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:	Kilcara House Nursing Home
Centre ID:	OSV-0000241
Centre address:	Kilcara, Duagh, Kerry.
Telephone number:	068 45 377
Email address:	Kilcarahouse@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mertonfield Limited
Provider Nominee:	Noel Kneafsey
Lead inspector:	Mary O'Mahony
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

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

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 November 2016 09:30	25 November 2016 19:00
28 November 2016 09:00	28 November 2016 18:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection of Kilcara Nursing Home by the Health Information and Quality Authority (HIQA) was carried out as part of the renewal of registration process. The inspection was announced and took place over two days. There were 30 residents in the centre and five vacancies on the days of inspection. Prior to the inspection, HIQA questionnaires were sent out to residents and family members. These were reviewed by the inspector and were seen to be complimentary of care in the centre. Residents

and visitors, who spoke with the inspector stated that they were happy and that the care was good.

During the inspection, the inspector met with residents, the provider, the person in charge, the nurse manager, nursing staff, care staff, household staff and visitors. The inspector reviewed documentation such as, the complaints and incidents books, the risk register, residents' care plans, training records as well as relevant policies. A number of staff files were checked for compliance with regulations. According to the roster seen by the inspector, the person in charge worked as a member of the nursing staff, as well as attending to administration duties. She was supported in the management of the centre by the nurse manager, who was the deputy person in charge.

On this inspection, the inspector found a number of improvements. New comprehensive policies and audit documentation were in place. In addition, the activities for residents had been augmented. These included, 'Sonas' sessions, musical entertainment and art and crafts. The premises, fittings and equipment were of a good standard and the centre was found to be warm and clean. There was evidence of individual resident's needs being assessed and medical attention was readily available. Staff were seen to support residents with their meals and care needs, where necessary. The nurse manager informed the inspector that community and family involvement were encouraged in the centre. There was a varied activities programme seen on the notice board. Photographs of various events were displayed on a TV monitor, at the entrance to the centre.

The findings of the inspection were set out under 18 Outcome statements. These Outcomes were based on the regulatory requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland, 2016. Some actions were required by the provider to ensure that the centre was in full compliance with the aforementioned statutory requirements. These included safeguarding and safety, risk management, governance and management, medication management, care planning and complaints management.

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector viewed the statement of purpose which accurately described the service that was provided in the centre. It contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. It was reviewed on an annual basis.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The quality of care was monitored and reviewed on an ongoing basis, according to the audit documentation reviewed by the inspector. Effective management systems and sufficient resources were in place. There was a clearly defined management structure in

place, that identified the lines of authority and accountability. New policies procedures and audit systems had been sourced, since the previous inspection. According to the person in charge and the deputy person in charge, external support was being accessed, to improve compliance with regulations. However, the inspector found that an annual review of the quality and safety of care delivered to residents was not in place for 2015. The provider undertook to complete this annual review for 2015 and 2016 and to make it available to residents and to the inspector. In addition, there were some issues of poor staff supervision, which were discussed with the provider. This was further discussed under Outcome 7: Safeguarding and safety.

There was evidence of consultation with residents and their representatives. Minutes of residents' meetings were reviewed and staff appraisals were ongoing.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
There was a resident's guide available. It contained all the required information. A copy was seen in each hallway. In a sample of residents' files reviewed, the inspector found that there was a written contract signed and agreed on admission. Each resident's contract outlined the care and services available in the centre. The contracts specified the fees to be charged and specified the services which were to be paid for by residents, for example, hairdressing fees and bus outings.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was an experienced nurse manager. Staff, residents and relatives all identified the person in charge as the person with the overall responsibility for the delivery of care. She was supported in her role by the nurse manager and was knowledgeable of the regulations and standards, when spoken with by the inspector. She had regular meetings with the management team and the staff. Minutes were maintained of these.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The records required under the regulations were viewed by the inspector.

Fire safety records were seen and met the requirements of the regulations as regards training, testing and maintenance of the fire protection equipment. The centre was adequately insured against injury to residents. The incident and accident forms were up to date and contained details of learning from the events. The directory of residents and the residents' guide were up to date and contained all the relevant information.

The inspector viewed a sample of residents' care plans. Each care plan outlined the medical and social care needs of residents and details of how to support residents in having these needs met. Medical care records and assessments from allied health professionals were easily retrievable. A record of each drug and medicine administered was documented in residents' medication records. A daily narrative note was maintained for each resident. The inspector found that appropriate restraint records were maintained including signed consent.

The inspector reviewed a sample of staff files. Most of the regulatory documents were in place. However, two staff members did not have the required vetting disclosure in place. This was addressed under Outcome 7: Safeguarding and safety. The duty roster was reviewed and it was found to correlate with actual staffing levels, in the centre.

Complaints management in the centre was reviewed. Appropriate, external, agencies were involved in complaints investigation, where required. Not all issues had been resolved at the time of inspection. This was addressed under Outcome 13: Complaints. The inspector viewed the policies, which were required to be maintained, under Schedule 5 of the regulations. These were seen to be signed by staff.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The provider was aware of his statutory duty to inform the Chief Inspector of the proposed absence of the person in charge and the arrangements in place, for the management of the centre, during her absence. There was a suitably qualified person in place to deputise in the absence of the person in charge.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Policies and procedures were in place for the prevention of abuse, which referenced best evidence practice. Elder abuse prevention training formed part of staff induction. Residents with whom the inspector spoke stated that they felt safe in the centre.

Systems were in place to safeguard residents' money. The provider and deputy director of nursing outlined practices used to record financial transactions. The provider stated that fees were handled separately to personal money/belongings. He stated that invoices were sent out regularly, which reflected payments made. He informed the inspector that he would review the practice of not providing receipts for some services and any extra purchases. Personal money transactions were recorded in a lodgement book and signed by two staff members. A sample of these were checked and seen to be correct.

Residents were assessed for behaviour issues associated with the behaviour and psychological symptoms of dementia (BPSD) on admission, in line with centre policy. Strategies to de-escalate BPSD were outlined in residents' care plans, where appropriate. However, similar to findings on previous inspections there was evidence that all staff had yet to receive training, to update their knowledge and skills, in this area of care.

An assessment of each resident's needs including cognitive, environmental, psychosocial and physical needs had taken place. The inspector reviewed the use of restraint assessment forms, risk balance tools and restraint consent forms, in residents' files. A restraint log was maintained.

A significant safeguarding issue was found when reviewing a sample of staff files. Two staff members were seen to have been rostered to work in the centre without the required Garda Vetting (GV) in place. This was required for all staff under the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012-2016. This serious non compliance with legislation was discussed with the person in charge and a verbal immediate action plan was issued by the inspector. The provider was asked to specify in writing the actions he proposed to take, prior to completion of the inspection. The provider stated that these staff members would not be rostered on duty in the centre, until this requirement was fulfilled. Following the inspection, the provider stated that all staff in the centre will have the required GV in place, in future, prior to commencing their employment.

In addition, a concern had been received by HIQA prior to the inspection, which was discussed with the provider and person in charge. This concern was in relation to, an allegation that some staff members raised their voices, to residents. The provider and person in charge stated that some staff could raise their voices and they were aware that this could be misconstrued. However, these events had not been documented, or addressed, formally, with the staff members involved. Training in appropriate communication had not been provided for those staff.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
A health and safety statement, dated January 2016, was available in the centre. The risk management policy was reviewed and risk assessments were relevant to different areas in the centre. Controls were in place to prevent accidents such as falls. Risk assessments were updated following incidents. Handrails were available on each corridor, grab-rails were located in toilets and an audit of health and safety was undertaken monthly. The procedures in place for the prevention and control of infection were satisfactory. For example, hand gels were in place and hand wash facilities were readily available. A contract was in place for clinical waste removal and disposal. An emergency plan had been developed an staff spoken with were aware of this. Suitable fire equipment was provided and there were adequate means of escape from the premises. A record was maintained of daily checks in relation to fire exits, ensuring the alarm panel was working and weekly testing of the fire alarm. The fire alarm panel and the fire prevention system were serviced regularly. Fire fighting equipment was serviced on an annual basis. These records were viewed by the inspector. However, the certificates for the quarterly servicing of emergency lighting were not available at the time of inspection. These certificates were produced following the inspection. The procedure for the safe evacuation of residents and staff was prominently displayed. Staff received training in fire safety. Fire drills took place on a three-monthly basis. The last fire drill had been held on 11 November 2016. However, the records of fire drills were not sufficiently detailed, to indicate if all staff responded appropriately and to highlight the timeframe for evacuation, during the event.

Staff were trained in moving and handling of residents. Training records viewed by the inspector confirmed this. Documentation was available which indicated that equipment was serviced regularly. There was closed circuit TV (CCTV) in the external areas and hallways. This was supported by signage and a policy.

A number of residents smoked in the smoking room. Some residents had been risk assessed as safe, to keep their cigarettes and lighter on their person. However, the condition of one person who had previously been assessed as suitable for this practice had disimproved and the person required re-assessment. The smoking room was

equipped with a fire extinguisher, a bell and a smoking apron. However, similar to previous inspection findings the smoking room door remained open all day. The person in charge stated that residents would not sit in there, if the door was closed. The person in charge was asked to risk assess this practice and put any required controls in place to prevent a fire risk. The effect of the open door meant that there was a strong smell of cigarette smoke in the hallway outside this room. In addition, there was a silver wire mesh type waste paper bin in the smoking room, which was used as an ashtray. The person in charge removed the bin type ashtray during the inspection as it was not a robust enough, or suitable, for hot ashes.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
The centre-specific policy for medication management was recently reviewed. The processes in place for the safe storage, supply and disposal of controlled drugs were reviewed by the inspector and found to be robust. The controlled drugs register was checked and found to correspond with the balance of a sample of controlled drugs reviewed by the inspector.

The medication prescription sheets signed by the general practitioner (GP). Medications for crushing were prescribed as such. The person in charge stated that medications were reviewed on a three monthly basis by the GPs.

Medication that required refrigeration was stored appropriately. However, some medications that had been previously dispensed for residents, but were no longer required, were still available in the medication trolley. In addition, one of these medications had been supplied in a format that had not been prescribed. The nurse stated that this had not been dispensed to the resident, as it was in a sealed box. She undertook to return it to the pharmacy. Furthermore, not all medication administration sheets were clear, as the prescriber and pharmacy had used alternative names for a number of medications. The inspector found that an administration sheet for a medication, that was still in use for that resident, was filed away. The inspector also saw that an administration document for PRN (as required) drugs was not fit for purpose, as it did not have clearly defined spaces for the nurse to sign, when medication had been administered.

The centre was well supported by a pharmacist, who conducted regular medication management audits and reviewed residents' prescriptions. The person in charge stated that the pharmacist facilitated staff training and was available to speak with residents.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
There was an incident and accident log maintained for both residents and staff. The person in charge had notified HIQA of incidents and accidents, in line with the requirements under Regulation 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Quarterly notifications were submitted to HIQA as required. The person in charge was found to be aware of the regulations related to notifications.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Residents were assessed by the person in charge, or the nurse manager, prior to admission, to ensure the service was suitable to their needs. Since the previous inspection documentation was maintained of these assessments. In addition, medical letters were available, which confirmed residents' medical conditions. The inspector reviewed a number of residents' files and observed that residents had a comprehensive assessment and care plan in place, to meet their assessed needs. Care plans included a detailed profile of each resident. Residents and relatives, where appropriate, were involved in developing and reviewing the care plans.

Residents had access to allied health care professionals and the inspector noted that these were accessed for a number of residents. For example, the inspector noted that the speech and language therapist and the palliative services had provided care to residents, where necessary. However, similar to findings on the previous inspection, one resident had not been seen by the dietician for an extended period of time. The resident had a weight problem which was impacting on the resident's lung function. The resident was last seen by a dietician in March 2014. In addition, the resident had not been assessed for the risk of aspiration. The inspector found that the resident was seen by the GP on 17 November 2016 and was found to be 'chesty'. The inspector spoke with the resident and observed that the resident's breathing was laboured, during the inspection. This finding was discussed with the deputy person in charge and with the management team, at the feedback meeting, at the end of the inspection.

Nutritional needs of residents were met by the provision of a varied diet and nutritional supplements, where required. The inspector observed that residents were afforded choice at mealtimes and this was confirmed by residents, relatives and by the kitchen staff.

Residents were reviewed regularly by the GP. For example, the GP was seen to visit on two occasions during the inspection. Medication reviews were carried out and medications were seen to be adjusted, if any adverse effect was noted. Oral care assessments were carried out and dental referrals had been made for a number of residents. Eye care consultations and chiropody treatment were documented, in the sample of care plans seen.

The environment was stimulating, with plenty of objects to engage and interest residents. There were opportunities for reminiscence provided by a well stocked reminiscence corner and in the provision of appropriate activities. There were opportunities for residents to avail of one of three sitting areas, according to their needs and preference. Activity provision was addressed under Outcome 16: Residents' rights, dignity and consultation.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents,

conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The centre was a two-storey building that was purpose built in 1994 and had a lift and back stairs, to the top floor. It provided care for up to 35 residents. At the time of inspection there were five empty beds. There were 17 single bedrooms with en-suites, six twin bedrooms, three of which had en-suites and two three-bedded rooms, which had shared toilet and shower facilities. The provider was asked to continually risk assess the space and dependency levels of residents in the three bedded rooms, to ensure that each resident's privacy and dignity was maintained at all times. One of the three bedded rooms was occupied by two female residents. There was an empty bed in this room at the time of inspection. The inspector observed that the curtains used to screen the beds in these rooms were in good repair. These were seen to be utilised when care was being delivered. The bedrooms which did not have en suite facilities had a wash-hand basin in the room.

On the ground floor there was one shared toilet and one assisted bathroom with bath, toilet and wash-hand basin. On the first floor there was one communal bathroom which had a bath and shower area. The inspector spoke with the person in charge about the lack of hand drying facilities in some toilet and bathroom areas. She undertook to address this. There was also a separate communal toilet and wash-hand basin available for residents' use. Each resident had an individual locker and wardrobe and in the communal bathrooms each resident had an individual bathroom cabinet, for their belongings. Call bells and individual lights were in place over each bed.

The inspector found that there was adequate private and communal space in the centre. The communal living space for residents was on the ground floor and consisted of a dining room, a conservatory, two sitting rooms, a small prayer room and an indoor smoking room. The indoor smoking area was discussed under Outcome 8. Outdoor space consisted of concrete pathways and a secure accessible patio area. To the front of the building there was a parking area for staff and relatives.

Staff changing facilities were adequate and staff had storage facilities for personal belongings. Hoist, wheelchairs, walking frames, electric beds and electric mattresses were available for use, depending on the assessed needs of residents. The inspector viewed the service records for equipment in use in the centre. The premises was noted to be warm and bright. New signage was in evidence. The centre was clean and generally in good repair. The inspector saw evidence of a cleaning schedule for all areas. The kitchen was located in the centre of the home and was easily accessible to staff,

when serving meals to residents.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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 for making, investigating and handling complaints. The complaints procedure was displayed in the main reception area. The person in charge informed the inspector that complaints were discussed at staff meetings and the inspector viewed the complaints book. The statement of purpose and the residents' guide also contained details of the complaints procedure.

Staff were aware of the complaints procedure. The name and contact details of a nominated independent appeals person was displayed, for use in the event that a complainant was unhappy with the internal investigation. The inspector saw evidence that the services of this person had been employed to support residents making complaints.

However, an ongoing complaint had not been responded to, formally, at the time of inspection. The person in charge stated that this would be attended to, following the inspection.

External complaints agencies were engaged with the centre, at the time of inspection.

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
The centre's policy on end-of-life care was up to date and comprehensive. Residents' advanced wishes were recorded in their care plans. Residents who had died during the year were remembered annually, at a remembrance event.

Staff training records indicated that all staff had completed training on care of the resident at end of life. Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services and had access to ministers from different religious denominations. Monthly mass and weekly prayers were held in the centre. Family and friends were facilitated to be with the resident at end of life. Tea/coffee/snacks facilities were provided for relatives. Open visiting was facilitated. Overnight facilities were available for family members and there was a small oratory in the centre.

Residents had access to the specialist palliative care service. The deputy person in charge stated that when a resident died, his/her family or representatives were offered practical information on what to do following the death. There was a protocol for the return of personal possessions. Residents' personal inventories were updated when appropriate.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
A policy for the monitoring and documentation of nutritional intake was in place. Residents had a nutritional assessment on admission and this was repeated on a three-monthly basis. Residents' weights were checked and recorded monthly. The food provided was nutritious and available in sufficient quantities. It was varied and took account of dietary requirements. For example, home cooked cakes and home made soup were cooked on a daily basis. Meals were available at flexible times and at times suitable to residents. For example, one resident had requested that his meals would be

provided later in the day. This was facilitated. Residents had access to fresh drinking water and juice at all times. The inspector observed staff offering drinks to residents, throughout the day. A choice of food was provided at each mealtime.

Residents requiring support were assisted to eat and drink in a sensitive and appropriate manner. Most residents dined together in the dining room where the tables were seen to be suitably set up, with nice cutlery and tableware. A number of other residents were assisted to eat in the adjoining conservatory area. The inspector observed that mealtimes were seen to be relaxed occasions. Residents were seen to communicate and interact with staff, who sat with them while assisting them with meals. Residents spoke about their meals with the inspector and stated that the food was very good. Relatives and residents confirmed that there was always a choice available at each meal.

The chef had been in the centre for a number of years and had a good rapport with residents. She was found to be familiar with the dietary needs of residents. For example, low sugar products and desserts were available for those with diabetes. She had attended updated relevant training and communicated with the person in charge on a daily basis. The majority of residents were enabled to maintain independence when eating their meals and assistive cutlery was used where necessary.

Judgment:
Compliant

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

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The person in charge and the nurse manager informed the inspector that residents were consulted with, in the centre. Residents were enabled to make choices and maintain their independence. The inspector reviewed the minutes of residents' meetings and noted that concerns were addressed. The last meeting was held on 17 November 2016. In addition, there were residents' surveys undertaken. One resident had been appointed as residents' representative. The inspector was informed that there was an external, suitably trained, person who was available as an advocate for residents.

Residents were facilitated to exercise their civil, political and religious rights. Residents confirmed this with the inspector. Most residents had unrestricted access to a safe outdoor patio area. According to the person in charge, residents who were not at risk of absconsion were enabled to access the external unsecured garden. Appropriate seating was available in the garden areas and colourful flower pots were planted at the entrance to the centre.

Residents' wishes were prioritised when planning activities. There were many photographs on display which had been taken at events and birthday parties both inside and outside the centre. There were no restrictions on visitors and there were a number of areas where residents could meet visitors in private. On the day of inspection visitors were observed spending time with residents in the dining room, in the bedrooms and in the sitting rooms.

There was a variety of activities available to residents in the centre which were organised and facilitated by an activity coordinator. The weekly activity schedule included music, bingo, crafts, skittles, newspaper reading, religious activity, Sonas, and chair based exercise. During the inspection, two staff members spent periods of time with different groups of residents facilitating for example, singing sessions, Christmas crafts and a game of skittles. 25 residents attended mass during the inspection. Documentation confirming attendance at activities, or non attendance, was maintained. However, this documentation was not adequate, as it did not clearly highlight which residents had attended the activities. The activity co-ordinator, who was spoken with, stated that she was assigned to activities daily from 11.00 until 15.00. She stated she would adjust the activity documentation, to ensure clarity. She was found to be enthusiastic about her role and knowledgeable about residents' likes and dislikes.

Life stories were available for each resident. This documentation included details of residents' individual interests, level of communication, preferences and background. These had not been included in each resident's individual care plan, however staff were aware of where to access the information. Residents had care plans for the communication need of residents. There was a communication policy in place that included strategies for effective communication with residents who had dementia. However, staff had not been afforded training in communication with residents, as appropriate to their needs. This was addressed under Outcome 7: Safeguarding and safety.

As discussed under Outcome 12: Premises, the provider was asked to continually assess that the privacy and dignity needs of residents could be protected in the two three-bedded rooms. The deputy person in charge explained the dependency needs of residents in the three-bedded rooms and stated that one resident required the use of a hoist. The inspector observed that it would be difficult for this resident to gain access to the shared toilet in the bedroom. If a commode was required to be used, this would impact on the resident's privacy and that of the other two residents. However, the deputy person in charge stated that residents were given a choice to move to another room and had declined this.

Judgment:
Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
Residents maintained control over their personal property and possessions. The inspector viewed the policy on personal possessions and clothing. There were adequate laundry facilities with systems in place to ensure that residents' personal clothing was marked and safely returned to them. Bed linen was laundered internally and adequate clean supplies were stored in the linen cupboard. Personal clothing was washed at home by residents' representatives in the case of a number of residents.

There was adequate space for each resident to store and maintain their own clothes and other possessions. Each resident had been supplied with a locked drawer in their bedroom for personal items.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:

The inspector spoke with a number of staff individually about their view on the staffing levels, on day and night shift. Staff spoken with stated that they were satisfied with the current staffing levels. Appraisals were conducted annually by the person in charge. An actual and planned roster was maintained in the centre. There was a nurse on duty daily, as well as consistent care staff. The centre had the services of maintenance personnel for the gardens and the premises.

Records viewed by the inspector confirmed that all staff had completed mandatory and appropriate training in areas such as safeguarding, manual handling and fire safety. However, as discussed under Outcome 7: staff had not been afforded appropriate training in communication. The recruitment policy seen on inspection met the requirements of regulations. However, this had not been fully implemented as two staff members had been employed without the required Garda vetting, as previously discussed. The inspector reviewed a sample of staff files and the information required to be maintained in these files, under Schedule 2 of the Regulations. This was discussed under Outcome 5: Documentation and Outcome 7: Safeguarding and safety.

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:

Mary O'Mahony
Inspector of Social Services
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:	Kilcara House Nursing Home
Centre ID:	OSV-0000241
Date of inspection:	25 and 28 November 2016
Date of response:	18 January 2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that there was an annual review of the quality and safety of care delivered to residents in the designated centre, to ensure that such care was in accordance with relevant standards set by HIQA, under section 8 of the Act and approved by the Minister under section 10 of the Act.

1. Action Required:

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

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that 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.

Please state the actions you have taken or are planning to take:
Annual review of quality and safety of care has been completed and available to residents.

Proposed Timescale: Complete 04/01/2017

Proposed Timescale: 04/01/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had failed to put in place management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This related to staff supervision.

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Any risks identified to a resident, Health risk, Safety risks or risk of abuse will be discussed at the quality management system meeting and all staff will be informed in a timely manner. Management will review adherence to policies, and take appropriate action if not adhered to. The new management system that we have initiated will overcome this issue arising again. The provider is fully committed to providing a safe management system for all residents and staf.f
Training in communication will be rolled out for staff and staff issues will be addressed as they arise.
In relation to staff supervision we have appointed a senior Health care assistant, as a liaison officer for all Health Care assistants,
to help improve the two way communication between Health Care assistants and management.
Any concerns brought to her attention by any Health Care assistant will be acted on as per Nursing Home Policy.
Going forward this will enhance consistency and effective monitoring of all staff.

Proposed Timescale: 19/01/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that occurred, as a result of the behaviour and psychological symptoms of dementia.

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

Please state the actions you have taken or are planning to take:
Any risks identified to a resident, Health risk, Safety risks or risk of abuse will be discussed at the quality management system meeting and all staff will be informed in a timely manner. Management will review adherence to policies, and take appropriate action if not adhered to. The new management system that we have initiated will overcome this issue arising again. The provider is fully committed to providing a safe management system for all residents and staff
We will continue to monitor the situation.
New staff training has been scheduled.
All allegations Of abusive interactions will be recorded
Communication training will be delivered to staff.
Vetting has been procured for the two staff. No staff will be employed without the required vetting.
Timescale 19/01/17
All long term staff had training on Dementia care at time of the inspection which involved behaviour and psychological symptoms. Training has been booked for new staff members.
The two staff members who are working without Garda Vetting, had previous come from another nursing home and had Garda clearance. We had applied for Garda vetting and we were awaiting clearance at the time of inspection. One staff member had received Garda clearance at the time of inspection and the other was taken of the rota until clearance.

Proposed Timescale: Training Dates:16/01/2017-19/01/2017
All staff now have Garda clearance.

Proposed Timescale: 19/01/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Allegations of alleged verbal abuse had not been recorded.

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

Please state the actions you have taken or are planning to take:
Any risks identified to a resident, Health risk, Safety risks or risk of abuse will be discussed at the quality management system meeting and all staff will be informed in a timely manner. Management will review adherence to policies, and take appropriate action if not adhered to. The new management system that we have initiated will overcome this issue arising again. The provider is fully committed to providing a safe management system for all residents and staff
We will continue to monitor the situation.
New staff training has been scheduled.
All allegations Of abusive interactions will be recorded
Communication training will be delivered to staff.
Management of nursing home were not aware of any such allegations, however, training on appropriate communication has been booked following staff meeting, as some long term staff are over familiar with some residents and speak to them on a raised tone. All staff have been re-informed that appropriate action will be taken and documented should this issue arise again.

Proposed Timescale: 19/01/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All reasonable measures had not been taken to protect residents from abuse.
For example:
Not all residents had current Garda Vetting on file.
Staff who did not communicate with residents in an appropriate manner had not been addressed and appropriate training had not been provided.
Receipts had not been provided for all services.

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

Please state the actions you have taken or are planning to take:
Training has been provided to all staff on appropriate communication towards residents, as long term staff can be overfamiliar with long term residents. We have also ensured that all residents have an Elder abuse risk assessment in their care plan, which will give each resident the opportunity to voice any concerns he/she may have. Families will also be involved in assessment if there are any concerns identified. Any risks identified to a resident, Health risk, Safety risks or risk of abuse will be discussed at the quality

management system meeting and all staff will be informed in a timely manner.Training on appropriate communication has been booked following staff meeting. All staff have been re-informed that appropriate action will be taken and documented, should this issue arise again.
GV has been procured for both staff members.
As per National Vetting Bureau (Children and Vulnerable Persons) Acts 2012-2016 Kilcara will not be employ any new members of staff without Garda clearance
The new management system that we have initiated will ove come this issue arising again.
The provider is fully committed to providing a safe management system for all residents and staff
We will continue to monitor the situation .

Proposed Timescale: 19/01/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire safe door in the internal smoking room, in place to contain any fire, was always open.
An ashtray bin was not suitable for use as an ashtray.
One resident required re-assessment, in relation to keeping the cigarette lighter. The resident's condition had disimproved since the last risk assessment.

6. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The smoking room door contains a door guard which will automatically release should the fire alarm go off. Following residents meeting all were in agreement that smoking room door needs to be closed.
A suitable ashtray had been put in place, in smoking room, at the time of inspection.
The resident involved was unwell at time of inspection, and was not smoking, but risk assessment was done. Same resident is well now and following a new risk assessment can keep the lighter.

Proposed Timescale: Complete 15/12/16

Proposed Timescale: 15/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drill records had not been adequately maintained.

7. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Under the health act 2007 (care and welfare of residents in designated centre for older people), regulations 2013 we will continue with the live risk register. Our action plan is to update the live register more often and bring same on a monthly basis to our quality management meetings for further discussions and improvements. There will be a set time frame and a person allocated to alleviate/reduce risk identified.
Health and safety and protection of residents action plan
Our health and safety statement and Elder abuse policy were updated in 2016.
All staff have been allocated time to re-read policies.
Management will review adherence to policies, and take appropriate action if not adhered to.
Records of fire drills have been documented, but will provide more details of evacuation events.

New documentation form in place,

Proposed Timescale: 18/01/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Drugs which were no longer in use were still stored in the medication trolley.

8. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
Ensure that all medications no longer in use are returned to pharmacy within 2 days.

Proposed Timescale: Ongoing

Proposed Timescale: 18/01/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all medications documented on the administration sheet were clearly correlated with the prescription.
A document in use for recording PRN medication was unsuitable as there were no clearly defined areas for the nurse to sign the time of administration of the medication.
A medication had been supplied in a form that had not been prescribed.

9. Action Required:
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

Please state the actions you have taken or are planning to take:
Following the inspection the registered provider, the person in charge and assistant director of nursing met with the pharmacist to discuss the medication management system and how to improve it. The Director of Nursing will continuously review the medicines management policies and procedures in place in the service to ensure that they are in line with evidence based practice and legislation, and that they continue to meet resident's needs and expectations. The Director of Nursing and pharmacist will audit and review adherence by staff to the medicines management policies and procedures. The director of nursing will take appropriate action when these documented policies and procedures are not being adhered to. This ensures that medicines management is continuously improved in the service.
All administration sheets are now clearly documented and defined.
One drug which was given by pharmacy in a different format as it was not available in prescribed format. Same was discussed by GP and pharmacist.
It was not dispensed and was returned to pharmacy at time of inspection.

Proposed Timescale: 30/11/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had not been reviewed by the dietitian to review her current weight since

2014.

10. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
The resident has been reviewed by the dietitian on 18 /01/2017. Recommended low fat diet , sugar free drinks and encouraged healthy eating guidelines.

Proposed Timescale: 18/01/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident who required a hoist, to aid his transfer from bed to chair, could not easily access the toilet in the shared bedroom.
Towel dispensers or other hand drying equipment were not available in some toilet/shower areas.

11. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
There are two three bedded rooms and occupancy is determined by dependency level following a Risk Assessment.
The resident was moved to another room.
Hand paper towels are now available in all toilets and bathroom areas.

Proposed Timescale: Complete 6/12/16 and 18/01/17

Proposed Timescale: 18/01/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A written complaint had not been responded to by the provider.

12. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
The complaint has been responded to.

Proposed Timescale: 05/12/2016

Outcome 16: 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:
Those residents who shared the three bedded rooms had little space to carry out activities in private particularly as regards having their care needs and toileting needs, attended to.

13. 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:
Following a Risk Assessment on all three residents and speaking with family members involved, it was highlighted unsafe to move one resident. Second resident refused to move to a different room and same was respected. Third resident involved, who required a hoist for movement was quiet happy to move.

Proposed Timescale: 18/01/2017