Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Kilbrew Recuperation and Nursing Care
Centre ID:	OSV-0000143
Centre address:	Curragha, Ashbourne, Meath.
Telephone number:	01 835 8900
Email address:	info@kilbrew.eu
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Kilbrew Recuperation and Nursing Care Limited
Provider Nominee:	James Keeling
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	68
Number of vacancies on the date of inspection:	6

About Dementia Care Thematic Inspections

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
31 August 2016 10:00	31 August 2016 20:30

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

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

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. The inspection also considered notifications and other relevant information including unsolicited information received by HIQA in July 2016 in relation to prevention of pressure related skin breakdown and some aspects of healthcare. This information was partially substantiated. Inspectors' findings confirmed that residents had timely access to appropriate healthcare however, some procedures for prevention of pressure related skin breakdown required improvement. There were no actions required from findings of the last inspection in November 2015.

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

inspection process. Prior to the inspection, the provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Residents' accommodation in the centre was provided on ground floor level. The centre did not have a dementia care unit and residents with dementia integrated with the other residents in the centre. The design and layout of the centre met its stated purpose and provided a comfortable and therapeutic environment for residents with dementia. Inspectors found the person in charge and staff team were committed to providing a quality service for residents with dementia.

Inspectors met with residents, some relatives and staff members during the inspection. Residents and their relatives spoke in complimentary terms about the service provided and staff in the centre. Inspectors tracked the journey of a sample of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined relevant policies including those submitted prior to this inspection.

There were policies and procedures in place to safeguard residents from abuse. Staff were knowledgeable about the steps they must take if they witness, suspect or are informed of any abuse taking place. However, training records did not reference completion of training by all staff. There were also policies and practices in place around managing responsive and psychological behaviors of dementia. Some revision was found to be required in documentation procedures for use of bedrail restraint and interventions to de-escalate responsive behaviors.

Residents had good access to medical and allied health professionals as necessary. Staff completed risk assessments to inform residents' needs documented in plans of care to support and optimize their health and well-being. Residents' activation provision required improvement to ensure that assessment of their changing interests and capabilities were addressed with an appropriately focused activation programme.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out inspection findings relating to healthcare, nursing assessments and care planning. The findings in relation to social care of residents with dementia in the centre are comprehensively covered in Outcome 3 in this report.

The centre catered for residents with a range of needs. On the day of this inspection, there were a total of 68 residents. 38 residents had dementia and others had symptoms of dementia. Inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of a sample of residents with dementia and also reviewed specific aspects of care such as safeguarding, nutrition, wound care and end-of-life care in relation to other residents with dementia in the centre.

There were systems in place to optimise communications between residents/families, the acute hospital and the centre. The person in charge or senior nurse visited prospective residents in hospital or their home in the community prior to admission. Inspectors were told that many residents currently in receipt of continuing care transitioned from admission on a respite basis. Prospective residents and their families were also welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave residents and their families information about the centre and also ensured them that the service could adequately meet their needs.

A copy of the Common Summary Assessments (CSARs), which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme, was kept routinely in residents' files in addition to pre-assessment documentation completed by the person in charge. The files of residents' admitted to the centre from hospital also held their hospital discharge documentation including a medical summary letter, multidisciplinary assessment details and a nursing assessment. Inspectors examined the document used for residents who were transferred to hospital from the centre. This summary document had being revised by the person in charge and staff team to enhance the scope of information about the needs of the resident transferring to hospital. The document recorded appropriate information about residents'

physical, mental and psychological health, medications and nursing needs. However there was limited reference to information to support residents with physical and psychological symptoms of dementia (BPSD) or responsive behaviours. Although at an early stage and not completed for all residents, arrangements were in place to complete residents' 'Key to Me' documentation. Arrangements were in place to maintain a copy of this document in each resident's bedroom. Completion of this information was being done with the support of residents and their relatives where appropriate. A communication passport was not currently in use for residents with communication needs going to hospital at the time of this inspection. However the person in charge advised inspectors that she envisaged that on completion, a copy of the 'Key to Me' document would form part of each resident's transfer documentation. This documentation will be of value in supporting the communication needs of residents with dementia accessing services outside the centre to outline their individual preferences, dislikes and strategies to prevent or to support those with physical and psychological symptoms of dementia. The nutrition and hydration needs of residents with dementia were met; however, some improvement was required in dining arrangements in one of the two dining rooms. Residents were generally protected by safe medicine management policies and procedures but some improvements were required in prescription of 'as required' (PRN) medications and documentation of times of administration to ensure maximum permissible doses over a 24 hour period were not inadvertently exceeded.

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs were attending to the needs of residents in the centre, giving residents a choice of general practitioner. Residents attended out-patient appointments and were referred as necessary to the acute hospital services. Documentation reviewed and residents spoken with by inspectors confirmed they had access to GP care including out-of-hours medical care. Some residents who lived in the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents had good access to allied healthcare professionals. Physiotherapy occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and podiatry services were also available to residents as necessary. Community psychiatry of older age specialist services attended residents in the centre with dementia and supported GPs and staff with managing residents experiencing behavioural and psychological symptoms of dementia as needed. Residents' positive health and wellbeing was promoted with regular exercise as part of their activation programme, an annual influenza vaccination programme, regular blood profiling and medication reviews. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during 'end of life' care if required.

There were systems in place to meet the health and nursing needs of residents with dementia. There was evidence of on-going work to ensure assessment and documentation of residents' needs was maintained to a good standard. While the majority of residents' care plans were person-centred and informative, inspectors found on this inspection that some interventions stated in behavioural support care plans were generic. The interventions to direct care actions in activation care plans required some improvement to clearly inform the scope of residents' individual interests and capabilities especially residents with levels of dementia that negatively impacted on their ability to

participate and benefit from group activities.

Assessments of residents' needs were carried out within 48 hours following admission and care plans were developed based on assessments of need and thereafter in line with residents changing needs. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive function and skin integrity among others. Care plans were updated routinely on a three-monthly basis or to reflect residents' changing care needs as necessary. Inspectors found that all staff spoken with were knowledgeable regarding residents' likes, dislikes and needs. There was evidence of involvement of residents and their families in residents' care, improvement was required to ensure they were consulted with in relation to care plan development and reviews thereafter. Residents had a section in their care plan that addressed their communication needs. However, the communication policy document available required improvement to include strategies to inform communication with residents who had dementia.

Staff provided end-of-life care to residents with the support of their medical practitioner and community palliative care services as necessary. No resident was in receipt of palliative care services at the time of inspection. A pain assessment tool for residents, including residents who were non-verbal was available to support pain management. Inspectors reviewed a number of 'End of life' care plans and found that they outlined the physical, psychological and spiritual needs of residents. Residents' individual wishes regarding place for receipt of 'end of life' care were also recorded. Advanced directives were in place for some residents regarding resuscitation procedures. This documentation recorded family input on behalf of the resident in most cases in the documentation reviewed. However, there was some room for improvement to ensure residents were involved in these decisions where appropriate. Residents had access to an oratory in the centre. Single rooms were available for 'end of life' care and relatives were facilitated to stay overnight with residents at the 'end of life' stage of their lives. Staff outlined how residents' religious and cultural practices were facilitated. Members of the local clergy from the various religious faiths provided pastoral and spiritual support to residents.

There were care procedures in place to prevent residents developing pressure related skin injuries. Each resident had their risk of developing pressure sores assessed. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate risk of ulcers developing. Since the inspection the Health Information and Quality Authority (HIQA) were notified of one incident of pressure sore that occurred since 01 January 2016. Inspectors were told that no residents in the centre had a pressure related skin injury on the day of this inspection. Staff discussed care procedures for residents at risk of developing pressure related skin injuries and the care of one resident with a grade 1 (redness) injury which reflected evidence-based practice. However, inspectors observed that the level of assessed risk did not comprehensively inform care interventions including pressure relieving equipment that should be implemented in response to level of risk found, resulting in inconsistency in procedures in place to prevent pressure related skin injury. Inspectors were told that air pressure in pressure relieving mattresses was determined by residents' weight; however, the mattress control units in use did not inform this practice. Arrangements were in place to ensure the nutritional needs of residents with pressure ulcers were reviewed by a dietician and tissue viability specialist services were available to support staff with

management of pressure wounds that were deteriorating or slow to heal. Inspectors reviewed wound management procedures in place for one resident with a chronic wound. Inspectors were told this was the only resident with a wound in the centre. A policy document informed wound management. While wounds were not routinely photographed, wound dimensions were measured to monitor progress with healing and a treatment plan informed dressing procedures.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration however improvement was found to be required. A policy document was in place and although referenced use of the 'Malnutrition Universal Screening Tool' (MUST), details of the assessment procedure including a template of the tool was not included in this advisory document Residents were screened for nutritional risk using the MUST assessment process on admission and reviewed regularly thereafter. Residents' weights were checked routinely on a monthly basis and more frequently where residents experienced unintentional weight loss. Nutritional assessment and care plans were in place that outlined the recommendations of dietician and speech and language therapists where appropriate. Systems were in place for recording and monitoring residents' nutritional and fluid intake where required. Inspectors saw that residents had a choice of hot meals for lunch and tea. While there were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements, some improvement was needed to ensure copies of the original recommendation sheets were consistently provided to the chef. Inspectors found that residents on weight-reducing, diabetic and fortified diets, and residents who required modified consistency diets and thickened fluids, received the correct diets. Although staff supported residents requiring assistance, not all residents received assistance in a timely manner in one dining room and were observed to be waiting for assistance with their meal and with leaving the dining room. This finding is discussed in outcome 5.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed on admission and regularly thereafter for risk of falls. There was evidence of identification and implementation of learning as outcomes of fall reviews. HIQA was notified of two incidents of residents falling since 01 January 2016 May, both of whom sustained a bone fracture. Procedures were put in place to mitigate risk of further falls and residents at risk of falling were appropriately risk assessed with controls such as hip protection and sensor alarm equipment put in place. All residents were appropriately supervised by staff as observed by inspectors on the day of inspection.

There were written operational policies informing ordering, prescribing, storing and administration of medicines to residents. Inspectors found that practices in relation to prescribing, administration and medication reviews met with regulatory requirements with the exception of PRN (as required) medications. The maximum dosage of PRN medication permissible over a 24hour period was not consistently stated by the prescriber and the times of administration of PRN medications were not consistently recorded by staff administering these medications. Inspectors observed that staff were trained to administer subcutaneous fluids to treat dehydration in order to avoid unnecessary hospital admissions. Fluids for subcutaneous administration were prescribed for some residents at risk of dehydration and as such could be administered

staff if deemed necessary. However, the point at which this intervention was appropriate was not documented to clearly direct fluid supplementation by the prescriber. The pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. There were procedures for the return of out of date or unused medications. Systems were in place for recording and managing medication errors.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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 there were measures in place to safeguard residents, particularly those with dementia, and protect them from abuse or harm.

There was a policy and procedure in place informing protection of residents and management of any allegations, incidents or suspicions of abuse. While some staff had been trained in the prevention detection and response to abuse, training records provided to inspectors indicated that not all staff had received this training. Inspectors spoke with staff, who confirmed that the provider and person in charge ensured that there are no barriers to the reporting of abuse. Staff members were aware of their responsibility to report and could describe the various types of abuse, and what they would do in the event of an allegation, suspicion or disclosure of abuse. While there were no investigations into an allegations, incidents or suspicions of abuse in the centre, there was a system in place to support this process. Inspectors spoke with a number of residents on the day of the inspection, who stated that they felt safe in the centre and complimented the staff team caring for them. Interactions observed between staff and residents were respectful and supportive.

The inspectors observed that some residents experienced behaviours and psychological symptoms of dementia (BPSD). A policy document was in place to inform management of responsive behaviours. Staff who spoke with inspectors could describe the interventions they implemented for individual residents. Interventions were selected from a list of appropriate generic interventions to de-escalate behaviours and psychological symptoms of dementia, to inform residents' behavioural support care plans. However, improvement was required to ensure that the interventions prescribed were consistently person-centred for each resident. While access to the centre was controlled, residents could access two safe and secure garden areas at will. Inspectors observed residents using the gardens and being accompanied by relatives to walk in the grounds outside the centre.

The centre maintained a restraint register, which detailed the number of residents using forms of restraint, including bedrails. This documentation evidenced that bedrails were removed every two hours, in line with the centre's own policy. Inspectors noted that a number of residents were using half-length bedrails as enablers, which did not restrict their movement in and out of bed. Although all residents' safety with use of bedrails was completed, risk assessment documentation required improvement to reflect this process. Improvement was also required in documentation to reference alternatives tried before bedrail restraint was used. No residents were receiving chemical restraint on the day of inspection however some residents were prescribed for this medication if required to de-escalate responsive behaviours. While the person in charge advised inspectors that chemical restraint was used as a last resort intervention, this was not consistently documented in some residents' positive behaviour support plans. This finding was not in line with national restraint policy guidelines.

There was a system in place to safeguard residents' finances and valuables. Secure, lockable storage was provided in each resident's bedroom for their use to store their valuables safely. Arrangements were in place for some residents' monies to be held in safekeeping on their behalf. Inspectors checked a sample of these finances and found all of them to be securely stored and accurate. All records of transactions were double-signed by two members of staff, and the resident where possible.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Residents with dementia were consulted with and supported to participate in the organisation of the centre. Overall residents' privacy and dignity was generally respected. However closed circuit television (CCTV) cameras were in operation in communal sitting areas and the dining rooms where a level of privacy for residents would be expected. Residents were supported to make choices about their day-to-day lives. While there was opportunity for most residents with dementia to participate in activities that suited their interests and capabilities, a sensory-based programme of activities required development to meet the individual needs of residents with dementia with needs not met by group activities provided.

Inspectors' findings indicated that improved assessment for residents with dementia was required to ensure that activities provided met their interests and capabilities including

whether 1:1 or small sensory based group activities were more appropriate to meeting their needs. An activity co-ordinator had responsibility for co-ordinating resident activities to meet their interests and capabilities including residents with dementia. While a member of staff had completed accredited training in sensory based activity provision suitable for residents with dementia, a robust sensory focused activity programme was not available for residents with dementia on the day of inspection. Addressing the social needs of residents was integral to the role of healthcare assistants; however, inspectors observed that activities were regularly interrupted to provide care. Although there was evidence in residents' documentation records and from inspectors' observations that although some residents enjoyed the activities provided, this was not the finding for many residents with dementia. For example, inspectors observed that while care staff made every effort to engage residents in the activities provided in one of the sitting rooms, a number of residents slept throughout or were unable to participate. A schedule of activities was displayed in one of the dining rooms and although the location and time of each activity was indicated, correlating location signage on the various communal areas required improvement to ensure residents could access the activity of their choice. The procedure for displaying the schedule of activities required review to ensure residents who accessed areas other than the dining room where it is currently displayed were informed of the activities scheduled. Although the number of residents with severe dementia was small, approximately 50% of residents had a formal diagnosis of dementia or had symptoms indicative of dementia. This finding was discussed at feedback of inspection findings with the person in charge and members of the management team.

Residents with dementia had access to Independent advocacy services. Resident meetings were occurring every two months and minutes were documented. The minutes evidenced decisions made regarding locations for outings in consultation with residents. There was also evidence that residents with dementia attended these meetings.

Residents were facilitated to exercise their civil, political and religious rights. Staff sought the permission of residents with dementia in the centre before undertaking any care tasks and they were consulted about how they wished to spend their day and about care issues. Residents spoken with generally expressed their satisfaction with opportunities and choices afforded to them in their day-to-day lives in the centre. Arrangements were in place to ensure residents had opportunity to exercise their right to vote. Residents' wishes were prioritised when planning excursion venues. Residents' wishes and preferences also informed their daily routine regarding the times they retired to bed and got up in the morning. There were no restrictions on visitors and residents could meet visitors in private in a number of comfortable areas in the centre. Inspectors spoke with and observed residents' visitors visiting them throughout the day of inspection. Two pet dogs were accommodated in the centre during the day and residents spoke positively about them to inspectors. They were not present on the day of this inspection. A married couple were accommodated in a twin room in the centre which they were facilitated to personalise to their wishes. They were also supported to have their pet dog living with them.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record the quality of interactions between staff and residents at five minute intervals in the sitting room and the dining room area. The scores for the quality of interactions are +2 (positive connective care), +1 (task

orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the effect of the interactions on the majority of residents. Inspectors' observations on this inspection concluded that while there was good evidence of positive connective care with individual residents, the quality of staff interactions with some residents who had dementia was poor. Neutral care was observed when some residents with dementia were not facilitated to participate in activities which other residents were enjoying.

Inspectors saw that staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. While there were some twin bedrooms, the majority of residents were accommodated in single bedrooms. Privacy curtains were provided in twin bedrooms. Staff were observed knocking on bedroom and toilet/bathroom doors. Privacy locks were in place on all bathroom and toilet doors. Bedroom and toilet/bathroom doors were closed during all personal care activities. Inspectors observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff and residents knew each other well. Inspectors observed that the privacy of residents at risk of falling was protected by a system of colour-coded cues displayed on their bedroom doors to alert staff. However, personal information regarding some residents' needs was not adequately protected as it was displayed in their bedrooms. Inspectors observed that CCTV (closed circuit television cameras were functioning in communal sitting and dining areas. While a policy was in place to inform use of this technology, the rationale of security and protection of residents provided for its use was not supported by inspectors' findings as residents were supervised by staff in communal areas at all times and access to the centre was controlled. There were no incidents of security breaches identified.

There was a communication policy in place but did not inform communication of residents with dementia and strategies to effectively meet their communication needs. Residents had a section in their care plan that referenced their communication needs with identified aids to support them. For example communication boards and translation of key words for residents for which English was not their native language. However, improvement opportunities were identified for practice to ensure communication boards were used by staff for residents requiring them during all interpersonal interactions.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:

There was a policy and procedure in place for the management of complaints. However, improvements were required to ensure that complaints were dealt with and recorded appropriately.

A copy of the complaints procedure was displayed at the entrance of the designated centre; however, it was presented in a format that was not easily accessible to all residents, particularly those with dementia.

The complaints log contained evidence that complaints were investigated and closed out effectively and promptly. While the person in charge was nominated to deal with complaints, a second person had not been nominated to ensure that complaints were appropriately recorded and responded to. A complaints log was made available to inspectors on the day of the inspection, and while complaint records contained most of the information required by the Regulations. The satisfaction of the complainant with the outcome of investigation of complaints was not consistently recorded. There was an appeals process in place for complainants, should they be dissatisfied with the outcome of their complaint. However, this process, as documented in the complaints policy, required improvement to ensure complainants were directed to the appropriate appeals channels.

Inspectors spoke with staff, who could describe how they would support residents to make a complaint, particularly those with dementia.

Judgment:
Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
While inspectors found that the numbers and skill mix of staff were suitable to meet the needs of the residents, improvements were required to ensure that staff were appropriately trained and supervised.

A staff training matrix was maintained in the centre, which evidenced some deficits in addressing the mandatory training needs of staff. Records provided to inspectors indicated that the majority of staff had received up-to-date training in the prevention, detection and response to abuse; however, ten staff were not recorded as having completed this training. A number of staff were also not recorded as having completed training in fire safety, and while the majority of staff had been trained in moving and handling practices, the training for 27 out of 57 staff members was out of date.

Inspectors observed that some moving and handling of residents by staff did not reflect safe moving and handling best practice procedures. This finding was brought to the attention of the person in charge and members of the management team on the day of this inspection during the inspection feedback meeting. The person in charge confirmed that a number of training dates had been scheduled in the weeks following the inspection for fire safety, the prevention, detection and response to abuse and moving and handling practices. The training matrix indicated that the majority of staff had received training in responsive behaviours, and some staff had also recently undertaken training in areas such as dementia care and nutrition. Inspectors spoke with staff, who discussed the various types of training they had recently undertaken, including mandatory training.

Supervision of staff in the one dining room and in one sitting room required improvement to ensure staff practices met the needs of residents and were in line with the best practice guidelines. The person in charge confirmed that staff appraisals were ongoing for this year, but that completed appraisals had already been used to identify training needs and opportunities for staff. Inspectors were informed that staff meetings were held every four to five weeks.

Inspectors examined a sample of staff files, all of which were found to contain the information required by Schedule 2 of the Regulations including vetting procedures. Nursing PINs (personal identification numbers) confirmed up to date registration for nurses with their professional regulatory organisation on the day of this inspection.

A copy of the actual and planned staff roster for the centre was made available to inspectors, which was found to reflect staff working in the centre on the day of the inspection.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Overall, the centre premises met the needs of all residents, and promoted the dignity, independence and wellbeing of residents with dementia.

The designated centre is purpose-built premises which can accommodate a total of 74 residents in 12 twin bedrooms and 50 single bedrooms, all of which were located on the ground floor. The premises were found to be clean and suitably furnished on the day of

the inspection. There were a variety of communal areas for residents including a number of sitting rooms, two dining rooms, a library, oratory, sensory room and an activity room. There were two enclosed gardens that residents could access independently and provided therapeutic areas for residents with dementia. The gardens were designed with features to support the sensory well-being of residents with dementia including shrubs, scented flowers, wandering pathways and a water-fountain. While there was evidence that all communal areas had been addressed in terms of décor and layout to provide a therapeutic environment for residents with dementia, there was opportunity for further improvement in the sitting rooms which the person in charge told inspectors was already recognised and was part of the on-going plans for the centre premises.

Bedrooms, which were suitably decorated, were also personalised by residents if they chose to do so. Bedrooms contained sufficient storage and were of a suitable size and layout to meet the needs of residents including residents with assistive equipment. Each bedroom included en-suite facilities and there were also a number of communal assisted shower rooms and bathrooms located for residents' convenience throughout the centre.

Handrails and grab-rails were in place on both sides of corridors and in toilets, shower rooms and bathrooms as appropriate. Signage or visual clues were in place in some areas to support residents with dementia to navigate throughout the centre. However, further improvement was required. For example, the communal rooms were not clearly named and the centre's circulating corridors were painted the same colour throughout. While bedroom doors were a contrasting colour to the surrounding walls, they were identifiable by a number and were all the same colour. Contrasting coloured fittings were present in toilets in the most recently constructed wing of the centre; however residents with dementia were accommodated in all areas of the centre. The person in charge told inspectors that these issues had already been identified as areas for further improvement by the centre.

Laundry facilities were located on-site, and were suitably laid out to adhere to evidence based infection control procedures.
A functioning call bell system was in place throughout the centre.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Kilbrew Recuperation and Nursing Care
Centre ID:	OSV-0000143
Date of inspection:	31/08/2016
Date of response:	07/10/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A nutritional policy document was in place and although referenced use of the 'Malnutrition Universal Screening Tool' (MUST), details of the assessment procedure including a template of the tool was not included in this advisory document.

1. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement

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

policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
A copy of the MUST tool is available in all residents charts. A hard copy in now available as part of the nutritional policy.

Proposed Timescale: 07/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The interventions to direct care actions in activation care plans and behaviour support care plans required improvement.

2. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
A full review of activation plans is underway. A Recreation Assessment has been implemented to ensure all aspects of residents activity needs are identified and their care plans enhanced where necessary.

We are reviewing our behavioural support care plans on foot of this assessment activity.

Proposed Timescale: 16/01/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that the care plans were not developed in response to the assessed level of risk for pressure related skin injury.

3. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
The care plans are under constant review. The implementation of best practice guidelines has always enhanced our care provision. We have introduced the SSKIN Bundle Tool for Pressure Ulcer Prevention as a means of identifying further the possible

future risk to residents of skin integrity changes that may require pressure relieving interventions and strategies.

Proposed Timescale: 10/12/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was some room for improvement to ensure residents were involved in advanced directive decisions where appropriate.

4. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
As with all our care interventions we endeavour to ensure the resident is included in all decisions related to their care and well being. This includes the resident at end of life decisions. A full detailed discussion takes place with the G.P. the resident and their family or care representative present. The recording of their preferences takes place and is available. The medical care pathway is explained and discussed. This pathway forms a communication tool which enables where possible the resident to decide their end of life needs and where this is not possible their family or care representative engages in their best interests. This criteria is on the form at present and is fully reviewed with all concerned on a three monthly basis. All decisions are recorded in the medical and nursing documentation.

Proposed Timescale: 14/12/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although staff supported residents requiring assistance, not all residents received assistance in a timely manner in one dining room.

5. Action Required:
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
The staff has been notified and more supervision has been put in place to ensure no future delays occur.

Proposed Timescale: 07/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The maximum dosage of PRN medication permissible over a 24hour period was not consistently stated by the prescriber and the times of administration of PRN medications were not consistently recorded by staff administering these medications.

The prescription for subcutaneous fluid administration did not comprehensively direct administration procedures

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

Please state the actions you have taken or are planning to take:
We have engaged with our prescribing G.Ps and have notified them of the need to include the maximum dose that may be administered within a twenty four period must be recorded when prescribing PRN medication on a consistent basis.

The nursing staff have been alerted to their roles and responsibilities associated with medication management with emphasis on their roles in administration and recording of administered medication.

We have included the administration procedures on the Drug Kardex for the commencement of subcutaneous fluids where they have been prescribed

Proposed Timescale: 14/12/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While the person in charge advised inspectors that chemical restraint was used as a last resort, this strategy was not clearly documented in some residents' positive behaviour support plans.

7. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a

designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
A updated list of interventions will form part of the decision making criteria currently utilized to form the residents care plan in this area. Resident specific interventions will be highlighted in individualized criteria. As these interventions are time and situation sensitive we will continue to be lead by the resident and their need for reassurance at the time.

The use of PRN psychotropic medication will only be considered when all other strategies of intervention have been exhausted this strategy will be clearly documented in the residents care plan.

Proposed Timescale: 14/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that prescribed interventions for de-escalation of responsive behaviours were person-centred.

8. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
A compressive list of workable strategies for de-escalation activities will be made available in the residents individualized care plan. These techniques will be reviewed as the residents needs change

Proposed Timescale: 14/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records provided to inspectors indicated that not all staff were trained in the prevention detection and response to abuse.

9. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
As discussed at the time of the inspection the new train the trainer program for prevention detection and response to abuse (Safeguarding) is only available in October / November. This program will enable the completion of our training in the area of safeguarding as soon as possible after the training program. We have received our invitation to participate in this training program which will be run by the HSE. In the interim we have been advised to continue with our currently HSE based program.

Proposed Timescale: 16/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Bedrail risk assessment documentation was not sufficiently comprehensive. Improvement was also required in documentation to reference alternatives tried before bedrails were used.

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

Please state the actions you have taken or are planning to take:
On review of our current bed rail assessment and the one revised on the day of the inspection we find that the two documents are in fact in line with each other accept in one area the availability of a multi disciplinary team member.

All alternative interventions will be recorded in the residents care plan and nursing documentation prior to the application of bed rails.

Proposed Timescale: 16/12/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The communication policy in place did not reference residents with dementia and strategies to effectively meet their communication needs.

11. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement

policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The communication policy is under review and will be enhanced further to meet this criteria.

Proposed Timescale: 16/01/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Closed circuit television (CCTV) cameras were in operation in communal sitting areas and the dining room where a level of privacy for residents would be expected.

Personal information regarding some residents' needs was not adequately protected as it was displayed in their bedrooms.

12. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
The propionate use of CCTV in our facility enables our security to be enhanced as we are in a rural setting. The use of CCTV internally provides for the discreet unobtrusive monitoring of the general area and does not encroach on the freedom of movement, civil rights or personal integrity of all those entering, living and working in the centre. The exception of privacy is valued and promoted for all involved. All recoded material is deleted with in thirty days and is viewed only where it is deemed that learning opportunities may be found from the reordered material.

In the rooms where information is displayed this is directly related to the family's request for same. This provision is as a means of inclusion in the care provision for the small number of residents referred to. The information referred too will be displayed in a more decreed manner with the co-operation and consent of the resident and their family members.

Proposed Timescale: 16/01/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors' findings indicated that significantly improved assessment for residents with dementia was required to ensure that activities provided met their interests and

capabilities including whether 1:1 or small sensory based group activities were more appropriate to meeting their needs.

13. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
A full re-assessment and review of the individual activation needs of our residents is under way. This review will provide us with more precise information on the current needs and capabilities of our residents. The result of this review will enable us to further enhance the programs we provide ensuring that the individuality, interests and changing capabilities of our residents are identified and their programs modified to meet their requirements.

Training dates for the program identifies at the time of the inspection have been arranged. We will continue to provide two opportunities for 1:1 interaction in our sensory room and also in our activity room Bernie's boutique.

Proposed Timescale: 14/02/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement opportunities were identified to ensure communication boards were used in practice for residents requiring them.

14. Action Required:
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

Please state the actions you have taken or are planning to take:
All staff have been instruction to increase the use of the communication boards available. These boards will be updated and reviewed as the resident's requirements change thereby enabling us to provide them with new more up to date information that may assist in the decision making activity.

The updating and review of information and activity notice boards will take place on a daily basis.

Proposed Timescale: 14/12/2016

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no nominated person to ensure complaints are appropriately responded to and records are maintained.

15. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
A nominated person in now indicated in our policy.

Proposed Timescale: 07/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The satisfaction of the complainant with the outcome of the complaint was not consistently recorded.

16. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
We have revamped our complaints management forms to ensure that all actions taken to resolve the complaint are recorded and to ensure that the outcomes to resolve the complaint are to the satisfaction of the complainant are recorded on a consistent basis.

Proposed Timescale: 07/10/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received mandatory training in fire safety, safe moving and handling

practice and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
As discussed on the day of the inspection our training program was continuing and will be completed by the end of November.

Proposed Timescale: 30/11/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supervision of staff in the one dining room and in one sitting room required improvement to ensure staff practices met the needs of residents and were in line with the best practice guidelines.

18. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
More supervision has now been put in place.

Proposed Timescale: 07/10/2016