

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Kylemore House Nursing Home
<b>Centre ID:</b>	OSV-0000055
<b>Centre address:</b>	Sidmonton Road, Bray, Wicklow.
<b>Telephone number:</b>	01 286 3255
<b>Email address:</b>	info@kylemorehouse.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Kylemore Nursing Home Limited
<b>Provider Nominee:</b>	Ruth Behan
<b>Lead inspector:</b>	Nuala Rafferty
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	36
<b>Number of vacancies on the date of inspection:</b>	2

## **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.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
27 September 2016 09:00	27 September 2016 17:30
28 September 2016 07:30	28 September 2016 19:30

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Major
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Major
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant
Outcome 08: Governance and Management		Non Compliant - Major
Outcome 10: Suitable Person in Charge		Compliant
Outcome 12: Notification of Incidents		Non Compliant - Major

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection monitored progress on the actions required arising following the last follow up inspection carried out on 7 February 2014 and a thematic inspection on

nutrition and end-of-life care in October 2014. The inspection also considered information received by HIQA in the form of notifications and other relevant information. The provider had completed a self-assessment tool on dementia care in 2016 and had assessed the compliance level of the centre as compliant in all six outcomes. However, the findings of this inspection do not accord with the provider's assessment.

As part of the inspection, the inspector met with residents and staff members observed practices and reviewed documentation such as clinical records, staff files and management processes. Residents who spoke to the inspector were very complimentary about the care they received from staff. There was an obvious familiarity between residents and staff and most residents knew the names of staff and the management team.

The inspector found that a high standard of nursing care was not being provided to effectively manage the needs of all residents. Safe administration of medicines that reflected current guidance from the Irish Nursing Board was not found. Effective systems were not in place to deliver safe appropriate and consistent levels of service that meets residents' needs in relation to nutrition, health and social care and religious needs. Supervision systems were not in place to guide and monitor staff practice.

Changes to the management team had occurred since the last HIQA inspection. The current person in charge had commenced in the post in October 2015. However, the findings of the inspection as evidenced under outcomes 1,3,8 and 12 does not demonstrate a good knowledge of the Health Act 2004 Care and Welfare Regulations 2013 (as amended) or the National Standards of Care for Older Persons 2016.

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 Centres for Older People) Regulations 2013(as amended) 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:**

Systems were in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff were observed to check and document the balances of all controlled drugs at the change of the morning shift.

Medication prescribing practice was found to be in line with current professional guidance. These included prescribing practices with name, time, form, dose, route and frequency identified. The prescriber's signature was recorded for all medicines and also date, time and signature for discontinued medicines. Maximum dosage for all as required medicines were also identified.

However, the administration of medicines did not comply with professional regulatory requirements or guidance and potential risks for efficacy and safety associated with delayed and omitted medicines were found.

-The inspector found evidence that medicines were consistently not administered as prescribed, placing residents at risk of serious adverse outcomes. Risks related to omitted or delayed medicine administration have been identified through medical research studies including;

1. Complications and adverse outcomes resulting from delays in administration of regular analgesia and antibiotics.

2. Negative impacts particularly in the case of medicine used to treat symptoms associated with Parkinson's disease where symptom control is significantly reduced.

-Medicines were consistently administered later than prescribed. On the days of the inspection, some critical medicines were administered up to 5.5 hours later than prescribed. On review of medication administration records for three weeks preceding the inspection, a medicine was not administered until 12.5 hours after the prescribed time. Staff outlined that medicines may be delayed due to resident's preferred sleep regimes and/or mood.

- There was evidence that medicines were omitted and the reason for omission was not

recorded.

-Accurate records for medication administration were not kept. The inspector saw evidence that actual time medicines were administered and the time recorded were different.

-On the second day of inspection the inspector noted that the time of administration for a medicine had been altered from the first day of inspection. The alteration was not signed or dated and implies that the medicines administered over a total of 19 days were administered at the times prescribed which was not the case. This was raised with the person in charge and the provider nominee who recognised the seriousness of altering records and gave assurances that this would be investigated.

Although the inspector observed that nurses were occasionally interrupted during the administration process, the interruptions were not frequent or overly long. It was noted that nurses did not use any identification to show they were giving the residents their medication or request they were not disturbed during the administration of medicines.

Although a system for checking medication practices was in place it did not include a check of the duration of medication administration to ensure it took place within recommended timeframes. Effective medication reconciliation procedures were not in place to avoid medication incidents errors and omissions.

**Judgment:**

Non Compliant - Major

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

A high standard of safe and suitable evidenced based nursing care was not found to be delivered to all residents.

Access to medical and allied health professionals was available. The majority of residents were under the care of local general practitioners (GP) and visits by the doctors from the local clinics were regularly made on referral or on a needs required basis. Access to a range of allied health professionals was available. Documented visits, assessments and recommendations by dietician speech and language therapists, physiotherapy and occupational therapist reviews were viewed. Residents were also reviewed by opticians, dentists and chiropody services on a regular and as required basis.

Samples of clinical documentation including nursing and medical records were reviewed. These showed that all recent admissions to the centre were assessed prior to admission. The pre admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident.

Records viewed showed that systems to ensure the transfer of information within and between the centre and other healthcare providers were not effective or consistent. Discharge letters for those who had spent time in acute hospital, or had attended emergency departments were maintained, but letters from consultants detailing findings after clinic appointments were not always available. Letters or notes as to the outcome of the appointments were not on the medical file or in any of the nursing documentation, also no record of any verbal information received, for instance, from relatives who accompanied residents or any further follow up by the nursing team was documented. Therefore updates on resident's condition with results of investigations, recommendations for treatment or ongoing monitoring as a consequence of clinic appointments were not available.

The care planning system in place in the centre to meet residents' assessed needs was not properly implemented and there was inadequate assessment planning and evaluation of resident's care needs. The nursing process ( a scientific method used by nurses to ensure the quality of patient care) includes assessment of each resident's health status and the determination of potential risks to their health. Care plans are then developed to prevent, reduce or manage risks identified. The plans are based in part on information from recognised assessment tools used to check for risk of deterioration in areas such as; risk of falls, nutritional status, levels of cognitive impairment, skin integrity, pain, continence and communication.

Some of these assessment tools were in use. However, it was found that where care plans were in place they did not always reflect the most up to date risk assessment. Examples included; restraint, continence and nutrition assessments. It was also found that care plans were not in place for all identified needs. Examples of healthcare needs, where care plans were not in place included; low blood pressure, respiratory problems, dementia, confusion, risk of absconsion, responsive behaviours, or mental health issues.

Also some plans were not specific enough to guide staff and manage the needs identified, examples included; nutrition care plans that did not always include reference to the frequency of weight or intake monitoring, food fortification or type of diet required; positive behaviour support plans did not identify or guide staff on possible triggers, measures to alleviate or manage the behaviour such as distraction techniques and other ways to reduce or prevent the behaviours. Where plans were in place, they were not always implemented.

Evidence that a high standard of nursing care was being delivered to all residents to effectively maintain health and well being was not found.

Examples included:

- care plans were not in place to recognise signs and symptoms of clinical deterioration and refer residents experiencing headache and dizziness, breathlessness and wheeze.
- some residents identified as high absconsion risks and for whom care plans to manage this were not in place or not effective, were found to have absconded.
- positive behaviour support plans were not in place to guide staff on how to manage behaviours such as non compliance with medical therapy for life limiting conditions such as insulin dependent diabetes or to manage physical and verbal altercations between residents to reduce or prevent recurrence. Regular and recurrent episodes of both behaviours were recorded for some residents.
- some care plans were not being reviewed on a quarterly basis or as needs or

circumstances changed. Where they were being reviewed, this mostly consisted of a new date being inserted onto the end of the care plan. Some care plans had not been properly updated to reflect the changes in residents' condition in almost a year. Examples include safe environment care plans with a revision date of August 2016 referencing the need to escort a resident who had been a full time wheelchair user since November 2015 and personal care and dressing plans referencing the need to wear glasses although the resident had surgery that negated the need for glasses earlier in the year.

Nurses' daily progress records did not provide enough detail on the overall status of residents. The notes did not always comment on the care delivered, signs of improvement or deterioration in physical emotional or psychological state. They did not indicate how the resident had spent their day. This meant that a general picture of each person's overall health and well being could not be determined.

Overall it was found that the standard of clinical documentation and recording of care delivery was not sufficiently detailed, accurate or complete to give a clear picture of each resident's current condition.

Some systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents' weights were checked on a monthly basis, and where required, daily intake charts were in place to monitor food or fluid intake. The menu was written up on a daily basis on a small board in both dining areas. There were no printed menus available. The inspector asked how the menu was devised or how frequently it was changed to give variety. The chef said the menu changed every week but although the inspector asked to see some sample weekly menus- the chef could not locate them. Soup was served as a starter to lunch, but although residents were asked if they would like to have soup, they were not told what type of soup was being served. A choice of fish or pork was available for lunch, although resident's on modified diets received mince. There were three choices for dessert. The inspector discussed the food options and meal preparation with the chef. Aspects of meals such as soup and custard were prepared from commercially prepared packet stocks and not made fresh. A dietician had not reviewed the menu to determine whether the food options available were nutritionally complete and tailored to meet the requirements of therapeutic diets such as diabetes, low fat or low calorie diets.

On review of the documentation and recording of residents' nutrition the inspector noted that there were no residents assessed as being underweight or malnourished. On the contrary, many residents were assessed as being overweight and some were risk assessed as obese at the time of the inspection.

However, it was found that all residents were not being provided with their correct diet. The inspector was told that the main diets consisted of soft/pureé/minced textures. No other diets were included on the most up to date diet sheet provided to the chef on 13 September, but the inspector learned that there were several residents who were diabetic, some were insulin dependent. Several residents were assessed as being obese and were recommended to be on low calorie and low fat diets and some others had been recommended to have high calorie high protein diets. There was no evidence that a structured communication system, reviewed on a regular basis was in place to ensure residents were receiving their correct diet. Meals were served plated from the kitchen



area that was situated in the middle of the centre on the ground floor and close by the ground floor dining room. Two staircases at the front and rear of the centre were also nearby which helped meals be brought to residents on the first floor in a timely manner. Plated meals were then brought in batches to each dining area on an open tray. These were left on a worktop until served to each resident. Modified (chopped or pureed) meals were brought up and served first to those residents who needed assistance. The remaining residents' meals were then brought up and served. However, the inspector observed that many of the meals looked exactly the same and there was no labelling or other system to distinguish between 'normal' meals and special diet meals. It was therefore difficult to be sure that all residents were receiving their correct diet as most meals were collected in batches and brought on trays to the dining rooms. It was also noted that prior to the end of the lunch service on the first day of inspection, the last meals were cold before the resident's received them. The gravy and white sauce options, which were sent to the dining rooms in large plastic jugs were also cold. This was brought to the attention of the chef who used a temperature probe to check the temperature of the potatoes that were in the kitchen in a metal container. The probe indicated the potatoes were still at an appropriate temperature. However, the food that the inspector found cold had been plated some ten minutes earlier and the sauce had been sent to the dining rooms 30 minutes earlier.

The inspector looked at the system in place to monitor food and fluid intake. Up to six residents were identified as requiring monitoring. It was noted that the recording of intake was not always timely or contemporaneous. Most entries were not made for both breakfast and lunch until the early afternoon and for some residents there were gaps of up to nine and ten days since their intake had last been recorded. The inspector checked with the health care and nursing staff to find out which residents needed to have their intake monitored on a daily basis and again there were inconsistencies in staff responses. Where intake was being recorded it was noted that it was not accurate enough for meaningful analysis. Consistency of approach was found to be required and determination of portion sizes in order to be able to accurately assess intake when diaries refer to 'half/ quarter/ full' meal taken.

**Judgment:**  
Non Compliant - Major

### ***Outcome 02: Safeguarding and Safety***

**Theme:**  
Safe care and support

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

**Findings:**  
Evidence that measures were in place to protect residents from being harmed or suffering abuse was found. Staff had been provided with training on the prevention of

elder abuse. All staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse.

A review of the use of restraint found that there was a reduction in the use of bed rails throughout the centre although bed rails were still in place for some residents. The use of bed rails and lap belts was reduced. Some efforts to promote a culture of a restraint free environment were evident with the use of alternative safety measures such as bed alarms in place for three residents noted. However increase in the provision of other alternatives such as ultra low beds to facilitate continued reduction in the use of mechanical restraint use was required. This is further referenced under Outcome 6 Premises.

The inspector reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded. These processes were discussed with the provider who informed the inspector that all financial records related to residents finances had recently been independently audited and found to meet good accounting procedures.

The inspector viewed the computerized system in place to manage transactions related to residents' monies. All residents were allocated an individual coded ledger where details of all transactions were recorded. The provider raised the difficulties of opening individual bank accounts for residents in particular for those residents without capacity to make decisions about the use of their funds. The provider was directed to refer to HIQA guidance on these issues.

The inspector noted that the procedures in place did not fully reflect HIQA guidance issued to providers on the management of residents finances in that;

-Monies of residents for whom the provider acted as a pension agent were lodged to the centre's main business account and not into an individual interest bearing bank account for each resident.

Staff interactions with residents were respectful and measured. Privacy and dignity was maintained where required and assistance with aspects of care such as mobility was gentle and professional. Residents who spoke to inspectors said they felt safe.

However safeguarding measures such as robust recruitment processes were not fully completed. Garda vetting disclosures for one staff person working in the centre on the day of inspection was not available. This was brought to the attention of the provider prior to the end of the inspection. The provider forwarded evidence that the vetting disclosure had been received on the day following the inspection.

**Judgment:**

Non Compliant - Moderate

***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:**

Some evidence that residents were consulted with and participated in the organisation of the centre was found. Residents' rights, privacy and dignity were respected with personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitors in private. Resident meetings were held monthly where residents were facilitated to give feedback on how the centre was run. However, when the inspector read a sample of the minutes from three different meetings held in April, June and July, it was found that the minutes of each meeting were exactly the same with the exception of the comments/complaints section and planned activities section.

There were no suggestions or requests made by residents on how the centre was run included in any of the minutes read.

Comments viewed showed residents had voiced dissatisfaction on a number of practices such as; the use of communal hair brushes and staff not always respecting privacy by entering rooms without knocking on the door. However, actions taken to address these issues were not recorded in these minutes.

The Inspector was told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling. This was confirmed by some residents who spoke with the inspector.

Access to advocacy services was not available and contact details for advocacy services were not displayed.

Appropriate and respectful interactions were observed throughout the day between residents and staff who respected resident's dignity and choice during care interventions and in their daily routine.

An activities programme was in place delivered by an activities coordinator. The programme was delivered over six days each week. In conversation with some residents the inspector was told they were satisfied with the care provided and many spoke warmly of the friendly and helpful attitude of staff. All said they felt very safe. In general residents were happy with the activities available although some said they did not get out as much as they used to and would prefer more opportunities to go into the local village.

The activities programme included both group and one to one activities. The inspector was told that one to one time was scheduled for residents with more severe dementia or cognitive impairment or who would not participate in the group activities, and that this time was used for sensory stimulation such as chatting or providing hand massages. The programme also included arts and crafts, physical exercise games board games, daily outings, music and dancing and dementia relevant activities such as reminiscence and sonas (a therapeutic communication activity primarily for older people, which focuses on sensory stimulation)

Details on residents life stories and backgrounds were gathered in a file kept in the nurses office. This included some information on residents past interests and hobbies. The activity coordinator tried to incorporate some residents' personal preferences and past interests into the activity programme including some male orientated activities such as golf and basket ball exercise games and quizzes.

While the programme included a time period for daily outings after lunch it was found

that access to the community for the majority of residents was very limited. In conversation with the activity coordinator the inspector learned that only five 'outings' had been planned for 2016 and of these only two had taken place, a trip to the park across from the centre and one to the seafront promenade

Outings planned included three trips to the seafront promenade within walking distance of the centre. One shopping trip to the village also in walking distance and one trip to the local park located diagonally across the road from the centre.

The inspector was told this was due to the poor summer weather and costs associated with paying for taxi's to go on outings. As the centre does not have it's own transport this severely curtails residents opportunities to go out and about in the community. Even so, it was also found that where there were enough staff on duty, opportunities to take residents for short walks on days when it was bright dry and not very cold such as the day of inspection were not taken.

It was also noted that opportunities for residents to attend religious services such as Mass was limited. The inspector was told that Mass was celebrated in the centre up to three or four times during the year, primarily around Christian holidays such as Christmas and Easter. Otherwise residents watched Mass on the national TV station, unless family or friends could bring their loved ones to the local church in the village.

The inspector spent time observing interactions prior to and after lunch and in the afternoon.

The inspector observed some residents prior to and during their lunch in the first floor dining room. Two staff were providing assistance to a small number of residents at the dining table. Both staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Whilst these residents were being assisted, approximately eight others were sitting in comfortable armchairs or wheelchairs which were lined up against the wall of the room. A relaxing atmosphere was created for residents, a diffuser scented the room with calming oils, sensory lights patterned one wall and gentle music played in the background. However, throughout the half hour period when the carers were giving assistance to residents with their lunch, the inspector noted no conversation was initiated. At one point a resident sitting within the group lined up against the wall, tried to start a conversation about the pictures and large jigsaws left on a table beside them, which had been part of an activity session earlier in the morning. The conversation was brief as the other residents did not respond. The care assistants who were in the room did not try to encourage the conversation and there were no efforts observed to stimulate or encourage any meaningful stimulating human interaction. Similarly when the remaining residents, who did not require assistance, were having their lunch, conversations were limited to brief infrequent comments between residents. The interactions between staff and residents were confined to enquiries from staff as to choice of drinks, sauce and whether they were finished the meal.

The inspector then observed a reminiscence session provided to a group of eight residents. The activities coordinator played a background tape of songs to which residents were then encouraged to sing along. A lavender oil diffuser created a relaxing aroma and residents were also encouraged to do some physical exercise such as waving their arms and swaying in time to the music. Tea and biscuits were served when the activity was finished. Residents were observed to try to engage each other in conversation across the room. This proved difficult for some due to the seating arrangements in the room, which was arranged around the walls of the room. This

meant residents could see each other and everyone who entered and left the room but could only have a conversation with the people seated closest to them. Two residents seated beside each other, were observed having a discussion on the newspaper they had both read and laughingly using terms of endearment to each other. It was noted however that all these conversations lasted only a few minutes and although some residents continued through facial expressions and eye contact to try to make conversation with fellow residents, this went unnoticed by staff in the room who did not help to stimulate engagement but concentrated solely on the task of serving tea.

**Judgment:**  
Non Compliant - Major

#### ***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:**  
A complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. The process included an appeals procedure.

The complaints policy which was displayed met the regulatory requirements. Some residents spoken to could tell inspectors who they would bring a complaint to. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

**Judgment:**  
Compliant

#### ***Outcome 05: Suitable Staffing***

**Theme:**  
Workforce

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

**Findings:**  
The number and skill mix of nursing and direct care staff on planned rosters appeared

sufficient to meet the needs of the current profile on this inspection. The staff rota was checked and found to be maintained with all staff that worked in the centre identified. Actual and planned rosters were in place. Systems were in place to provide relief cover for planned and unplanned leave. Cover for planned and unplanned leave was provided within the current staff complement and from a bank of relief staff made up primarily of former staff who are familiar with the work systems and layout of the centre.

Records reviewed showed that staff had been provided with opportunities to receive updated training in areas such as: safeguarding; moving and handling; fire safety; responsive behaviours; nutrition: dementia care and food hygiene. Staff spoken too were familiar with the procedures in place to respond to the fire alarm and the principles of food fortification for improved nutritional intake. It was noted that some of the catering staff, who, although they had catering experience did not have recognised catering qualifications. These staff were promoted within the organisation and were now responsible for ensuring the safety and quality of food being provided to residents. However it was found that all staff were not provided with training and development opportunities to enable them develop skills required for their role. The inspector found that staff were not appropriately supervised to ensure that a good standard of care was delivered which met residents needs in accordance with their care plan as described under outcome 1 or to provide holistic person centred care as outlined under outcome 3.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The centre was found to be well maintained, warm, comfortably furnished and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising. Suitable and sufficient communal space such as sitting and dining rooms were available on each floor. A separate quiet room was also available on the ground floor.

There were 14 single and 12 twin bedrooms across two floors some with toilet and wash hand basin ensembles.

The bedrooms were personalised to reflect residents' individual wishes with pictures photograph's and mementos. Some also contained items of furniture with sentimental value such as armchairs dressing tables and other occasional furniture.

The premises and grounds were clean and well maintained. Grab rails and hand rails

were installed were required. There was a functioning call bell system in place within the centre, and hoists and pressure relieving mattresses were in working order. A small enclosed paved rear garden and first floor balcony were available for resident's use.

Appropriate signage and cueing to support freedom of movement for residents with dementia was not in place. There were some small picture cues placed on the doors of dining rooms but contrasting colour cueing on bedroom or bathroom doors or contrasting toilet seats were not in place.

**Judgment:**

Substantially Compliant

***Outcome 08: Governance and Management***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The senior management team included the provider representative, the person in charge and administrative officer. However, management systems to ensure an effective and appropriate level of care was being delivered, in accordance with the statement of purpose was not found.

The inspector found that there was a lack of clinical governance such as appropriate supervision direction and communication provided to staff.

-Effective communication between staff both verbal and written was poor. The inspector witnessed the early morning handover from night to day staff. Most of the information was summation and little specific information on progress or deterioration on current condition of any resident was given. Confusion between the verbal information received and poor documentation in care plans and progress notes contributed to staff's conflicting knowledge of residents' condition and treatment regimes. This was evidenced where staff gave conflicting responses when asked which residents needed to have intake monitored and which residents were on recommended special diets. Nurses did not follow up the outcomes of consultant appointments to determine what if any further treatment or referrals were required.

-The catering team did not have an up to date or complete list of specialised diets recommended for residents such as diabetic, reducing or high protein high calorie diets.

-The inspector was given a copy of the staff allocation sheet. The sheet showed that staff allocation systems were limited to the division of staff on duty into two teams one on ground floor and one on the first floor. The sheet also included the times of lunch breaks for the care assistant staff. Defined responsibilities or work systems to ensure the needs of residents were met such as; for supervision, personal or pressure area care, nutrition, were not identified. Care staff worked together in teams and delivered all of the personal care during the morning when nurses who were involved in the administration of medicines were unable to supervise this care directly, but it was also

noted that although a third nurse was rostered on a daily basis, (usually the person in charge from Mon-Friday) they did not work alongside the care staff team to monitor practice. During the handover the person in charge reminded care staff to be pay attention to basic care details such as nails, dentures and shaving. It was observed that all residents were assisted with personal care to the extent that they required assistance. However, although many were neatly dressed in good quality clothing, some residents clothing were observed to be worn and in need of replacement. The inspector noted that the appearance of some residents' hair indicated a lack of attention and was told that some could not afford to attend the hairdresser on a very regular basis. But it was also noted that these residents would have benefitted from more care to ensure their hair was washed and styled.

-As evidenced under Outcome 3 it was found that care delivery was not person centred but neutral or task orientated.

A system of audit on aspects of clinical and non clinical care was in place. The purpose of audits is to check the knowledge of staff on the policies and procedures in place to guide good practice and to determine the extent to which these are implemented. The inspector looked at the medication, infection prevention and control (IPC) and care planning audits. Audits were conducted using a check list assessment tool. However it was noted that:

-The audits were not detailed enough or broad enough to identify trends or current or future risks or where these may occur. For example:

-Audit processes in place were not effectively monitoring practices and cultures in medication administration or assessing planning and recording of care.

-Audits did not identify risks associated with medication administration outside recommended timeframes, they did not identify errors omissions or that nurses were not administering medicines in line with professional guidance. Other risks were not identified such as; ineffective care assessment and planning of residents needs; failing to notify serious incidences to HIQA as required by regulation 31 and lack of appropriate monitoring and supervision of practice. As a result actions were not taken to address the issues identified by this inspection.

**Judgment:**

Non Compliant - Major

***Outcome 10: Suitable Person in Charge***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The centre was managed by a suitably qualified and experienced nurse. The person in charge held authority, accountability and responsibility for the provision of the service.

**Judgment:**

Compliant



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## ***Outcome 12: Notification of Incidents***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

A record of all incidents occurring in the designated centre was maintained. However, all relevant incidents were not notified to the Chief Inspector as required, under Regulation 31. These included incidents related to resident absconsion and accidental injuries resulting in transfer to emergency departments for review.

**Judgment:**

Non Compliant - Major

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## **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:***

Nuala Rafferty  
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<sup>1</sup>

<b>Centre name:</b>	Kylemore House Nursing Home
<b>Centre ID:</b>	OSV-0000055
<b>Date of inspection:</b>	27/09/2016
<b>Date of response:</b>	22/11/2016

### 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Evidence that all care plans were fully reviewed for effectiveness as residents needs changed and complete records of residents current overall condition as required by the regulations were not available

#### **1. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

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

4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

**Please state the actions you have taken or are planning to take:**

1)As outlined previously all residents' assessments and care plans will be reviewed and updated with completion by the 31/01/2017.

2)A new handover sheet has been developed for nurses to complete at the end of each shift. This form is used to record and communicate information about residents' whose condition has changed as well as any incidents/events that have occurred during the shift.

3)A new person in charge has been appointed and commenced employment on the 7th November 2016 and has the following responsibilities for ensuring that resident's care and care plans are updated in accordance with changing needs:

- The PIC reviews the completed handover sheets and meets with the nurse each morning to receive handover and identify any residents whose condition has changed.
- The PIC checks with nurses during the shift to ensure that any follow up activities arising from changes in a resident's condition or incidents/ events have been completed.
- The PIC also attends the midday huddle to receive updates on residents and care activities. She checks with nurses throughout her shift to ensure that residents' records, including care plans have been updated in accordance with changing needs as well as ensuring that other relevant documentation has been completed.
- Records and reminders of reviews will be maintained on the new system and these will be monitored by the PIC to ensure that residents have formal reviews of their care plans completed on a four monthly basis.
- The ADON will deputise for the PIC in her absence and will have responsibility for the above activities.

4)Auditing of care plans will commence on the week ending the 13th January, which will allow for an additional monitoring of care plans to ensure they are factual, accurate and current.

Proposed Timescale: 1) 31/1/2017; 2) Immediate; 3) 13/01/2017.

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Assessment and care planning were not specific enough to direct the care to be delivered in an holistic manner as evidenced by examples such as residents non compliance with medical therapy for life limiting conditions and recurrent responsive behaviours.

**2. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the

assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**

1) All residents' care plans, including those residents with behaviours that are challenging, will be reviewed and updated to ensure that they are individualised and holistic. Care plans will address any assessed needs and/or risks as well as recognising each resident's preferences and abilities.

2) Nurses will receive training on consent and positive risk taking, to ensure that nurses are enabled to develop care plans that support residents with autonomous decision making regarding risk.

Proposed Timescale: 1) commencing week ending 2/12/2016 to be completed by 31/01/2017; 2) 15/12/2016.

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Assessment, care planning and clinical care did not accord with current evidence-based practice.

Complete comprehensive nursing assessments were not carried out for each resident in respect of every identified need.

**3. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**

1) With the support of external consultants, a new electronic assessment and care planning system has been implemented. This system includes screening and comprehensive assessment of 19 domains / activities of living. This system has been installed.

2) Nurses are receiving training on the use of the system which will be completed by the week ending the 25th November 2016.

3) Nurses will receive mentoring in assessment and care planning, using the new system commencing the week ending the 2nd December 2016.

4) All residents' assessments and care plans will be reviewed and updated so that each resident will have a comprehensive person centred assessment and care plan in place which will be updated in accordance with changing needs. This will commence during the week ending the 2nd December to be completed by the 31st January 2017.

Proposed Timescale:

1) Completed 2) 25/11/2016; 3) 2/12/2016 4) 31/1/2017.

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

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

All the care needs of all residents were not being met and suitable safe and sufficient care was not being provided.

**4. 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:**

This will be addressed through the implementation of the new care planning system and mentoring of nurses as well as the following:

- 1) Handover procedures to ensure that all nursing and care staff have accurate and up to date information on residents assessed needs and any changes to their care or condition has commenced. Standardised documentation has been introduced for both nursing and care staff to use at handovers. A new midday 'huddle' has been introduced to ensure that all staff on duty are kept up to date with the progress of each resident and any changes to care, treatment or condition. This commenced on the 18th November 2016.
- 2) A standard protocol has been developed for nursing staff to direct nurses on record keeping during their shift. The protocol is displayed at the nurses' station on the first floor and the main office on the ground floor. This will include making timely entries into residents' records. This will ensure that information related to the outcome of residents ie ' reviews carried out by a specialist both on-site or at external clinics has been obtained and recorded in the relevant sections of the residents' healthcare and nursing records Completion of required documentation following incidents/adverse events and deterioration in a resident's condition. This commenced on the 21st November 2016.
- 3) Nurses will receive training on this protocol on the 25th November 2016.
- 4) We will provide training to nurses and care staff on recognising and responding to deterioration on the 9th December 2016.
- 5) A system of recognising and responding to deterioration will be implemented as part of the new documentation on the 12th December 2016.
- 6) All residents care plans will be reviewed and updated, commencing the week ending the 2nd December and completed by the 31st January 2016. Formal 4 monthly reviews of care plans will be carried out and recorded on the new system in accordance to the most recent HIQA Standards (2016).
- 7) Auditing of care plans will be carried out as part of the audit programme for the Centre. This will commence on the week ending the 13th January 2017.

Proposed Timescale: 1) 18th November 2016; 2) Completed 21st November 2016;d  
3) 25/11/2016; 4) 9th December 2016; 5) 12th December 2016; 6) Commence 2nd  
December 2016 to completed by 31st January 2017; 7) 13th January 2017.

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

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

The documentation of care was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered to all residents to fully meet their personal social and healthcare care needs.

**5. 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:**

- 1) Nurses will receive mentoring in assessment and care planning, using the new system commencing the week ending the 2nd December 2016.
- 2) All residents' assessments and care plans will be reviewed and updated so that each resident will have a comprehensive person centred assessment and care plan in place which will be updated in accordance with changing needs. This will commence during the week ending the 2nd December to be completed by the 31st January 2017.
- 3) Both the new PIC and ADON will have responsibility for checking that resident's care plans have been updated in accordance with changing needs on a daily basis and for checking that residents have formal reviews of their care plans completed on a four monthly basis. This will commence immediately. Records and reminders of reviews will be maintained on the new system and these will be monitored by both the PIC and ADON to ensure that reviews are carried out in a timely manner.
- 4) The new electronic system has a section for allied healthcare professionals records and the system alerts nursing staff when a new entry has been made by any allied healthcare professional.
- 5) Auditing of care plans will commence on the week ending the 13th January, which will allow for an additional monitoring of care plans to ensure they are factual, accurate and current.

Proposed Timescale: : 1) 2/12/2016; 2) 31/1/2017; 3) Immediate; 4) 31/1/2017 5)  
13/01/2017

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The nutritional needs of all residents were not being met and some specialised diets as prescribed by specialist staff were not being implemented or included in updated care plans based on nutritional assessments.

**6. Action Required:**

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

**Please state the actions you have taken or are planning to take:**

1. The dietary sheets have been revised and updated to ensure that the recording of all residents' dietary needs related to texture or consistency of food and/or fluids as well as needs such as allergens, diabetic diet, coeliac, diet, weight reducing diet, high fibre diet, and so on, will take place.
2. The PIC (or ADON in her absence) is responsible for checking these forms on a daily basis to ensure the information recorded is contemporaneous and is / has been updated where there is a change to resident's dietary needs.
3. A copy of these sheets has been given to catering staff in the main kitchen and dining rooms.
4. The use of colour coded trays or plates are currently being explored to support easy identification of residents on modified diets. This will be implemented by the 30th November 2016. In the meantime, all meals will be labelled.
5. The menu has been reviewed by a nutritionist.
6. Nutritionally balanced menus have been developed by a consultant nutritionist and are now in place.
7. Additional training has been provided for the two chefs and the registered provider also attended same. The dietician has also committed to providing mentoring to the two chefs on an on-going basis. This will commence before December 15th 2016.
8. The format of menus will be reviewed and the use of large font and pictures will be explored to support residents with communication difficulties such as poor sight. This will be completed by the 25th November 2016.
9. The centre will source a heated trolley, for the first floor by the end of January 2017, subject to delivery.
10. As previously outlined, nurses will receive mentoring in the implementation of the new assessment and care planning system which will include the development of person centred nutrition and hydration care plans by the week ending the 2nd December 2016.
11. The updating of care plans will be monitored on a daily basis by the PIC and ADON, commencing immediately.

**Proposed Timescale:** 1) Completed 2) Completed 3 Completed 4) 30/11/2016; 5

Completed); 6) Completed 7) 15/12/2016; 8)25/11/2016; 9) 01/2017; 10) 2/12/2016; 11) Immediate.

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

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

The documentation of care was not sufficiently accurate or complete to provide an accurate record of residents current overall condition or determine that a high standard of evidence based nursing care was being delivered to all residents to fully meet their personal social and healthcare care needs.

Records of the food provided to residents were not maintained to enable a determination be made on the adequacy of the diet being provided as required under Schedule 4(5)

**7. 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:**

- 1.A standard protocol has been developed for nursing staff to direct nurses on record keeping during their shift. This includes making timely entries into residents' records; ensuring that information related to the outcome of residents' reviews carried out by specialist both on-site or at external clinics are obtained and recorded in the relevant sections of the residents' healthcare and nursing records; completion of required documentation following incidents/adverse events and deterioration in a resident's condition.
- 2.Nurses will receive formal training on this protocol on the 25th November 2016.
- 3.The newly developed daily care and handover sheet for healthcare assistants will include the comprehensive recording of care given by healthcare assistants on a daily basis. It will be reviewed by nursing staff prior to the completion of their daily nursing narrative records. This commenced on the 14th November 2016.
- 4.The healthcare assistants' daily care and handover sheet will facilitate the recording of each residents food, drinks and snacks intake each day by documenting the percentage of the meal/ snack that was taken.

Proposed Timescale: 1) Completed; 2) 25/11/2016; 3) commenced 14/11/2016; 4) commenced14/11/2016.

**Proposed Timescale:** 25/11/2016

**Theme:**



Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Medicines were not administered in full accordance with current legislation and professional guidance.

**8. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**

- 1) We have informed staff nurses of the finding of the inspection with regard to recording medicines administered.
- 2) We will carry out a review of the medication administration rounds in the morning so as to ensure that residents receive their medicines in a timely manner. This will include:
  - A review with the relevant G.Ps of the prescriptions for each resident, whose administration times do not meet the resident's needs.
  - Introduction of medication administration as a protected activity with the use of the 'Do not disturb' red tabard and information for residents and families about same.
  - Observation and audit of medication administration rounds to identify any areas of non-compliance that require improvement actions.
- 3) Medication management education sessions for nursing staff took place with Abbey HealthCare Pharmacy on 05th October 2016.
- 4) Additional training was provided for nurses 17th November 2016. The training focused on safe administration, prevention of medication errors and the roles and responsibilities of nurses in the cycle of medication management.
- 5) Audit of medication administration sheets will commence on the week ending 25/11/2016 and weekly thereafter for the next four weeks and if compliance has been achieved, these audits will be carried out 2 monthly as part of the medication audits for the centre.
- 6) The PIC and Provider met with all nurses with regard to the report and outlined the concerns raised by the inspector and arranged for the nurses to receive mentoring on the safe administration of medicines. This was carried out by the dispensing pharmacist.
- 7) A formal system of medication reconciliation will be implemented on admission, re-admission, transfer and discharge for all residents as part of the implementation of the assessment and care planning, commencing 9th December 2016. In the meantime, nurses will be required to complete manual records of medication reconciliation for all admissions, re-admissions and transfers of residents. This will be monitored by the PIC and ADON in her absence.
- 8) The Centre's medication management policy will be updated to reflect these changes.

Proposed Timescale: 1) Completed; 2) Completed 3) Completed; 4) Completed 5) 25/11/2016; 6) Completed; 7) Immediate; 8) November 30th 2016.

**Proposed Timescale:** 30/11/2016

### **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:**

Processes in place to safeguard residents finances did not fully reflect HIQA guidance in that;

Relevant residents funds were being lodged to the centres' main business account and not to a specific interest bearing individual residents account.

Evidence that all robust recruitment processes including Garda vetting disclosures were in place for all staff working in the centre was not found.

**9. 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:**

- 1) Additional low- low beds have been purchased.
- 2) The registered provider has opened a separate residents account for residents for which she is agent
- 3) Garda vetting disclosures are in place

Proposed Timescale: 1) Completed 2) Completed; 3) 30/11/2016.

**Proposed Timescale:** 30/11/2016

### **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:**

Independent advocacy services were not available to residents

**10. Action Required:**

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

**Please state the actions you have taken or are planning to take:**

- 1) The centre has advocacy services in place through SAGE and also currently a resident is receiving advocacy services through the National Advocacy Services for people with disabilities.

2)The Centre supports all residents to access advocacy services in keeping with their preferences and wishes. Information regarding services available and contact details of Sage (Support and Advocacy Services for Older People) and the National Advocacy Services for People with Disabilities are displayed on the residents' notice board.

3)We will revise and update our template for recording minutes of residents meetings so as to ensure greater opportunity for eliciting the views of members on services and care delivery actions required; timeframes for actions and the follow up and completion of actions arising from issues raised are recorded.

Proposed Timescale: 1) Completed; 2) 16/12/2016.

**Proposed Timescale:** 16/12/2016

**Theme:**

Person-centred care and support

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

Opportunities for residents to avail of religious services within the centre or in the community and access to the community for social interaction or events were very limited.

**11. Action Required:**

Under Regulation 09(3)(c)(iv) you are required to: Ensure that each resident has access to voluntary groups, community resources and events.

**Please state the actions you have taken or are planning to take:**

- 1.Residents can avail of our weekly prayer groups held in dayrooms. Additionally, Sunday Mass is available to watch on the television. Some residents attend mass locally. A Eucharistic Minister attends the Centre on a weekly basis to offer communion to residents. The Centre has spoken with the parish priest with regarding to holding mass in the centre on a more regular basis. Currently the local parish cannot say mass more frequently in the centre, but is exploring the availability of another priest outside of the parish who would be available to say mass in the centre. For other residents who are of other denominations arrangements have been made
- 2.The wishes and preferences of residents attending outings have been discussed at a recent resident's meeting and a calendar of activities, including external outings has been developed in response to the preferences expressed by residents at this meeting. Activities will be discussed at each residents meetings / forum on a monthly basis and the monthly activity calendar will be developed in response to this.
- 3.We have one full time and two part time activities personnel for the centre. Residents are afforded the opportunity to take trips to the village, the promenade or local Park. They can also attend events occurring in the community such as Turning on Christmas lights, St. Patricks day parade, Bray Festival or whatever is happening locally .
- 4.We have recruited an additional staff member to assist with taking residents on trips outside of the centre.

Proposed Timescale: 1) completed 2) completed 3) completed 4) completed.

**Proposed Timescale:** 22/11/2016

**Theme:**

Person-centred care and support

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

Opportunities for residents to engage in meaningful activities in accordance with their interests and capacities were very limited.

**12. 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:**

In addition to actions under 09(3)(c)(iv) we will:

- 1) Review the layout of the activities room to allow residents to engage more with each other and to provide for a more sociable environment.
- 2) We have spoken to staff about the importance of encouraging and facilitating conversation between residents during communal activities, such as mealtimes and formal activities.

Proposed Timescale: 1) Immediate 2) Immediate

**Proposed Timescale:** 24/11/2016

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff were not appropriately supervised to ensure that a good standard of care was delivered which met residents needs in accordance with their care plan.

**13. 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:**

- 1) A new PIC has been recruited and her responsibilities include the supervision of nursing and care staff as outlined previously. She will also be on the floors while

medicines are being administered to ensure supervision of residents' care.

2)A standardised system of handover has been implemented which includes both nurses and carers providing feedback to each other on the care and condition of residents during the shift.

3)A midday 'huddle' has been introduced to facilitate the sharing of information about the care and condition of residents.

4)Appropriate skill mix is now in place to facilitate the care needs of our residents  
Continuous monitoring /supervision by the PIC will ensure that this skill mix is correct at all times

5)Handover procedures will take cognisance of the need to recognise and respond to deterioration in residents' condition and therefore are based on international patient safety goals for safe handover and recognising and responding to deterioration in residents.

Proposed Timescale: 1) Completed 2) Completed 3) Completed ; 4) Immediate; 5) Completed

**Proposed Timescale: 22/11/2016**

**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

All staff were not provided with training and development opportunities to enable them develop skills required for their role.

**14. 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:**

1)The chefs have completed a course on nutrition.  
2)Additional training will be provided by a nutritionist to both chefs.  
3)Additional training for nurses has been scheduled for the remainder of 2016, to include:

- Medication management.
- Recognising and responding to deterioration in a resident's condition.
- Mentoring on assessment and care planning.
- Completion of daily records for residents.
- Consent and advocacy.

4)Healthcare assistants will also receive training on:

- Recognising and responding to deterioration in a resident's condition.
- Completion of daily records for residents.
- Consent and advocacy.

5)A training needs analysis will be carried out so as to develop an annual training plan for 2017.Both the annual training needs analysis and ongoing training needs will be

informed by clinical governance activities in the centre, including:  
Monitoring of KPIs; complaints; incidents; safeguarding information; feedback from residents' forum meetings; informal monitoring of staff performance; formal staff appraisals; changes in residents' profile as well as changes to standards, legislation, national and local policies. A standard template for same will be developed with the assistance of external consultants and be used to inform same.

Proposed Timescale: 1) Completed ; 2) 01/2017; 3) and 4) commenced on the 17/11/2016 on going to the 15/12/2016; 5) 13/01/2017

**Proposed Timescale:** 31/01/2017

### **Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

Appropriate signage and cueing to support freedom of movement for residents with dementia was not in place.

**15. Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**

The Centre is currently exploring various signage and will erect appropriate directional signage that will meet the need of residents with dementia.

Proposed Timescale: Completed by 31st December 2016.

**Proposed Timescale:** 31/12/2016

### **Outcome 08: Governance and Management**

**Theme:**

Governance, Leadership and Management

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

Management systems and clinical governance including; robust audit processes, effective communication and staff allocation systems

appropriate supervision direction and professional guidance for all staff that ensured the

delivery of safe sufficient person centred and holistic care were not found.

**16. 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:**

1) We have recruited a new PIC for the home who commenced employment on the 7/11/2016.

2) We have arranged for mentoring from external consultants to strengthen our clinical governance systems in the following way:

- A new nursing handover sheet will include key quality information related to each shift, which will be used to collect monthly KPIs.

- Monthly KPIs will be collected and trended, reviewed and analysed by the clinical governance committee.

- The clinical governance committee will identify areas for improvement based on trending and analysis of KPIs and any changes to legislation, standards and / or policies.

- A quality improvement/clinical governance action plan will be maintained for the centre and will be updated according to the analysis of quality and safety data; audits; inspections and any other evidence of the need to make improvements. This plan will be reviewed at each clinical governance meeting.

- A standard format will be used to conduct each meeting.

- The person in charge will be the clinical governance lead for the centre.

3) We will develop an annual audit plan for the home with the assistance of external consultants. . This will be achieved by:

- Identifying 'external must do' audits based on requirements of national standards and regulations.

- Use of metrics to be completed on a scheduled basis.

- Develop audit tools for priority / must do audits to include hand hygiene; medication management, care planning; restraint use; nutrition and so on.

4) Training will be provided to designated staff on completion of audits.

5) We will commence trending and analysis of quality and safety data with the assistance of these consultants.

6) Additional auditing of medication administration sheets will commence on the 25/11/2016.

7) Standardised handover procedures commenced on the 18/11/2016.

8) Rosters and allocation of staff will ensure sufficient skill mix arrangements for supervision of staff.

9) Auditing of staff files will commence by the 30/11/2016.

Proposed Timescale: 1) Completed 2) 31/01/2016; 3) 31/01/2016; 4) 31/01/2016; 5) 31/01/2016; 6) 25/11/2016; 7) 18/11/2016; 8) Immediate; 9) 30/11/2016

**Proposed Timescale:** 31/01/2017

**Outcome 12: Notification of Incidents**

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

All relevant incidents were not notified to the Chief Inspector

**17. Action Required:**

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

**Please state the actions you have taken or are planning to take:**

All relevant incidents will be reported to the Chief Inspector by the Person in Charge in the time-frame required .

Proposed Timescale: Completed.

**Proposed Timescale:** 22/11/2016