

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Knightsbridge Nursing Home
<b>Centre ID:</b>	OSV-0000145
<b>Centre address:</b>	Longwood Road, Trim, Meath.
<b>Telephone number:</b>	046 948 2700
<b>Email address:</b>	gmcdonald@barchester.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	HC Developments Unlimited Company
<b>Provider Nominee:</b>	Fiona Moncur
<b>Lead inspector:</b>	Una Fitzgerald
<b>Support inspector(s):</b>	Catherine Rose Connolly Gargan
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	114
<b>Number of vacancies on the date of inspection:</b>	3

## **About monitoring of compliance**

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:
12 April 2017 09:30	12 April 2017 17:15
13 April 2017 08:05	13 April 2017 17:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliant
Outcome 07: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 08: Governance and Management	Substantially Compliant

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection carried out by the Health Information and Quality Authority (HIQA), which focused on specific outcomes relevant to dementia care in the centre. Four actions from the last inspection were satisfactorily completed. The inspection also considered statutory notifications forwarded to HIQA since the last inspection in the centre in May 2016.

Other relevant information was also reviewed including unsolicited information received by HIQA in November and December 2016, and the provider's response to the issues raised which included staffing levels, restraint, care of residents at night and a failure to protect residents' property. Unsolicited information was also received on the management of complaints. Inspectors found that a number of the areas of concern outlined in the information received were addressed or in the process of being addressed.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was

developed on best practice in dementia care. Prior to this inspection, the person in charge completed a self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016. The judgment of the self-assessment and the inspection findings are detailed in the table above. Inspectors also monitored two additional outcomes; 'Governance and Management' and 'Health and Safety and Risk Management'.

The centre was generally well- maintained, bright, visibly clean, comfortable and warm. The design and layout of the centre, where residents with dementia integrated with other residents within six units over three floors, required improvement to ensure residents with dementia had reasonable, independent access to a safe and secure outdoor space and other amenities, as appropriate. Inspectors found the management and staff team were committed to providing a good service for residents with dementia. This commitment was demonstrated in work ongoing and completed to date to create a comfortable and therapeutic environment for residents with dementia, especially on the first floor where most residents with dementia resided.

Inspectors met with residents and relatives and the feedback was generally positive regarding the care and support they received. Inspectors tracked the journey of residents with dementia within the service. Care practices and interactions between staff and residents who had dementia were observed using a validated observation tool. Inspectors met with staff and reviewed documentation such as care plans, residents' medical and nursing records, staff training and employment files. Inspectors examined relevant policies and procedures, including those submitted prior to this inspection.

There were policies and procedures available to inform the safeguarding of residents. All staff had completed training and were knowledgeable about the steps they must take if they witness, suspect or are informed of any abuse taking place. There were also policies and practices in place around managing behaviours and psychological symptoms of dementia, and the use of restrictive procedures as part of some residents' care. Inspectors found that residents were safeguarded from risks and an enabling approach was promoted. The need for improvement was identified in relation to the management of bedrails.

Residents' healthcare needs were met to a satisfactory standard. Assessments of need and evidence of resident and relative consultation for care plan review required improvement. Some improvements were necessary around managing medicines. While the residents were offered a range of activities, improvement was required to ensure the activity programme provided for residents, including residents with advanced dementia, met their interests and capabilities.

Staff were knowledgeable about residents' needs and their life histories. Staff used opportunities to engage positively with residents and interacted with them in a meaningful, sensitive and compassionate way. While arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day

basis were described, further work was in progress to ensure residents with dementia were supported to express their views. A staff training programme was in place but not all staff had attended annual fire safety training. The staff numbers in the centre appeared appropriate while inspectors were on-site. However, inspectors were not assured that the staffing levels in the evening and night time were sufficient to ensure that the needs of residents were met consistently.

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 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

This outcome sets out the inspection findings relating to clinical assessments and care planning, access to healthcare and maintenance of records. The social care of residents with dementia is reported in Outcome 3.

The centre catered for residents with a range of needs including dementia, acquired brain injury and intellectual disability. On the days of this inspection, there were a total of 114 residents in the centre. Fifty-one residents had a diagnosis of dementia and seven residents had symptoms of dementia. The inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of some residents and also reviewed specific aspects of care such as nutrition, medicines management, wound care and end-of-life care in relation to other residents with dementia in the centre.

Pre-admission assessments undertaken by the person in charge or deputy person in charge were available as part of residents' records. The files of residents admitted to the centre from hospital also held their hospital discharge documentation which detailed a medical summary, multidisciplinary assessment details and a nursing assessment. Procedures were in place for completing transfer documentation that accompanied residents who were transferred to hospital from the centre.

There were arrangements in place to meet the health and nursing needs of residents with dementia. The person in charge confirmed that a number of general practitioners (GPs) were attending to the needs of residents in the centre, giving residents a choice of GP. Residents' documentation reviewed by the inspector confirmed they had access to GP care including out-of-hours medical care. Community psychiatry of older age specialist services attended residents in the centre with dementia. They supported GPs and staff with the care of residents experiencing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) as necessary.

Some residents who lived in the locality were facilitated to retain the services of the GP

they attended prior to their admission to the centre. Residents also attended out-patient appointments and were referred as necessary to the acute hospital services. Residents had access to allied healthcare professionals including occupational therapy, physiotherapy, dietetic, speech and language, ophthalmology, dental and chiropody services.

Comprehensive assessments of the health, personal and social care needs of all new residents was carried out within 48 hours of their admission and care plans were developed accordingly. The assessment process involved the use of validated assessment tools to assess each resident's dependency level, cognitive status, risk of fall and skin integrity among others. Care plans reviewed were noted to be person centred. In the main, care plans contained the required information to guide the care of residents. However, some improvement was required to ensure one resident's care plan was reviewed following a fall which resulted in the resident reporting pain. While a suitable pain assessment tool was available for residents with dementia, the resident did not have a pain assessment completed and was not given analgesia.

Inspectors saw that care plan reviews were carried out routinely every two months by staff. Inspectors were told that residents or their relatives, where appropriate, were consulted regarding care plan development and subsequent reviews. However, there was documentary evidence that these consultations took place every six months and not on a four-monthly basis as required by the regulations.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed on admission and regularly thereafter for risk of falls. There was a high incidence of resident falls necessitating admission to hospital in 2016. The person in charge and staff team had worked on falls prevention which resulted in an overall reduction in incidence in recent months. Procedures were put in place to reduce the risk of further falls, and residents at risk of falling were appropriately risk assessed with controls such as hip protection and sensor alarm equipment put in place.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services, as necessary. Residents with dementia had access to specialist palliative care services for support with pain and symptom management during end-of-life care as necessary. While no residents were receiving end-of-life care on the days of inspection, residents' care plans detailed their end-of-life physical, psychological and spiritual care wishes. Residents' individual wishes regarding place for receipt of end-of-life care were also recorded. Advance care plans were in place for some residents regarding resuscitation procedures which recorded residents' and family's wishes, as appropriate. This information was regularly reviewed. Each resident was accommodated in a single bedroom and their relatives were facilitated to stay overnight with them at the end-of-life stage of their lives. Members of the local clergy from various religious faiths provided pastoral and spiritual support to residents. A large oratory was provided which was made available to residents for end-of-life services. A remembrance service was held recently in a local church to remember all deceased residents.

Residents were generally protected by safe medicine management policies and procedures but some improvements were required in relation to timeliness of medicine administration to residents and medicines administered in 'crushed' format. There were

written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Actions required from the last inspection in May 2016 were satisfactorily completed. Practices in relation to prescribing and medicine reviews met with the legislation and regulatory requirements. Nursing staff were observed administering medicines to residents and practices reflected professional guidelines. Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage.

A new electronic medication system was being piloted on one floor. When a resident required their medications crushed, this system instructed that all medicines were to be crushed unless the doctor specified otherwise. Inspectors had concerns about the potential risks associated with a system which defaulted to crushing of medications unless otherwise stated. Inspectors also observed that medications were not always administered to residents within a reasonable timeframe of the prescribed administration time.

The centre used an electronic system for recording medicines administered to residents. The inspectors viewed a number of medication administration records over a number of days and found that, in particular night-time, medicines were administered up to two hours past the prescribed time for administration. The pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. There were procedures for the return of out-of-date or unused medications. Systems were in place for recording and managing medication errors.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently if clinically indicated. Residents' intake and output was recorded and referenced a good level of detail including portion sizes. There was access to a safe supply of fresh drinking water at all times.

A varied menu was provided. Inspectors saw that residents had a choice of hot meals. Staff confirmed that alternatives were also available to the menu available each day if residents did not like the dishes on offer. There were arrangements in place for communicating residents' dietary needs between nursing and catering staff to support residents with special dietary requirements. Residents on specialised diets such as diabetic, fortified and modified consistency diets and thickened fluids received their correct diets and fluid consistencies. For the most part, residents received discreet assistance from staff with eating where necessary. Staff were trained to administer subcutaneous fluids to residents at risk of dehydration which reduced the need for hospital admissions.

Residents were assessed to identify their risk of developing pressure-related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There were no residents with pressure ulcers on the days of inspection. There was a policy and procedures in place to guide and manage residents' wound care. The inspector reviewed wound management procedures in place for one resident with a chronic wound. Tissue



viability specialist services were available to support staff with managing any residents' wounds that were deteriorating or slow to heal.

**Judgment:**

Non Compliant - Moderate

***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:**

The centre had measures in place to protect residents from suffering abuse. These measures were demonstrated in practice in relation to alleged incidents brought to the attention of the person in charge since the last inspection in May 2016. Policies and procedures were in place to inform management of any allegations, suspicions or incidents of abuse. Staff had received training on safeguarding of residents. Staff who spoke with inspectors were knowledgeable regarding the different types of abuse and their responsibility to report any concerns. All interactions observed by inspectors between staff and residents were respectful, patient and kind.

A policy was in place to support staff working with residents who experienced responsive behaviours. This policy was informed by evidence-based practice and was demonstrated in practice by staff. Staff adopted a positive, person-centred approach towards the management of responsive behaviours. Residents responded positively to sensitive and empathic approaches used by staff. Staff spoken with by inspectors were knowledgeable regarding the triggers to responsive behaviours and were able to voice the appropriate de-escalation interventions for individual residents. Residents' behavioural support care plans informed person-centred prevention and de-escalation techniques. For example, one resident must have her handbag in her possession at all times. This information was detailed within her behavioural support care plan.

A policy was in place that promoted a restraint-free environment. However, inspection findings indicated that improvements were required to ensure procedures and practices reflected national restraint policy guidelines. The restraint register recorded that 45 residents used bedrails. Fourteen residents used lap belts as a safety measure while in their wheelchairs. The register included the date that restraint was implemented. While inspectors were told that practice procedures by staff were in place to ensure residents with bedrails did not have their independence restricted for prolonged periods, there was an absence of consistent records maintained to confirm this practice occurred as required. For example, inspectors observed in one resident's file that there were gaps in the documentation to evidence that this resident was consistently checked and that their bedrails were removed at regular intervals.

Additional equipment to reduce the use of restraint such as low-level beds, floor mats and sensor alarms were seen in use for a number of residents. The restraint register confirmed that some residents with dementia had bedrails in place since 2012. A monthly review of need procedure was in place to be carried out for all residents using bedrails to ensure they continued to be required. However, inspectors found that this review was not consistently completed for some residents. The management and staff team were working to reduce bedrail use and a small reduction in numbers from December 2016 to date was evident. Risk assessments were completed for each resident to ensure that their safety was not compromised by bedrail use. Inspectors were told that no residents received psychotropic medications on a PRN (a medicine only taken as the need arises) basis for management of responsive behaviours when all other interventions were tried and failed.

The provider was an agent for one resident's social welfare pension and managed petty cash for others. Systems and arrangements were in place for safeguarding residents' finances and property. The accounting process was demonstrated to an inspector by staff. The procedures and processes for safeguarding residents' finances were clear and transparent. Procedures were in place to facilitate residents to access their money at all times.

The person in charge confirmed to inspectors that all staff, including volunteers, working in the centre were appropriately vetted.

**Judgment:**

Substantially Compliant

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Residents' views were welcomed and residents were consulted in relation to the running of the centre. Some residents with dementia attended residents' meetings. Although not structured or minuted, there was evidence that residents with dementia were encouraged and supported to express their views on a one-to-one basis. Inspectors also saw that the person in charge and staff team were in the process of setting up an Alzheimer's café type forum to enable residents with dementia to voice their views in an environment that enhanced support for them in terms of their individual communication needs.

There was evidence of efforts made by staff to make the communal environment on the

first floor comfortable and homely for residents with dementia. Most residents' bedrooms were personalised to a good standard with residents' input, such as their favourite colours, photographs, ornaments and other memorabilia that reflected their individual life stories. Some residents had favourite items of furniture such as chairs, lamps and framed paintings. One resident also had a small refrigerator in their bedroom. Residents' artwork and photograph collages of events they attended were displayed.

There was a policy of open visiting in the centre, with protected mealtimes in line with residents' wishes. Inspectors observed visitors visiting residents on the days of inspection. There were comfortable seated areas available in the centre outside of bedrooms where residents could meet their visitors in private if they wished. A restaurant was also available on the ground floor where residents with dementia could join their visitors for refreshments if they wished.

Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. Staff were found to engage positively during care tasks with residents who had dementia. Inspectors also found that staff knew residents well and availed of every opportunity to facilitate meaningful connections with them. Residents responded positively to staff interactions. Staff skilfully engaged and reminisced with residents using information they knew about their interests, families, friends and pets. Inspectors found that the atmosphere was warm and generally happy in the centre.

An activity coordinator on each floor facilitated activities for residents with the support of care staff. Group activities provided were varied and tailored to meet the interests and capabilities of residents with dementia. Residents with one-to-one needs were also provided with activities to meet their interests and capabilities. A recent one-to-one initiative implemented to meet the needs of residents who became unsettled in the evening had positive outcomes for them. While inspectors observed that residents participated in and enjoyed the group activities, there was room for improvement in order to maximise opportunities for all residents to participate in activities in accordance with their interests and capacities. Consideration should be given to the numbers who participate in group activities and the availability of staff to support the facilitator to help less-able residents to participate in an activity. One inspector observed an activity coordinator facilitate an activity for a group of 20 residents. The room was too small to comfortably accommodate the group and there was no other staff member present to deal with issues as they arose or to attend to residents who might require additional assistance. The activity was interrupted when the facilitator had to assist a person who came into the room while the activity was in progress. Inspectors found that comprehensive assessments with activity plans had been completed to inform residents' activity needs.

While residents were supported to meet their religious and spiritual needs, access to the centre's oratory and outdoor garden required review. The key code system in operation could not be easily operated by residents with cognitive impairment to enable them to independently access the oratory or the garden. Residents with dementia in one unit on the ground floor had free access to a safe outdoor space. However, the controlled access on doors and on the lift on the first floor was not dementia friendly. For example residents with dementia who were accommodated on the first floor did not have ready

access to an outdoor space or the oratory which was situated on the first floor. Inspectors observed that a balcony area was provided off a sitting room on the first floor but was locked throughout the days of inspection. Some residents used the balcony to smoke. Inspectors were also told that the balcony surface posed a risk of slip as a resident fall has occurred in this area. Residents' freedom of movement was also curtailed by the key code system in place. These arrangements required review as they limited residents' access around the centre and to the outdoors.

Arrangements were in place to ensure residents could exercise their right to vote in elections. Inspectors observed that staff got consent from residents and gave them choice regarding all care activities in the centre. Residents' privacy and dignity needs were met. Inspectors observed staff knocking on residents' bedroom doors and closing doors to bedrooms and toilets during personal care activities. Residents were provided with discreet assistance with eating as necessary.

A communication policy was available which included reference to communication with residents with dementia. Each resident's communication needs were assessed on admission and a care plan was developed as necessary. There was evidence of effort made to assist residents with communication needs by use of signage on key areas. For example, key areas such as communal toilets were painted a different colour to other doors. However, there was opportunity for further improvement in the use of signage and directional cues to other key areas such as the various communal rooms, a safe outdoor area and the oratory.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place in the reception area. Residents were also informed on admission of the complaints procedure and reference to the procedure is outlined in the residents' guide. The person in charge was the nominated person responsible for management of all complaints received. A record of complaints received was maintained. There were two complaints documented for 2017.

Complaints received were investigated promptly; a record of the investigation process and outcome was documented. There was also reference to the complainant's satisfaction with the outcome of the investigation. The centre had an appeals process

and arrangements were in place to direct the complainant appropriately if unhappy with the outcome. The inspectors also saw evidence of improvements made for residents as a result of complaints received. The centre also has a nominated person who reviewed the complaint process records as required.

Residents spoken with told inspectors that they would not hesitate to make a complaint if they had one. Relatives said that they were satisfied with the care given and were aware of who they could complain to if they needed to. An advocacy service was available if required by any resident to support them.

**Judgment:**

Compliant

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

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

**Findings:**

The staff numbers in the centre appeared appropriate while inspectors were on-site; however, inspectors were not assured that the staffing levels in the evening and at night were sufficient to ensure that the needs of residents were consistently met.

An actual and planned roster was made available to inspectors, which reflected the levels of staff on duty in the centre on the days of the inspection.

Inspectors recommended a review of staffing levels for the following reasons:

- \* Relatives and a number of staff who spoke with inspectors expressed concerns about staffing levels in the evenings and at night, particularly whenever additional nursing interventions are required.

- \* The nursing staff voiced that they were under significant pressure to fulfil their nursing responsibilities such as administering medicines while also having responsibility for supervising residents.

- \* Medications were administered 60-120 minutes after the prescribed times. This was evidenced in the electronic system that documents the actual time of medicines administered.

There was a training programme in place for staff. Inspectors observed good manual handling practices and found that all staff were up to date with training in safe moving and handling practices. Staff had attended training in prevention, detection and response to abuse in the last two years.

A robust induction programme was in place for newly recruited staff, which included

periods of supervision and interim reviews. Annual staff appraisals were completed for 2016 and were ongoing for 2017. The person in charge used this information to inform staff training and professional development needs.

All documents as required by Schedule 2 of the Regulations for staff were maintained and were made available for inspection. All staff nurses had up-to-date professional registration with An Bord Altranais agus Cnáimhseachais na hÉireann. Appropriate vetting procedures were completed for staff in the sample of staff files reviewed by inspectors. The person in charge confirmed that all staff including volunteers working in the centre had appropriate vetting procedures completed. An action from the last inspection requiring the centre to set out the roles of volunteers in writing was satisfactorily completed.

**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:**

Residents' accommodation in the centre was arranged in six units, over three floors. While residents with dementia integrated with other residents on all floors, the majority of residents with dementia were accommodated on the first floor in DeLacy, Swift and Ledwich units. Boyne and Tara units were located on the ground floor and Butler and Bective units were on the second floor.

The centre's internal environment was bright and spacious throughout. Residents on each floor had access to a variety of communal rooms including a dining area, a sitting room and activity room. There were plenty of seating bays which residents used throughout the days of inspection. Corridors and door entrances used by residents were wide and spacious to facilitate their safe mobility with aids used and required by them. Bedrooms were spacious and accommodated personal equipment and devices required to support residents with ease. Handrails were fitted on both sides of the corridors in a contrasting colour to the surrounding walls which enhanced their visibility for residents with dementia. All residents were accommodated in single bedrooms. Each bedroom had an en suite toilet and most also had a shower available. Residents' bedrooms were spacious and bright and provided them with sufficient floor and storage space to meet their needs. Matt flooring throughout helped to minimise glare and was suitable for people with dementia. Floors on corridors were covered with carpet and wood and bedroom floors were covered with non-slip linoleum. There was good use of natural light and every opportunity was taken to light corridors, bedrooms and communal areas with

natural light. The centre was suitably decorated in a style that optimised the comfort of residents with dementia. Wall hangings, paintings and full wall-size familiar scenes were displayed. Items of traditional furniture that were familiar to residents were used.

A grab-rail was provided in communal toilets and residents' showers. A contrasting coloured toilet seat was fitted in the communal toilets on the first floor to aid access for residents with dementia, however, this was not in used in en-suite toilets. With the exception of some minor repairs, the centre was generally well-maintained and warm.

Landscaped garden areas surrounded the premises and included a spacious, safe and secure garden for residents.

**Judgment:**

Compliant

***Outcome 07: Health and Safety and Risk Management***

**Theme:**

Safe care and support

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

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

**Findings:**

Inspectors' findings on this inspection demonstrated that the health and safety of residents, staff and visitors was protected and promoted. There was a safety statement available for the centre.

The risk management policy as required by Regulation 26 did not reference the procedures in place to manage risk of self-harm. However, this policy has been implemented and was received by HIQA in the days following the inspection. The risk policy informed practices in relation to residents at risk of violence and aggression, abuse and unexplained absence and were demonstrated in practice. A risk register was maintained that referenced identification and assessment of risks with controls to prevent potential adverse incidents to residents, visitors and staff. The risk register included clinical risks such as residents with restraints to support their care needs and safety. Risk assessments were completed for individual residents who smoked, including the need for supervision of residents who were at risk of leaving the centre unaccompanied. The sluice room and other hazardous areas were kept locked to prevent unauthorised access.

Health and safety was an agenda item for discussion at two-monthly head-of-department meetings, chaired by the person in charge. Management of health and safety in the centre was also addressed by the provider representative at monthly meetings with the person in charge. The minutes from these meetings were made available to inspectors.

All incidents and accidents involving residents, staff and visitors were documented. Inspectors observed that they were reviewed by the person in charge and communicated to the provider. Data on resident falls was collated, analysed and used to inform risk management strategies and staffing resources. There was evidence of learning implemented from review of any serious incidents involving residents. There was a high incidence of resident falls in the centre in 2016 that necessitated hospital care. Inspectors observed that a focus on prevention by the person in charge and staff team resulted in a reduction in the accidents and incidents to residents in 2017 to date. Each resident has a risk of fall assessment completed on admission. This was regularly reviewed thereafter and after any fall incidents with the input of a physiotherapist who visits the centre each week. Hip protection equipment, low-level beds, foam floor mats, handrails provided in corridors, staff supervision and sensor equipment were used to reduce risk of fall injury to vulnerable residents.

There were adequate precautions taken against the risk of fire in the centre. Fire safety management procedures were demonstrated with consistent checking and servicing of fire equipment and fire exits provided. Each resident had an evacuation risk assessment completed and documented. Inspectors observed that fire evacuation drills were completed at regular intervals. Inspectors were told that fire evacuation drills simulated day and night-time resources and conditions to ensure residents could be safely evacuated at all times. However, the records made available to inspectors did not record sufficient details of fire evacuation drills completed or times of simulated night-time scenarios. Staff who spoke with inspectors were knowledgeable regarding the emergency procedures in the event of a fire occurring in the centre. However, training records provided to inspectors referenced that four staff had not completed annual fire safety training as required. The traffic light system in place states 'red indicates that training has expired or has not been taken'. Records provided on the day showed that four staff were listed as 'red' in relation to fire safety training.

The centre was visibly clean. Hand hygiene facilities were located throughout the premises. Environmental cleaning procedures were in place to reflect best practice in infection prevention and control procedures. The procedures for segregating clean and soiled linen in the centre's laundry also reflected evidence-based practice. An infection control policy informed procedures for management of communicable infection and infection outbreak to guide and inform staff. However, two cleaning trolleys were observed to be heavily soiled. An action from the last inspection in May 2016 in relation to infection control and prevention procedures in a sluice area was satisfactorily completed.

**Judgment:**

Non Compliant - Moderate

***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:**

A defined management structure was in place; however, information in the centre's statement of purpose required review to accurately detail the organisational structure in place. Lines of authority and accountability were defined and all members of the team spoken with were aware of their roles, responsibilities and their reporting procedures. Monthly governance meetings were held and minutes were made available to inspectors. The provider representative attended the centre for four days each month and with the person in charge reviewed the outcomes of quality and safety monitoring during this time. The person in charge confirmed that the provider representative could be contacted by telephone and email at all other times if necessary. Effective team communication was promoted by regular staff meetings at each grade. All meetings were minuted. There was evidence of actions taken in response to meeting discussions.

Management arrangements and monitoring systems were in place to review the quality of care delivered to residents. Inspectors also found quality and safety monitoring systems were in place to ensure that the service provided was safe, appropriate, consistent and regularly reviewed. Key areas reviewed included aspects of clinical care, the environment and feedback including any areas of dissatisfaction from residents and their relatives. Inspectors found that the information collated was analysed and actioned where necessary to inform service improvements. Inspectors found that the person in charge and staff were committed to ensuring that residents were comfortable, safe and well cared for in the centre. Although inspectors found non-compliance with the regulations in a number of outcomes, the provider and person in charge provided assurances that areas for improvement identified would be addressed.

Residents and relatives were familiar with management personnel and the arrangements in place. Inspectors found sufficient resources were made available to meet residents' needs in terms of facilities, staff training and assistive equipment to ensure care was delivered in accordance with the centre's statement of purpose. However, inspectors' findings indicated that staffing resources required review to ensure residents' needs were met in the evening and during the night. This finding is also discussed in Outcome 5.

A report on the quality and safety of care delivered to residents in the designated centre for 2016 was made available to inspectors. A satisfaction survey was completed in 2016 with feedback from 23 residents and 12 relatives, the results of which were generally positive.

**Judgment:**

Substantially Compliant

**Closing the Visit**

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Una Fitzgerald  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Knightsbridge Nursing Home
<b>Centre ID:</b>	OSV-0000145
<b>Date of inspection:</b>	12 April 2017
<b>Date of response:</b>	15 August 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 01: Health and Social Care Needs

#### Theme:

Safe care and support

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

Care plans were not consistently updated post a clinical change in a residents condition that required an assessment and follow up care.

Inspectors were told that residents or their relatives where appropriate were consulted regarding care plan development and subsequent reviews. However there was documentary evidence that these consultations took place every six months and not on

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

a four-monthly basis as required by the regulations.

**1. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 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. A weekly clinical governance meeting takes place with CNM on every unit to ensure clinical changes are promptly acted upon and updated in care plan. An in depth audit has been carried out by management on care plans, education done with all nurses following same.

2. All care plan review meetings with residents and family members now take place at 4 monthly intervals. Care plan policy has been updated to reflect requirement for care profile reviews to take place at a minimum of every 4 months.

**Proposed Timescale:** 30/05/2017

**Theme:**

Safe care and support

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

A new electronic medication system was been piloted on one floor. When a resident required their medications crushed, this system instructed that all medicines were to be crushed unless the doctor specified otherwise. Inspectors had concerns about the potential risks associated with a system which defaulted to crushing of medications unless otherwise stated.

Residents' medicines were not always administered to residents within a reasonable timeframe of the prescribed administration time.

**2. 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. New electronic system has now been updated by the supplier and crush instruction is now outlined for each individual medication as indicated

2. Medications are administered now within the appropriate time-frame, and this has been audited and all nurses educated on same. This has been facilitated by the addition of a twilight shift for nurses.

**Proposed Timescale:** 01/05/2017

### **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:**

Bedrails were not used in accordance with the national restraint policy.

**3. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Full restraint audit conducted and new restraint audit tool introduced and to be continued quarterly. Education carried out with all staff regarding requirements to meet guidelines with National restraint policy. Knightsbridge is committed to reducing restraint within the Nursing home and continually working towards this. Appropriate use of restraint training is provided on induction to all new staff and refreshers done yearly

**Proposed Timescale:** 30/08/2017

### **Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The arrangements for providing group activities required review to ensure that group numbers were appropriate and to prevent overcrowding.

**4. 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:**

We have now opened a new large activity room on the first floor and opened unit doors so as residents can freely attend activities and oratory. This room was named by the residents as "The Snug" and official opening was on the 22nd of June.

New protocol in place whereby care staff must accompany if 8 or more residents attend activities.

**Proposed Timescale:** 22/06/2017

**Theme:**

Person-centred care and support

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

Residents freedom of movement was curtailed. Inspectors observed that a balcony area was provided off a sitting room on the first floor but was locked throughout the days of inspection. Inspectors were also told that the balcony surface posed a risk of slip following a resident fall in this area. Residents freedom of movement was also curtailed by the key code system in place. These arrangements required review as they limited residents' access around the centre and to the outdoors.

**5. Action Required:**

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

1. Balcony areas to be open pending risk assessment
2. Non-slip surface in place in balcony areas, surface does not pose risk
3. Doors to Dementia unit now open residents have access to atrium with activity room and oratory.

**Proposed Timescale:** 30/08/2017

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

Inspectors recommended a review of staffing levels and skill mix for the following reasons:

- \* A number of staff who spoke with inspectors expressed concerns about staffing levels in the evenings and at night whenever additional nursing interventions are required.
- \* Nurses rostered to work on a floor were sometimes required to provide assistance on another floor.
- \* The nursing staff voiced that they were under significant pressure to fulfil their responsibilities of the nursing specific duties like medicine administration while also having responsibility for supervision of residents.
- \* Medicines were administered 60-120 minutes post the prescribed times. This was evidenced in the electronic system that documents the actual time of medicines administered.

**6. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of

staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. Nurse hours added to include a twilight shift, additional nurse now works 6pm -12am
2. Nurses only go to other floors to provide assistance in an emergency situation

**Proposed Timescale:** 01/05/2017

**Outcome 07: 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 records of fire evacuation drills made available to inspectors did not record sufficient details.

**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:**

A more robust form is now in place for fire evacuation drills detailing the flow of actions.

**Proposed Timescale:** 30/06/2017

**Theme:**

Safe care and support

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

Two cleaning trolleys were observed to be heavily soiled.

**8. Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

An immediate inspection of all trollies was carried out, formal supervisions provided for all housekeeping staff in relation to the maintenance of cleaning trollies, new scheduling system for the cleaning of trollies now in place.

**Proposed Timescale:** 17/04/2017

**Theme:**

Safe care and support

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

Training records provided to inspectors referenced that four staff had not completed annual fire safety training as required.

**9. Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Traffic light system reflected company policy (fire training to be done every 6 months). We have now updated our local company policy to reflect the national regulation of yearly training. However 2 staff were out of date, one in induction post maternity leave at time of inspection and one bank staff. Training records reviewed and audited monthly to ensure no staff are missed.

**Proposed Timescale:** 30/04/2017

**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:**

Inspectors' findings indicated that staffing resources required review to ensure residents' needs were met in the evening and at night.

**10. Action Required:**

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

As stated in outcome 5 we have increased our Nursing hours in the evening to work with both day and night staff to assist with medications and any incidents that may occur.



**Proposed Timescale: 01/05/2017**