Kilrush District Hospital inspection report, 9 April 2013

Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Kilrush Nursing Home
Centre ID:	0452
Centre address:	Killimer Road Kilrush Co Clare
Telephone number:	065-9062686
Email address:	managerkilrush@mowlamhealthcare.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Mowlam Healthcare Limited
Person authorised to act on behalf of the provider:	Patrick Shanahan
Person in charge:	Carmel Hanrahan
Date of inspection:	9 April 2013
Time inspection took place:	**Start:** 08:50 hrs **Completion:** 17:10 hrs
Lead inspector:	Mary Costelloe
Support inspector(s):	N/A
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	44 + 1 in hospital
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This inspection report sets out the findings of a monitoring inspection, in which 10 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☐
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

On the day of inspection the inspector was satisfied that the residents nursing and healthcare needs were being met. The inspectors observed sufficient staffing and skill mix on duty during the inspection and staff rotas confirmed these staffing levels to be the norm.

The staff demonstrated a comprehensive knowledge of residents' needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

The inspector identified some risks during the inspection in relation to boiling water on the breakfast trolley and bedroom doors being wedged open; the clinical nurse manager (CNM) on duty undertook to address these specific risks during the inspection.

The centre was clean, warm and comfortable. The communal areas were appropriately furnished and the décor was pleasant.

The collective feedback from residents was one of satisfaction with the service and care provided.

As identified at the previous inspections, nursing documentation still required improvements.

Other areas for improvement related to medication management, staffing files and provision of safe floor covering , these are listed in the Action Plan at the end of this report.

Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 3

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge was on leave on the day of inspection. The person in charge is a nurse, her post was fulltime and she normally worked Monday to Friday. Staffing rotas reviewed and staff spoken to confirmed this to be the case.

The CNM was on duty and deputised for the person in charge. She demonstrated good clinical knowledge and was very knowledgeable regarding residents nursing and social care needs. She was knowledgeable regarding the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations (as amended), the *National Standards for Residential Care Settings for Older People in Ireland* and her statutory responsibilities.

The inspector observed that she was well known to staff and residents.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☒ Improvements required * ☐

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

Staffing Records

Substantial compliance ☒ Improvements required * ☐

Medical Records

Substantial compliance ☒ Improvements required * ☐

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found that measures were in place to protect residents from being harmed or abused.

The inspector reviewed the comprehensive policies on protection of residents from abuse, responding to allegations of abuse, management of whistle blowing and protection of resident's accounts and personal property. Staff spoken to confirmed that they had received training in relation to the prevention and detection of elder abuse and were knowledgeable regarding their responsibilities in this area. The inspectors found that staff were able to explain what their responsibilities were if they suspected abuse and they were aware of the policies on protection of residents. Training records reviewed indicated that all staff had up-to-date training.

The inspector was satisfied that robust safe procedures were in place for managing residents finances. Money kept for safekeeping on behalf of a small number of residents was maintained securely. Records of all transactions were clearly maintained and signed by two staff members and/or the resident.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector noted that improvements were required in relation to risk management.

There was a health and safety statement available. The inspector reviewed the risk management policy and risk registers. Risks specifically mentioned in the Regulations such as assault, accidental injury, aggression and violence and self harm were not included. Other risks identified by the inspector such as boiling a kettle of water on the breakfast trolley on the first floor corridor had not been assessed or identified as being a risk. The inspector discussed this high risk with the CNM. Later during the inspection, she confirmed that she had met with and discussed this issue with staff. She stated that the kettle would no longer be used and that staff would use the first floor kitchenette for making hot drinks.

The inspector reviewed the emergency plan which had been reviewed in 2012. The plan included clear guidance for staff in the event of a wide range of emergencies such as fire, flooding, power failure, communications failure and evacuation. Arrangements were in place locally for alternative accommodation in the event of the building having to be evacuated.

The inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in November 2012 and the fire alarm was serviced on a quarterly basis. The last fire alarm service took place on 18 January 2013. Systems were in place for daily checks on the means of escape, weekly testing of the fire alarm and these checks were being recorded. Records of fire drills which took place on a six-monthly basis were recorded. Fire safety training took place regularly and included evacuation procedures and use of fire equipment. All staff spoken to told the inspector that they had received fire safety training and were

confident in knowing what to do in the event of fire. Training records reviewed indicated that all staff had received up-to-date formal fire safety training. The inspector observed that on the morning of inspection some bedroom doors were wedged open contrary to safe fire practice. Automatic door guards had been fitted to some rooms and the CNM told the inspector that door guards had been ordered for all other rooms and were due to be fitted shortly. The CNM immediately addressed the issue and gave assurances to the inspector that door wedges would no longer be used.

Training records reviewed indicated that all staff members had received training in moving and handling. Staff spoken to confirmed that they had received training. The inspector observed good practice in relation to moving and handling of residents during the inspection.

Handrails were provided to all circulation areas and grab rails were provided in all toilets and bathrooms. Call bell facilities were provided in all rooms. Safe floor covering was provided throughout the building with the exception of one corridor. The floor to one ground floor corridor was uneven and the floor covering was defective. This issue had been identified and logged in the risk register and had also been discussed at health and safety meetings. A warning notice had been placed on the corridor wall to remind and warn users of the uneven surfaces. There were no resident's bedrooms in this area. The operations manager showed the inspector documentation indicating that this work was scheduled to take place in June 2013.

The inspector noted that infection control practices were robust. Hand sanitising dispensing units were located at the front entrance and throughout the building. Hand-washing stations were located on all bedroom corridors. Staff were observed to be vigilant in their use. Many staff had received training in infection control in 2012. The entire building was found to be clean and odour free. The inspectors spoke with housekeeping staff regarding cleaning procedures. Staff were knowledgeable regarding colour coding, use of appropriate chemicals and infection control procedures.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

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

Inspection findings

While the inspector noted that the policies and procedures for medication management were generally robust, improvements were required in the area of medication prescribing.

The inspector reviewed the medication management policy which was found to be comprehensive, and gave detailed, clear guidance on areas such as administration, prescribing, storage, disposal, crushing, "as required" (PRN) medications, medications requiring strict controls and medication errors.

The inspector spoke with nurses on duty regarding medication management issues. The nurses demonstrated their competence and knowledge when outlining procedures and practices on medication management.

The inspector reviewed a sample of medication prescribing/administration sheets. All medications were regularly reviewed by the general practitioners (GP). The issue in relation to transcribed medications not being signed by the nurse highlighted at the last inspection had been attended to. The inspector noted that all medications that required crushing were not individually prescribed by the GP. This issue had also been highlighted during recent pharmacy and in house medication audits. The CNM stated that she would address this issue with the GP involved.

Medications requiring strict controls were appropriately stored and managed. The inspector saw that these were stored in a double locked cupboard in the locked clinical room. Records indicated that they were counted and signed by two nurses at change of each shift in accordance with the centre's medication policy. Secure refrigerated storage was provided for medications that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis.

Systems were in place for the safe return of medications to the pharmacist. Medication errors were recorded in line with the medication policy. There was one recent error, this was clearly recorded as an incident and an action plan was documented.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The CNM was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge. Improvements were required in the area of falls management to ensure continuous quality improvements.

The inspector reviewed the incident log and saw that all relevant details of each incident were recorded in the incident log and on the computerised documentation system. Incidents were also discussed by the health and safety committee who met on a monthly basis. The health and safety committee were made up of staff from all departments in the centre such as nursing, catering, housekeeping and care staff. A health and safety audit was completed three times a year. Minutes of health and safety meetings were reviewed and issues such as falls had been discussed. The person in charge carried out a falls audit on a quarterly basis. The last audit was carried out in February 2013. Trends had been identified and a summary of the audit was displayed in the staff room. Staff confirmed that the results of the audits were discussed with them. They stated that that had increased awareness regarding the number of residents falling in their bedrooms and had increased supervision as a result. The inspector reviewed the files of a number of residents who had recently fallen and noted that falls risk assessments and care plans were not consistently updated following each fall.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

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

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Standard 12: Health Promotion Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence Standard 21: Responding to Behaviour that is Challenging
Action(s) required from previous inspection: Set out each resident's needs in an individual care.

Inspection findings

Overall, the inspector found that residents' healthcare needs were met and they had access to appropriate medical and allied healthcare services. Improvements were still required in relation to some nursing documentation.

All residents had access to GP services. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services was available on referral including speech and language therapy (SALT), physiotherapy, occupational therapy (OT) and dietetic services. Chiropody and optical services were also provided. The inspector reviewed residents' records and found that residents had been referred to these services and results of appointments were maintained in the residents' notes.

Nursing records were maintained on the computerised nurse documentation system. The inspector reviewed a number of residents' files including the files of residents with wounds, behaviour that challenged, weight loss, indwelling catheter and those using restraint measures.

Comprehensive nursing assessments were completed on admission but were not updated thereafter. A wide range of up-to-date risk assessments had been completed including nutrition, dependency, skin integrity, continence, restraint and manual handling however they did not always inform the care planning process. The inspector noted inconsistencies in the care plan documentation. The care plan interventions did not address the specific needs of some residents such as residents with a catheter and those requiring colostomy care. The care plans which the inspector reviewed did not include clear personalised interventions to address residents assessed needs and did not provide adequate guidance for staff to deliver care. The information in the care plan interventions did not reflect the delivery of care that staff discussed with the inspector.

The inspector reviewed the care plans of some residents who had wounds and found wound care to be well managed. The inspector noted that there were adequate records of assessment and appropriate plans in place to manage wounds. Up to date wound progress charts were also maintained.

The inspector noted that improvements were required in the nursing documentation for a resident who displayed challenging behaviour. Suitable interventions were not clearly documented to guide staff and there was no plan of care for the use of bedrails for this resident. Staff spoken with were clearly able to outline to the inspector detailed suitable interventions to calm this resident. There was a behavioural chart in place and the resident was reviewed by the psychiatric liaison nurse.

The inspector was satisfied that weight loss was being closely monitored. All residents were nutritionally assessed using a validated assessment tool. All were weighted monthly. All residents had been recently reviewed by the dietician. The inspector reviewed the file of a resident who had been losing weight. The resident had been reviewed by the dietician and speech and language therapy and their recommendations were documented and had been communicated to staff. Catering staff spoken to were knowledgeable regarding resident's special dietary needs and food likes/dislikes. Nutritional supplements were administered as prescribed.

The inspectors noted that staff continued to promote the reduction in the use of restraint. The number of residents using bedrails had reduced since the last inspection. There were seven residents using bedrails at the time of inspection. The restraint policy promoted a restraint free environment. Eight staff had recently attended training on the national restraint policy. Risk assessments had been completed for the use of bedrails. However, the assessment did not include the alternative measures that had been tried or considered. All residents using bedrails were checked on an hourly basis and this was being recorded. The CNM outlined how other alternatives had been considered and were in use for some residents such as low-low beds, crash mats and sensor mats.

There was no consistent system in place to include evidence of resident/relative involvement in the development/review of their care plans. The CMN showed the inspector the system that had been recently introduced whereby computerised care plans had been printed off for each resident. She stated that this would allow residents, relatives and staff to be involved in the review and updating of care plans.

Outcome 12

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:

Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The centre was warm, clean and odour free throughout. It was well maintained and nicely decorated.

There was a variety of communal day spaces on both floors including day rooms, dining rooms, smoking room, quiet room, visitors' room, oratory and seating provided in the front entrance area. The communal areas had a variety of comfortable furnishings and were domestic in nature.

Bedroom accommodation met residents' needs for comfort and privacy. There was adequate numbers of assisted toilets, bath and shower rooms. Assisted toilets were located beside the day rooms. There was a nurse call-bell system in place. Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. Some residents spoken to stated that they liked their bedrooms.

Residents had access to an enclosed garden area, which was paved and had raised flower beds. Some seating benches were provided.

There was appropriate assistive equipment provided to meet the needs of residents, including hi-low beds, hoists, specialised mattresses and transit wheelchairs. There was a lift provided between floors. The inspector viewed the maintenance and servicing contracts and found the records were up-to-date and confirmed that equipment was in good working order.

The floor to one ground floor corridor was uneven and the floor covering was defective. This has already been discussed under Outcome 7.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

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

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

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

Inspection findings

The inspector found evidence of good complaints management.

There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was clearly displayed and outlined the name of the complaints officer and details of the appeals process.

The inspector reviewed the complaints log which was maintained on the computerised system. Details of complaints, action taken, details of whether the complainant was satisfied or not with the outcome and lessons learnt were documented. There was one complaint received to date during 2013. All complaints to date had been acted upon and were closed.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Action(s) required from previous inspection:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Inspection findings

The inspector noted adequate staffing levels at the time of inspection. On the day of inspection there were two nurses and seven care assistants on duty during the day,

two nurses and five care assistants during the afternoon and evening. There were two nurses and two care assistants on duty at night time. The person in charge was normally also on duty during the daytime but was on leave on the day of inspection. The CNM was one of the nurses on duty on the day of inspection, she arranged for another nurse to come in so that she could facilitate the inspection. The CNM also worked two days per week in a supervisory role. The CNM told the inspector that the staffing levels and skill mix were based on the assessed needs and dependency levels of residents. The inspector noted that dependency levels were regularly reviewed and updated.

The inspector reviewed a sample of staff files. The files were not in compliance with the Regulations in that there were no evidence of physical and mental fitness to work included. Garda vetting was in place for all staff. Nursing registration numbers were available and up to date for all staff nurses. Details of staff induction training received, annual staff appraisals and training certificates were noted on staff files.

The inspector noted that ongoing training of staff was prioritised. A wide range of training had taken place in the past 12 months. Nursing staff had received training in wound management, continence care, cardiac pulmonary resuscitation (CPR), venapuncture, subcutaneous fluids, health and safety, medication management, palliative care, care plan evaluation, restraint and challenging behaviour. Care staff had training on infection control, continence promotion, cardiac pulmonary resuscitation, restraint and challenging behaviour. All care assistants had completed Further Education and Training Awards Council (FETAC) level five training course in care skills and care of the older person. Two staff had attended Sonas training (a therapeutic programme specifically for residents with dementia).

Closing the visit

At the close of the inspection visit a feedback meeting was held with the CNM and operations manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, provider and staff during the inspection.

Report compiled by:

Mary Costelloe
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

10 April 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	Kilrush Nursing Home
Centre ID:	0452
Date of inspection:	9 April 2013
Date of response:	30 April 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Outcome 7: Health and safety and risk management

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

Risks specifically mentioned in the Regulations such as assault, accidental injury, aggression and violence and self harm were not included.

All risks had not been identified such as boiling kettle of water on the breakfast trolley.

Some bedroom doors were wedged open contrary to safe fire practice.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental

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

injury to residents or staff; aggression and violence; and self-harm.
Action required: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.
Action required: Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A risk management policy has been drafted that covers the precautions in place to control the following specified risks; the unexplained absence of a resident: assault: accidental injury to residents or staff: aggression and violence and self harm. The policy will be finalized and approved by the Policy and Procedure Committee.	08 May 2013
Kettle has been removed from breakfast trolley and staff have been informed that this practice will not continue.	Completed
All door wedges have been removed from the building.	Completed

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: Some medications that required crushing were not individually prescribed by the GP.
Action required: Put in place appropriate and suitable practices and written operational policies

relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All medications that require crushing are individually signed by GP.	Completed

Theme: Effective care and support

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: Improvements were still required in relation to some nursing documentation. For example: ▪ comprehensive nursing assessments were not updated ▪ falls risk assessments were not consistently updated following a fall ▪ inconsistencies were noted in the care plan documentation ▪ care plan interventions did not address the specific needs of some residents such as those presenting with challenging behaviour, catheter care, colostomy care or those using restraint ▪ there was no consistent system in place to include evidence of resident/relative involvement in the development/review of their care plans.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.
Action required: Revise each resident's care plan, after consultation with him/her.

Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Work is on-going on reviewing and improving nursing documentation as it relates to assessments and individualized care planning. Each residents care plan is kept under formal review as required by the residents changing needs or circumstances, and no less frequent than at three monthly intervals. All residents care plans have been revised in consultation with the resident or relative as appropriate.	31 May 2013 Completed Completed

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: The floor to a ground floor corridor was uneven and the floor covering was defective.	
Action required: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Quotations have been sought for repair to ground floor corridor and it is anticipated that this work will be completed by 30 June 2013.	30 June 2013

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: Some staff files were not in compliance with the Regulations in that there was no evidence of physical and mental fitness to work included.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Recruitment procedures are in place to ensure that no staff members are employed in Kilrush Nursing Home unless they are physically and mentally fit for the purposes of the work which they are to perform. All employees appointed since July 2011 have completed a pre-employment medical questionnaire signed by their GP attesting to their mental and physical fitness to work. For those employees appointed prior to July 2011 where it was impracticable for the person to obtain such evidence, a declaration signed by the person that they are so fit is on file.	Completed