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St Kieran's Care Home, The Pike, Rathcabbin, Roscrea, Tipperary

Item Type	report
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Citation	Mary Costelloe, 'St Kieran's Care Home, The Pike, Rathcabbin, Roscrea, Tipperary', [report], Health Information and Quality Authority, 2017-12-14, Older People Inspection Report, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-16 08:10:51
Link to Item	https://hdl.handle.net/20.500.14765/86725

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Kieran's Care Home
Centre ID:	OSV-0005584
Centre address:	The Pike, Rathcabbin, Roscrea, Tipperary.
Telephone number:	057 913 9069
Email address:	stkieransnh@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Laurel Lodge Nursing Home Ltd
Provider Nominee:	Laurel Lodge Nursing Home Ltd
Lead inspector:	Mary Costelloe
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
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 his/her registration.

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 12 September 2017 10:00 To: 12 September 2017 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was the first inspection of this centre since the new provider Laurel Lodge Nursing Home Ltd had taken over the running of the centre in July 2017. This report sets out the findings of an unannounced inspection, which took place to monitor on going compliance with the regulations and following notification from the provider of a change to the person in charge. As part of the inspection the inspector met with residents, staff members, the provider representative and the person in charge. The inspector observed practices and reviewed documentation such as care plans, medical records, policies, procedures and staff files.

Overall, the inspector found that the person nominated to represent the provider and the person in charge demonstrated a commitment to meeting the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider continued to financially invest in the centre and renovation works were in progress at the time of inspection.

The location and layout of the centre was suitable for its stated purpose and met

residents' individual and collective needs in a comfortable and homely way. The inspector found it to be comfortable, bright and nicely decorated. It was warm, clean and odour free throughout.

There was evidence of good practice in many areas. The person in charge and 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.

On the day of inspection, the inspector was satisfied that the nursing and healthcare needs of residents were being met. There was evidence of timely access to general practitioners and allied health services. However, nursing documentation required improvement to support and reflect the care being delivered. A computerised nurse documentation system was due to be put in place in the coming weeks.

The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day.

Areas for improvement included agreeing contracts of care with all residents, providing mandatory training in fire safety, manual handling and infection control for recently recruited staff, care planning documentation, documentation to support the use of bedrails, fire drills, staff recruitment and induction training processes.

These areas for improvement are included in the action plan at the end of this report.

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 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

This was the centre's first inspection by the Authority.

Findings:

The provider had established a clear management structure. There was a recently appointed person in charge who worked full time in the centre. The person in charge was supported in her role by a clinical nurse manager (CNM), senior nurse, the provider representative and human resource (HR) consultant. The CNM deputised in the absence of the person in charge. The nurse management team met each other, residents and staff on a daily basis. The provider representative who was a director of the company visited the centre twice weekly and met with residents and staff. He attended monthly clinical governance meetings along with the person in charge, CNM, the other director of the company, HR consultant, chef, senior carer and activities coordinator. Residents and staff spoken with told the inspector that they felt well supported, that the management team were approachable and they could report or discuss any issue with any member of the management team. Residents spoken with told the inspector that the provider representative visited and spoke with them when he visited the centre each week.

The person in charge outlined the systems she was putting in place to review the quality and safety of care. She stated that she had developed an 18 outcome audit tool to assess on-going compliance with the regulations and standards and to ensure that improvements identified would be addressed. She advised that all 18 outcomes would be discussed at the monthly clinical governance meetings. She had arranged with a local pharmacist to carry out regular independent audits of medication management practices in the centre.

The person in charge advised the inspector that information from audits will be used to inform the annual review of the quality and safety of care. The system of review also included consultation with and seeking feedback from residents and their representatives. Residents committee meetings continued to be held on a regular basis.

The provider had recently carried out a resident and relatives satisfaction survey. While the questionnaires that had been returned indicated satisfaction with the service provided, they were waiting on further questionnaires to be returned.

The provider had continued to financially invest in the centre. A secure, enclosed paved garden area had been provided for use by residents. Renovation works were in progress to the first floor area at the time of inspection. The staff facilities such as changing rooms, toilet facilities and rest room were being upgraded, a family room with en suite toilet and shower facilities was being provided.

The provider outlined further plans to upgrade the laundry and kitchen areas, painting of all internal areas and enhancing the privacy and dignity for residents by removing some existing doors to shared bathrooms. New dining room chairs, medicines trolley and refrigerator were on order. The person in charge advised that many items of new equipment required for clinical care as well as computers and office equipment had been recently provided.

A new computerised nurse documentation system was due to be installed in the coming weeks.

Judgment:

Compliant

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

This was the centre's first inspection by the Authority.

Findings:

The provider had not agreed contracts of care with residents. The contracts in place were agreements between the residents and the previous provider. The person in charge told the inspector that updated contracts of care they would be issued to residents within the next week.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

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

<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): This was the centre's first inspection by the Authority.</p> <p>Findings: The person in charge commenced in her role on the 29 August 2017. She was a qualified nurse and worked full-time in the centre. She had the required qualifications and experience in the area of nursing the older adult.</p> <p>The person in charge was knowledgeable regarding the regulations, HIQA's Standards and her statutory responsibilities. She was knowledgeable regarding the individual needs of each resident.</p> <p>The person in charge had engaged in continuous professional development. Having previously undertaken level 6 qualification in gerontology, she had recently completed training in medicines management, national early warning scores, clinical supervision and clinical coaching.</p> <p>While the person in charge had only recently been appointed, she was known to residents and staff.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 05: Documentation to be kept at a designated centre</i> <i>The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): This was the centre's first inspection by the Authority.</p> <p>Findings: The inspector reviewed a sample of staff files. Some staff files did not comply fully with the requirements of the regulations for example, the date of commencement of employment, the position and job description was not available for all staff.</p>

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

This was the centre's first inspection by the Authority.

Findings:

The provider and person in charge had taken measures to safeguard residents from being harmed and from suffering abuse; however, improvements were required to ensuring that recently recruited staff received training in safeguarding of vulnerable adults and to documentation to support the use of bedrails.

The provider and person in charge stated that all staff and persons who provided services to residents had Garda (police) clearance in place.

There were recently updated policies on protection of residents from abuse, responding to allegations of abuse, security of residents accounts and personal property, management of residents money and accounts, use of restraint and management of behaviours that challenge.

Staff spoken with and training records viewed confirmed that staff had received ongoing education on elder abuse. However, some recently recruited staff had not had training.

The inspector reviewed the policies on use of restraint and behaviour that challenges, both of which had been recently reviewed.

Staff continued to promote a restraint free environment. There were eight residents using bedrails at the time of inspection, five were at the residents own request. The inspector noted that risk assessments completed for the use of bedrails were not in line with national policy on use of restraint. There were varying assessment templates in use and information was sometimes conflicting in the completed assessments. There was no clear rationale for use of bedrails and alternatives tried or considered were not recorded. Consent and care plans were documented in all cases. Staff carried out regular checks on residents using bedrails and these checks were recorded.

Nursing staff informed the inspector that there few residents with a dementia and currently no residents who presented with responsive behaviour. The inspector noted

that PRN (as required) psychotropic medicines were prescribed for a small number of residents but seldom administered. Some residents with anxiety had care plans in place however, the inspector noted that care plans reviewed were not informative and did not outline guidance for staff as to how to reassure and support the resident. The action relating to this issue is included under Outcome 11: Health and social care needs.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

This was the centre's first inspection by the Authority.

Findings:

There was an up-to-date health and safety statement available and risk management policies in place. However, the inspector had concerns that there were no records of recent fire drills and recently recruited staff had not completed mandatory training in fire safety, manual handling and infection control.

The inspector reviewed the risk register and found it to be comprehensive and had been recently reviewed. All risks specifically mentioned in the regulations were included. Systems were in place for regular review of risks, however, the inspector noted that the door to the sluice room was left open. This posed a potential risk to residents and visitors as the sluice room was used for the storage of cleaning chemicals and clinical waste.

There was a policy on responding to emergencies which included clear guidance for staff in the event of a wide range of emergencies including the arrangements for alternative accommodation should it be necessary to evacuate the building.

Training records reviewed indicated that staff members except for recently recruited staff had received up-to-date training in moving and handling. Staff spoken to confirmed that they had received this training.

The inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in January 2017 and the fire alarm was serviced on a quarterly basis. The fire alarm was last serviced in July 2017. Daily and weekly fire safety checks were carried out and these checks were recorded. Fire safety training took place regularly and included evacuation procedures and use of fire equipment. Recently recruited staff spoken with told the inspector that they had not received fire safety training. Training records reviewed indicated that staff except recently recruited staff

had received up-to-date formal fire safety training. Fifteen staff had attended formal fire safety training in February 2017. There were no records of recent fire drills. The person in charge had developed a new template to record fire drills which included the names of those attending, recommendations, learning outcomes and action plan. She stated that she planned to hold a fire drill during the next week.

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.

There was a comprehensive recently updated infection prevention and control policy in place. Hand sanitizer dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in the use of hand sanitizers.

The building was found to be clean and odour free. Most staff had completed training on infection control during 2017. Recently recruited staff including staff employed in the laundry area had not completed infection control training contrary to the centre's own policy and standards for the prevention and control of healthcare associated infections published by the Authority.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

This was the centre's first inspection by the Authority.

Findings:

The inspector generally found evidence of good medicines management practices and sufficient policies and procedures to support and guide practice. However, some gaps were noted in the medicines administration charts, appropriate codes had not been used therefore the inspector could not determine if the medicines had been administered as prescribed.

The person in charge told the inspector that she had in consultation with the pharmacist ordered a new medicines trolley and refrigerated storage unit for medicines. The pharmacist had agreed to provide training to staff and to carry out medicines audits in house.

The inspector spoke with a nurse on duty regarding medicines management issues. The nurse demonstrated her competence and knowledge when outlining procedures and practices on medicines management.

Medicines requiring strict controls were appropriately stored and managed. Secure refrigerated storage was provided for medicines that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis.

The inspector reviewed a sample of medicines prescribing/administration sheets. All medicines were regularly reviewed by the general practitioners (GP), all medicines were individually prescribed including those that were required to be crushed.

Systems were in place to record medicine errors and staff were familiar with them. Nursing staff told the inspector that there had been no recent medicine errors.

Systems were in place for checking medicines on receipt from the pharmacy.

Records were maintained of all unused/out-of-date medicines returned to the pharmacy.

Nursing staff spoken with and training records reviewed indicated that most nurses had attended recent medicines management training. Further training was planned by the pharmacist.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found that residents' healthcare needs were met and they had access to appropriate medical and allied healthcare services. Each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. However, nursing documentation required improvement to support and reflect the care being delivered.

All residents had access to a choice of general practitioner (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 and medical records supported that GP review was timely and responsive.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. 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 and recommendations were written up in the residents' notes.

The inspector reviewed a number of residents' files including the files of residents with restraint measures in place, nutritionally at risk, with wounds and presenting with anxiety. See Outcome 7: Safeguarding and Safety regarding restraint and behaviours that challenge.

The person in charge outlined that a new computerised nurse documentation system was due to be put in place. She advised that in house training of all staff was scheduled and that it was planned that the system would be commenced by mid October 2017 and in use by December 2017.

A range of risk assessments had been completed including nutrition, dependency, manual handling, falls, bedrail use and skin integrity.

The inspector noted that while care plans were in place, there were many inconsistencies noted in the nursing documentation. Care plans did not always support the care being delivered. Some care plans were not informative and did not guide the care of the resident. Some care plans were not always individualised or person centered. There were no care plans in place for issues such as dementia and communication. The individual wishes and needs of residents were not set out in their care plans for example, end of life wishes and social care needs. There were no care plans in place for some residents assessed as being at high risk of falls or at high risk of developing pressure ulcers. The recommendations of the dietician, SALT and OT were not always reflected in the relevant care plans.

Staff spoken with were knowledgeable regarding the specific needs of each resident and could clearly describe the care delivered, however, this was not reflected in the care plans.

There was a reported low incidence of wound development and the inspector saw that the risk of same was assessed regularly and appropriate preventative interventions including pressure relieving equipment were in use. There were no residents with pressure ulcers at the time of inspection. The inspector reviewed the file of the resident with a wound and noted adequate wound assessment and wound care charts in place. There was evidence of referral and assessment by the vascular consultant.

The inspector was satisfied that changes to residents' weights were closely monitored; residents were nutritionally assessed using a validated assessment tool. All residents were weighed monthly and more frequently if nursing staff had concerns. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident and liaise with the GP. Files reviewed by the inspector

confirmed this to be the case. Some residents were prescribed nutritional supplements which were administered as prescribed.

Residents' social care needs were met through a varied and meaningful activity programme. There was an activities co-ordinator on duty seven days a week from 8.00 to 18.00 hours. The activities schedule was displayed in the day room. Both group and 1:1 activities took place. Regular activities offered included reading the newspapers, hand massage, light exercise to music, sing a long, dog therapy, arts and crafts, card games, reflexology, flower arranging, baking, board games, movie afternoons, gardening and live music weekly. Residents were observed enjoying a variety of activities during the inspection and residents spoken with told the inspector that they enjoyed then variety of activities taking place.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

This was the centre's first inspection by the Authority.

Findings:

Accommodation for residents was provided on the ground floor, staff facilities were provided on the first floor. The new provider continued to invest in the building, some works were in progress at the time of inspection and other improvements works were planned.

A secure, enclosed paved garden area had been provided for use by residents.

Renovation works were in progress to the first floor area at the time of inspection. Staff facilities including changing rooms, toilet facilities and rest room were being upgraded.

A family room with en suite toilet and shower facilities was being provided on the first floor so that families could stay overnight if they wished.

The provider outlined further plans to upgrade the laundry and kitchen areas, repainting of all internal areas and enhancing the privacy and dignity for residents by removing some existing doors to shared bathrooms.

The building accommodated 23 residents in nine twin and five single bedrooms. Screening curtains were provided in all shared bedrooms and wardrobes with sliding doors had been fitted to maximise space. The person in charge confirmed that residents continued to be assessed prior to admission to ensure that their needs could be safely met. Many of the bedrooms were personalised with residents own photographs and personal items..

There were two assisted showers and four toilets for the use of residents. There was no bath provided therefore residents did not have a choice of bath or shower. There were three doors leading into some of the toilets which potentially posed a risk to the privacy and dignity of residents.

There was inadequate storage space for equipment. Equipment such as laundry trolleys, refuse trolleys and commodes were stored in the shower room areas.

The communal day areas including the entrance area, day room and dining room were bright, spacious and comfortable. They were appropriately furnished in a homely manner. Residents spoken with stated that they liked the communal day areas and their bedrooms.

There was a kitchen, laundry and sluice room. There was no separate cleaners room, this posed an infection control risk.

There was no separate private visiting space available to residents. The person in charge advised that residents would be offered her office if they wished to meet a visitor in private.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

This was the centre's first inspection by the Authority.

Findings:

Based on observations, staff spoken with and the review of staff rosters, the inspector was satisfied that there were appropriate staff numbers and skill mix to meet the assessed needs of the 21 residents. However, improvements were required to the staff recruitment, induction and training processes.

There was nurse and four care staff on duty throughout the morning and afternoon, one nurse and two care assistants on duty from 18.00 to 20.00 hours in the evening time and one nurse and one care assistant on duty at night time. The person in charge was normally on duty during the day time Monday to Friday and was on call out of hours and at weekends. In addition there were normally two catering, one housekeeper and an activities therapist on duty during the day time, seven days a week. The duty roster reviewed indicated that this was the normal staffing pattern.

The inspector spoke with some recently recruited staff members who stated that they had not received formal induction training and had not received mandatory training. There were no records of induction training completed maintained on those staff members files. The actions relating to these issues are included under Outcome 8: Health and safety and risk management.

The inspector reviewed a sample of staff files. Staff files were found to contain most of the documents as required by the Regulations, including Garda Síochána vetting, photographic identification, references and nursing registration numbers. However, the date of commencement of employment, position held and job descriptions were not always available. This action is included under Outcome 5: Documentation. The person in charge stated that the human resource consultant was currently consulting and meeting with existing staff and was in the process of drafting job descriptions and issuing contracts of employment to them.

The person in charge told the inspector that Garda Síochána vetting was in place for all staff and for all other persons who provided services to residents in the centre. She stated that there were no volunteers attending the centre.

The inspector noted that a variety of training had been provided to staff training during 2017. Training included fire safety, manual handling, safeguarding vulnerable adults, infection control, medicines management, nutrition, dysphasia, restraint management, managing challenging behaviour and dementia care.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary Costelloe
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 report¹

Centre name:	St Kieran's Care Home
Centre ID:	OSV-0005584
Date of inspection:	12/09/2017
Date of response:	12/10/2017

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

Contracts of care had not been agreed with residents.

1. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

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

New Contracts of Care for both Fair Deal Residents and Private/Short Term Residents have been agreed by the Management Team. Each Resident or their nominated representative has been furnished with a copy of the Contract for the Provision of Services in keeping with Regulation 14(1) for signing, and on their return will be maintained on file in the nursing home.

Proposed Timescale: Contracts have been sent out

Proposed Timescale: 12/10/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Some staff files did not comply fully with the requirements of the regulations for example, the date of commencement of employment, the position and job description was not available for all staff.

2. 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:

The person in charge is currently undertaking a full audit of all personnel files, and will systematically correct any non-compliances or gaps in personnel files to ensure they are accurate and complete

Proposed Timescale: 10/11/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Risk assessments completed for the use of bedrails were not in line with national policy on use of restraint. There were varying assessment templates in use and information was sometimes conflicting in the completed assessments. There was no clear rationale for use of bedrails and alternatives tried or considered were not recorded.

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:

The person in charge is commencing the new nurse documentation system which will address the risk assessments associated with the use of restraint.

Proposed Timescale: System is in place and commenced for completion by Dec 17

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

Some recently recruited staff had not received training in safeguarding of vulnerable adults.

4. Action Required:

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

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

A training schedule is currently being devised by the person in charge, who intends to undertake training for all recently recruited staff before Dec 31st 2017. This will ensure that all staff will have then received mandatory training and policy and procedural training on the minimum of the following subjects:

- Safeguarding
- Dementia Awareness and Engaging Patients with Dementia in Meaningful Activities
- Elder Abuse Prevention, Detection and Management
- Infection Control Management
- Patient Moving and Handling Training
- Fire Safety Awareness, Evacuation Procedures and Fire Management
- Management of Responsive Behaviours that Challenge

Proposed Timescale: 31/12/2017

Outcome 08: Health and Safety and Risk Management**Theme:**

Safe care and support

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

Recently recruited staff including staff employed in the laundry area had not completed infection control training contrary to the centres own policy and standards for the prevention and control of healthcare associated infections published by the Authority.

5. 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:

All staff, in particular those recently recruited, will receive induction training regarding all aspects of their work and responsibilities in addition to the formal mandatory training sessions proposed in the new training schedule

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

There were no records of recent fire drills.

6. Action Required:

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

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

The person in charge has undertaken three fire drills, two on days and one on night duty, unannounced. A simulated evacuation of residents was undertaken and fire drill record sheet completed for both and filed in the Fire Register. Additionally, retraining of all staff in Fire Management is scheduled to take place before Dec 2017. A protocol on "What to do in the Event of a Fire" has been devised by the person in charge and circulated across the home. This is in addition to the Fire Policy and Emergency Plan has been devised by the person in charge and circulated across the home.

Proposed Timescale: Completed - with ongoing training to be conducted

Proposed Timescale: 12/10/2017

Theme:

Safe care and support

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

Recently recruited staff had not received formal fire safety training.

7. 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:

All staff have received fire drill evacuation and use of firefighting equipment training from the person in charge by the end of Sept 17, and this is ongoing with fire drill training over the coming weeks and months. Additionally all staff will receive formal fire training before Dec 2017

Proposed Timescale: Completed - with on-going training to be conducted

Proposed Timescale: 12/10/2017

Outcome 09: Medication Management

Theme:

Safe care and support

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

Gaps were noted in the medicines administration charts. appropriate codes had not been used therefore the inspector could not determine if the medicines had been administered as prescribed.

8. Action Required:

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

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

All staff will be receiving medication management training from Breda O' Meara (Pharmacist) by end of October 2017. The person in charge is monitoring drug policy and procedure compliance closely and will be discussing concerns raised and non-compliances with RGN at the staff meeting on 29th October 2017

Proposed Timescale: 31/10/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

The inspector noted that while care plans were in place, there were many inconsistencies noted in the nursing documentation. Care plans did not always support the care being delivered. Some care plans were not informative and did not guide the care of the resident. Some care plans were not always individualised or person centered. There were no care plans in place for issues such as dementia and communication. The individual wishes and needs of residents were not set out in their care plans for example, end of life wishes and social care needs. There were no care plans in place for some residents assessed as being at high risk of falls or at high risk of developing pressure ulcers. The recommendations of the dietician, SALT and OT were not always updated in the relevant care plans.

9. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

The person in charge, who commenced employment on August 28th 2017, has already begun a full audit of the care planning and assessment process in the home. A new computerised nurse documentation system has been invested in and introduced, and it is envisaged that this will be completed and fully implemented into use by Dec 17. This will address all non-compliances found on this inspection.

Proposed Timescale: 31/12/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

There was inadequate storage space for equipment. Equipment such as laundry trolleys, refuse trolleys and commodes were stored in the shower room areas.

There was no separate cleaners room, this posed an infection control risk.

There was no separate private visiting space available to residents.

There was no bath provided therefore residents did not have a choice of bath or shower.

There were three doors leading into some of the toilets which potentially posed a risk to the privacy and dignity of residents.

10. Action Required:

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

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

The management team are currently addressing staff facilities and overnight facilities for relatives of those residents nearing end of life. Once this work is completed we intend to address the storage facilities for laundry, catering and domestic needs, ensuring that each area is assigned specific and separate storage facilities.

Private visiting space for residents and families is being addressed. Presently any resident or family member wishing to visit in private can either do so by using the residents' bedroom or the nurses station office.

All public toilets adjoining residents' rooms will have the doors locked so that they are only accessed from the corridors and not the bedrooms. In time these doors will be removed, with new walls constructed.

Proposed Timescale: 31/03/2018