. There were cleaning staff on duty during the inspection and this included a housekeeping supervisor. In general the centre was observed to be clean, however, terminal cleaning checks following deep cleaning were not completed. For example, there was signage on one bathroom wall with information relating to previous residents; the nurses station on Caha House had lots of used paraphernalia included a used scissors, unprotected thermometers and a trolley laden with open boxes of PPE and open hand sanitising gels that had been used in the COVID-19 positive wing. Large stocks of towels, bed sheets, waste disposal bags and oral hygiene trays were seen in residents' bedrooms. This impacted both infection control measures as well as taking up approximately one third of residents' wardrobe space.

The centre normally operated an open visiting policy but due to the COVID-19 pandemic visiting was restricted in line with Level 3 lock-down government guidelines. There were clear notices displayed at all entrances to the centre regarding this. Nonetheless, arrangements were put in place to enable relatives to visit with residents for end-of-life and compassionate grounds. Window visits were also facilitated and inspector was informed by residents that staff were committed to ensuring they remained in contact by means of Skype, WhatsApp, email and other video and telephone calls as appropriate. Visits were booked in advance and residents were delighted with these visiting arrangements.

Meals were pleasantly presented and tables were nicely set for residents prior to their meals with delph, napkins and condiments. The inspector observed that residents were assisted in an appropriate manner to enjoy their meal. The inspector spoke with the chef and was assured that specialist dietary requirements were catered for and residents spoke highly of the food they received.

Residents who spoke with the inspector reported that they felt safe in the centre and that their privacy and expressed wishes were respected. Residents looked well-groomed and those who spoke with the inspector confirmed that they were comfortable despite the limitations posed by the current HPSC guidance.

A weekly/fortnightly news letter was developed with news and chat for residents. The person in charge reported that there was newspaper reading in the morning in the dayroom of Sheen House. End-of-bed documentation showed that one-to-one activities were facilitated for residents receiving long-term care; there were plans in place to develop more specialist sensory activities for residents with dementia. Residents had access to daily newspapers, local media, Internet services and video messaging to facilitate them to stay in contact with their families, the community and keep up to date on the news.

Social distancing was in place in dining rooms and the inspector observed four residents in the dining room at lunch time. Some residents remained in their bedrooms as they were recent admissions to the centre and were adhering with

HPSc guidelines; some residents reported that they preferred to have their meals in their bedrooms.

Regulation 10: Communication difficulties

The inspector observed that residents with communication needs were assisted in a kind and respectful manner which promoted their independence and ensured their dignity.

Judgment: Compliant

Regulation 11: Visits

Visiting was facilitated in line with Level 3 HPSC guidance. The service was committed to ensuring residents and their families remained in contact by means of Skype, WhatsApp, email and other video and telephone calls as appropriate.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had sufficient space in which they could store their clothing and personal belongings, including lockable storage for valuables. In general, residents had personalised their bedrooms in accordance with their preferences, with their own decorations, flowers, ornaments, furniture and photographs.

Judgment: Compliant

Regulation 13: End of life

Records indicated that end-of-life preferences were discussed with residents and their relatives. As part of COVID-19 contingency planning, arrangements were put in place to enable relatives to visit with residents should the need arise. Residents' care plans were up-to-date regarding wishes if they became unwell due to COVID-19. Advanced care plans were in place for all residents and the inspector noted that there had been discussions regarding potential care options with residents or their

representative.

Judgment: Compliant

Regulation 17: Premises

The palliative care suite was being updated at the time of inspection to enable a separate entrance to the suite in line with HPSC guidance.

The backdrop of the prayer room was upgraded with stained glass of local scenery and wildlife.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had timely access to speech and language and dietician specialist services. Resident gave positive feedback about the food they were served in the centre.

Judgment: Compliant

Regulation 20: Information for residents

While the information folder available for residents contained information such as a welcome message and vision statement for the centre along with COVID-19 information and access to advocacy services, it did not detail the information required in legislation.

Judgment: Substantially compliant

Regulation 27: Infection control

Issues identified regarding infection control were:

- the hand-wash sink in the cleaners' room in Sheen House had domestic-type taps rather than hands-free taps
- the sluicing/flushing sink for emptying buckets was located directly

underneath the hand-wash sink
- terminal cleaning checks were not completed following deep cleaning
- large stocks of towels, bed sheets and waste disposal bags were inappropriately stored in residents' wardrobes which was not in keeping with HPSC guidance.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The community pharmacist attended the centre on a monthly basis to provide expertise and was facilitated to meet the obligations to residents in line with legislation and professional guidelines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Significant improvement was seen in the residents' care documentation. Care plans were comprehensive, personalised and very person-centered. They were reviewed and updated in accordance with the regulations, the changing needs of residents and the recommendations by allied health professionals. They were updated in relation to COVID-19 and the residents wishes regarding possible implications of COVID-19.

Judgment: Compliant

Regulation 6: Health care

The inspector was satisfied that the health care needs of residents were well met. There was evidence of good access to the medical officer and regular reviews took place. Access to allied health was evidenced by regular reviews by the physiotherapist, occupational therapist, dietician, speech and language, podiatry and tissue viability as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Care plans reviewed showed that behavioural charts were in use to determine anxieties or worries associated with challenging behaviours and actions taken to allay or prevent fears.

Judgment: Compliant

Regulation 9: Residents' rights

Large stocks of towels, bed sheets, waste disposal bags and oral hygiene trays were seen in residents' bedrooms which took up approximately one third of residents' wardrobe space.

There was just one residents meeting held in September for 2020 which would not ensure that residents were consulted with and participated in the organisation of the centre or provided with opportunities to influence their daily lives.

Therapeutic recreational activities records were maintained in bedrooms of residents receiving long-stay care and not for short-stay occupancy so it could not be assured that all residents enjoyed recreation, activation and socialisation.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kenmare Community Nursing Unit OSV-0000753

Inspection ID: MON-0029917

Date of inspection: 03/12/2020

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A/Director of Nursing has signed up to undertake a QQ1 Level 6 supervisory Management course which is commencing on the 20th of January 2021.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The A/CNM2 has alerted all team members in KCNU to the copy of the statutory instrument S.I 415 of 2013 Health Act 2007 (Care and Welfare of Residents in Designated Centers for older people) Regulations 2013 in the PPPG folder system. A separate copy is also available at each Nurses station for Staff to refer to.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All records will be reviewed for any gaps in administration. An audit has also been carried out on administration management. The A/CNM has discussed with all RGNS the importance of inserting the appropriate code / initial in the administration record.	

Completed 17\12\2020.
All administration records were reviewed to ensure medications are discontinued in line with professional guidelines. Nursing management have also discussed with the Medical Officer the requirement that all medications are signed and dated by the Medical Officer once discontinued. Nursing management are working on the Medication Management policy with the Clinical Development Coordinator, Medical officer and Senior Pharmacist re. Short stay \Respite admission drug kardex and the length of time that a medication kardex should be used for. It is purposed that a staff nurse within KCNU will be nominated to become a medication management lead in 2021.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Routine satisfaction surveys have recommenced for (Long Stay) residents to obtain their feedback on the service that they receive , this commenced on the 15/12/2020 and will be on going and a lead nurse and assistant HCA have been identified in this area also for 2021.
The CNM2 has conducted Quality of Life Audits 9 Via Web links on the ViClarity system which began on the 15\12\2020 and is ongoing. There were fewer meetings held in 2020 due to the unit's response to emergencies in relation to Covid. The last Residents meeting was held on the 9th of December 2020. It is anticipated that these meetings will be returned to 3 monthly in 2021 once it is safe to do so for the Residents.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose for KCNU is being updated at present and new maps have been requested from the Maintenance Department and Fire Officer. To be completed by the 15th of January 2021

Regulation 4: Written policies and	Substantially Compliant

procedures	

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Medication management Policy is been reviewed by the A/Director of Nursing , Pharmacist , Medical Officer and Clinical Development Coordinator to ensure staff are comprehensibly informed of the management of documentation associated with residents receiving Respite care. (Time frame for completion 31/01/2021)

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
The information folder available for residents will be reviewed and updated to ensure all information required in legislation is available for residents. Time Frame 31/01/2021

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Nursing Management has sought the advice of the infection prevention and control team regarding the recommended changing of the sluicing / flushing sink and taps.
• Terminal cleaning checks are now completed following deep cleaning. A/DON and A/CNM2 are undertaking surveillance of same. Completed and ongoing.
• Stocks of towels, bed sheets and waste disposal bags will no longer be stored in Residents/Patients ward robes for their personal use. Completed 15/12/2020

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Residents /Patients wardrobes will be for their own personal use. Stock of towels, bed sheets and waste disposal bags are now removed from wardrobes.
• Persons in short stay occupancy are encouraged to participate in activities and

therapies. Going forward the therapeutic record will be maintained for all persons in short stay occupancy to reflect the practice in place (Commenced on 21/12/2020)
• Routine satisfaction surveys have recommenced for long stay residents to obtain their feedback on the services provided. A lead and an assistant in this area has been identified for 2021. Nursing Management are organizing steering groups to include the Residents in the following areas of Activities, Nutrition and event organizations in Kenmare Community Nursing Unit. Time Frame 15/01/2021.
• It is anticipated that 3 monthly Residents meetings are held in 2021 or more frequently as may be needed to ensure that the voice of the Resident is always heard.

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 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Substantially Compliant	Yellow	20/01/2021
Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Substantially Compliant	Yellow	03/12/2020
Regulation 20(2)(a)	A guide prepared under paragraph (a) shall include a summary of the services and facilities in that designated centre.	Substantially Compliant	Yellow	31/01/2021
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include	Substantially Compliant	Yellow	31/01/2021

	the terms and conditions relating to residence in the designated centre concerned.			
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints.	Substantially Compliant	Yellow	31/01/2021
Regulation 20(2)(d)	A guide prepared under paragraph (a) shall include the arrangements for visits.	Substantially Compliant	Yellow	31/01/2021
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	17/12/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	15/12/2020
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that	Substantially Compliant		15/12/2020

	such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	15/12/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	15/01/2021
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	15/01/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief	Substantially Compliant	Yellow	31/01/2021

	Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	21/12/2020
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant		21/12/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	09/12/2020