Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Kilminchy Lodge Nursing Home
Name of provider:	Kilminchy Lodge Nursing Home Limited
Address of centre:	Kilminchy, Portlaoise, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	13 December 2021
Centre ID:	OSV-0000052
Fieldwork ID:	MON-0034391

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This is a single-storey purpose built centre. Kilminchy Lodge Nursing Home is staffed by qualified nursing and care staff at all times and caters for residents whose dependency levels range from low to maximum. It accommodates both female and male residents over the age of 18 years with a varied range of care needs. This centre can accommodate up to 52 residents. It has 44 single rooms, some of which has en suite facilities. Some single bedrooms have shared shower, toilet and wash basin facilities. Three of the four twin bedrooms have en-suite toilet and wash-hand basin facilities. Privacy screening is provided in the shared bedrooms. There is a large living room where many of the daily activities take place. The main kitchen is adjacent to the large dining area which leads to a secure outdoor area. The centre is situated in residential area in a busy town and is serviced by nearby restaurants/pubs/libraries/ pharmacies/ GP surgeries etc.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 13 December 2021	10:15hrs to 20:30hrs	Nuala Rafferty	Lead
Monday 13 December 2021	10:15hrs to 20:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Overall inspectors observed a relaxed and happy environment. Residents who spoke with inspectors said they were happy with the care they received within the centre and were observed to be content in the company of staff. However, inspectors observed that there were significant fire safety issues and the governance and management of the centre required improvement.

On entry inspectors followed the centres COVID-19 infection prevention and control protocols which included hand sanitising, mask wearing, recording temperatures and completion of a COVID-19 risk based questionnaire. The majority of residents and staff had received their vaccinations and additional booster.

Inspectors observed that staff had made efforts to create a homely and comfortable environment for residents. The lobby and sitting room were warm and pleasantly decorated and festive touches for the Christmas season were visible. A large Christmas tree was placed in the corner of the sitting room with twinkling lights and baubles and a small nativity scene underneath. Tinsel, cribs and various other ornaments were displayed to create a festive atmosphere. Residents were gathering in the sitting room following breakfast and personal care and were observed relaxing and socialising. An inspector spent time in the sitting room chatting with several residents. There were four ladies sitting together around a low table enjoying a cup of tea. All were in good form and were warmly dressed and well presented. One lady was wearing a pair of white shoes which were recently purchased and she said were very comfortable. All of the the ladies said they were happy and that staff took very good care of them. Another lady told the inspector she was waiting on a new wheelchair as the one she had was very uncomfortable; she had been waiting for the chair for quite a long time but was hopeful she would have it in the new year. The inspector heard that she loved to wear her lipstick and staff were careful to make sure she had it applied every morning. The inspector observed a member of staff sitting beside one gentleman trimming his nails and chatting with him. The resident was clearly enjoying the close attention and care from the staff member and also the banter to which he responded with laughs and smiles. One inspector sat and chatted with the resident when his nail care had finished. The resident was non-verbal (could not express himself using speech or words) but was very willing and able to communicate using visual mime and body cues. The resident communicated that he had difficulty mobilising and demonstrated how he was doing daily exercises to improve their mobility.

An inspector also had the opportunity to speak with a number of relatives who were visiting their loved ones. The inspector heard that although they believed staff worked very hard to provide good care, these relatives expressed mixed views on their experience of the services provided in the centre. The main concerns for these relatives were in relation to the frequency of personal care provided to maintain the residents skin integrity, food and nutrition and the standard of laundry. They also expressed dissatisfaction with the response from the management team when they

raised these concerns with them.

One inspector spoke with the designated activity person who supervised the sitting room to ensure residents' safety and also delivered the activity programme. The programme was posted on a wall in the sitting room and included a variety of activities such as; physical exercises and games, art and crafts, baking music, relaxation therapies such as sensory massage with oils and reminiscence therapy. The inspector heard that the centre had access to a bus owned by the provider so that residents could go out on local trips on a weekly basis. These outings usually took place on Thursdays when a small number of residents went to the local park, shops or a nearby animal farm. The number of residents who went on the outing was dependent on the mobility of the residents and whether the activity person had assistance from other staff. The number of residents that could go with two staff therefore, varied from one to three people. One inspector observed an activity in the sitting room where residents were encouraged to take part in a physical exercise routine followed by a group ball game which was focused to improve concentration, co-ordination and flexibility. Staff were observed encouraging residents participation and cheering them on. Several staff were seen to make the activity fun and residents were laughing with enjoyment.

Some staff who spoke with the inspectors were knowledgeable about the residents they cared for. They were familiar with the residents' preferred daily routines and the activities that they enjoyed. Staff were observed to be kind, caring and respectful in their interactions with residents. However, inspectors observed some aspects of care practices required improvements and heard some staff referring to residents using institutional forms of language.

Inspectors found the premises to be visually clean warm and tidy. Household staff were observed cleaning and using wet floor safety signs to alert residents and others to ensure their safety. However, some aspects of the design, layout and maintenance of the premises required improvement to meet residents needs and ensure their safety. Key risks in respect of fire safety were identified and are detailed under regulation 28 of this report. Other aspects of the premises that required to be addressed are detailed under regulation 17. The provider was aware that aspects of the premises required to be upgraded and already had plans in place to address many of the areas identified on this inspection. An extension to the centre was in the final stages of completion and on completion and registration, the provider had plans to upgrade the existing building with a full refurbishment.

Overall residents said they were happy with the choice and quality of food offered in the centre and residents were seen to enjoy their lunch time meal. Staff were seen providing assistance to some residents during lunch in a patient, respectful manner. Inspectors observed that resident's were wearing plastic aprons while having their meal and were told that this was to provide protection for the residents' clothing. However, residents were not asked prior to the apron being placed over their clothing and inspectors heard that a more dignified and appropriate option to protect their clothing was not available.

The next two sections of the report present the findings of this inspection in relation

to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found that the governance and management arrangements in place were not sufficiently effective or robust to ensure that residents received a high standard of person-centred care and support. Significant improvements were required to the level of clinical oversight and management systems to ensure the provision of a safe and sustainable delivery of care.

Key risks were identified on this inspection in respect of fire and infection prevention and control and as a result inspectors issued an immediate action plan on the day of inspection and two urgent action plans on the day following the inspection. In addition, a cautionary provider meeting took place following inspection where further assurances were received in respect of provider's plans to strengthen the governance and management arrangements and oversight in the centre and address concerns in respect of premises and fire safety.

Kilminchy Lodge Nursing Home Limited is the registered provider of this residential care facility. The company has three directors. This centre is part of a larger organisation known as Brindley Healthcare and is supported by a corporate structure that includes access to personnel with expertise in; human resources, finance, quality and facilities management. The provider has a good history of compliance with the regulations and had addressed, or was in the process of addressing, some of the non-compliances found on previous inspections.

The operation of the centre is supported locally by the registered provider representative who is a company director and two regional managers. Within the centre there is a full-time person in charge who is supported by the regional managers, two assistant directors of nursing and staff team of nurses, carers, catering, cleaning, laundry, activity, administration and maintenance staff. The provider had recently appointed a second assistant director of nursing who was commencing their first day of induction, on the day of inspection.

Documents were viewed that evidenced regular management team meetings including clinical governance meetings, where discussions on staff training, activity provision, COVID-19 precautions and guidance and financial matters were discussed.

However, the findings of this inspection did not assure inspectors that the roles, responsibilities and decision-making remits within and between the management team, or between the nursing staff and lead health care assistant were sufficiently clear. Additionally the cleaning/ laundry supervisor worked full-time as part of the team and did not have any supernumerary hours for their supervisory function. It was also noted that responsibility for stock control processes had been delegated to the front line staff. However, evidence that the management team retained

oversight of available and appropriate equipment and stock in the centre was not found. This is further discussed under regulation 23 governance and management.

Inspectors viewed evidence of the monitoring systems in place to audit, assess and review the delivery of services in the centre. This included regular reviews of clinical care and risk indicators such as accidents or incidents, use of restrictive practices, skin integrity, nutritional status, and rates of infection. However, some improvements were required to the analysis, evaluation and trend identification processes, so that the data from these key risk indicators were used to improve the safety and standard of care residents received.

From a review of the rosters available and on observation there were sufficient numbers of available staff to meet the needs of the number of residents living in the centre at the time of inspection, however it was observed that for some residents it was lunchtime before they received assistance with personal care and could leave their bedroom. As a result, the inspectors were not fully assured that the number of staff rostered were sufficient if the centre was at full capacity.

Staff had access to to a range of on-going training opportunities. Inspectors looked at records which showed staff participation at the training. However, evidence that staff practice was appropriately supervised and that the principles of training provided in infection prevention and control, moving and handling and waste management was not found. Consequently, significant improvements in staff knowledge and implementation of local policies and national guidelines were required to ensure a safe and consistent service, and therefore an immediate action plan was issued to the provider on the day.

All policies and procedures as required under Schedule 5 of the Care & Welfare Regulations 2013 (as amended) were available, and regularly reviewed in the centre. Implementation dates identified when the policies came into effect. However, improvements to staff knowledge and implementation were required.

The centre had a complaints policy and procedure in place and a number of complaints were recorded. However, some improvements to the complaints process in respect of the recording of complaints, timeliness of response and the level of satisfaction of the complainant were required.

Registration Regulation 4: Application for registration or renewal of registration

The application for renewal of registration of the centre contained full and satisfactory information required under Parts A and B in Schedule 2 of registration regulation 4(2). However, discrepancies were noted between the information provided on the statement of purpose and the floor plans which required to be addressed.

Judgment: Substantially compliant

Regulation 14: Persons in charge

A suitably qualified and experienced registered nurse was in charge the centre on a full-time basis.

Judgment: Compliant

Regulation 15: Staffing

The staffing levels and skill-mix on the day of inspection were sufficient to meet the assessed nursing needs of the 41 residents living in the centre on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Although staff were provided with opportunities for refresher training to maintain competency and knowledge in areas where it is mandatory to update knowledge either annually or bi-annually, relevant to their scope of practice, documentation viewed did not show that all staff had attended the training. Additionally, inspectors observed that the principles of training were not fully applied by staff in some aspects of their work.

Due to risks identified on inspection, and as part of an immediate action plan issued to the registered provider, additional training was provided to staff in moving and handling, hand hygiene, infection prevention and control and management of laundry on the days immediately following the inspection.

In addition, staff were not being appropriately supervised in their day to day practice in personal care delivery and the key areas referenced above.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management systems in place were not sufficiently robust to ensure a safe standard of quality care was provided to all residents. As a result the inspectors found significant non-compliances on this inspection which had not been identified by the provider or the management team.

Areas where governance and management systems required to be strengthened included;

- although the provider had made an application for the renewal of registration and given assurances that the new extension was ready for registration, inspectors found that the premises, including the new extension, did not meet the requirements of the regulations and further work was required
- the roles remit and decision-making responsibilities of the operational management team were not clearly defined. This resulted in inconsistent monitoring processes and the delegation of some stock control to frontline staff without appropriate oversight.
- communications and reporting structures were not clear for all staff, in particular for agency or relief staff and a formal communication system to report changes in residents condition or raise issues of concern during the day was not in place.
- poor identification and management of risks including fire safety, falls management and infection prevention and control issues
- insufficient clinical oversight to ensure residents consistently received care in line with their assessed needs and that staff practices were appropriate and in line with training principles.
- care planning, assessment and recording of care did not provide assurance for a high standard of care delivery
- poor management of complaints

In consideration of the fire safety matters identified during inspection, the inspector was not assured that appropriate management systems were in place to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider. The management systems in place did not ensure that identified significant fire safety risks were managed and effectively mitigated.

For example;

- Deficiencies were noted in the maintenance and fire performance of fire doors in the centre.
- Deficiencies were found in measures for containment of fire.
- Fire risks were not effectively managed in the centre which was evidenced by the number of risks identified on this inspection that had not been addressed by the provider. These risks are outlined under regulation 28 Fire precautions.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was provided to the Chief Inspector as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors found that a number of complaints were not managed or responded to in a timely manner and that the satisfaction of complainants verbalised to inspectors on the day of inspection did not accord with the complaints record viewed. Inspectors heard that written complaints made some months earlier did not receive a response. On review of the complaints record inspectors saw that dates entered for receipt of the complaint did not accurately reflect the dates on which the complaints were originally made, additionally the records were not sufficiently detailed to provide an accurate time-line of communications or interventions taken, to determine the adequacy of the response. In respect of another complaint, the complainant had to wait a further three weeks, following agreement on the manner of resolution, to have the complaint fully resolved.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All policies and procedures as required under Schedule 5 of the Care & Welfare Regulations 2013 (as amended) were available and regularly reviewed in the centre. However, it was found that not all were being fully implemented including policies related to;

- Risk management
- Monitoring and documentation of nutritional intake
- Fire safety management
- Infection prevention and control
- Complaints management

Judgment: Substantially compliant

Quality and safety

Residents were provided with a good standard of care and support that met their basic needs, but significant improvements were needed to ensure that residents were adequately protected from environmental hazards and risks, such as fire and infection prevention and control. Improvements were also required to care assessment and planning arrangements and to uphold residents rights to autonomy and choice.

Appropriate care practices with warm empathetic interactions were observed during this inspection. Staff respected resident's rights to privacy and dignity. Overall, appropriate processes were in place to protect residents from abuse and were being implemented. The inspectors spoke with several residents and those residents who could voice their opinion told inspectors that they felt safe. Inspectors also saw that some residents, who could not give a verbal opinion, displayed body language associated with feeling safe.

Residents' had timely access to all allied health and social care professionals such as, physiotherapy, occupational therapy, dietetics,optical, dental and podiatrist services. The residents were seen by their general practitioner on a regular basis. Residents were closely monitored for signs and symptoms of COVID-19, and clinical observations were recorded twice daily.

Full-time staff, communicated with on the day of inspection, were familiar residents' care needs and preferences. However, improvements were required to move to a person-centred model of care. The inspectors observed that care was task-orientated and did not take account of residents' holistic care needs on an individual basis, particularly in relation to personal care needs. Although care plans were initiated on admission and reviewed at regular intervals, inspectors found that there was scope to ensure they were accurate, reflective of residents' current needs and more person-centred, so that they included adequate detail to support staff who were unfamiliar with the residents to meet their needs. This is discussed further under Regulation 5: Individual Assessment and Care Plan.

At the time of this inspection, plans to upgrade the centre premises were in progress. The centre was found to be visually clean and clutter-free.The provider had built an extension to the premises which, when fully completed, would enable the commencement of a full refurbishment of the existing footprint. This new extension to the current designated centre premises will provide 26 single, full en-suite bedrooms and increase in the amount of communal and storage accommodation, as per the proposal submitted by the registered provider.

This inspection was, in part, to review the new extension to determine whether it met all of the requirements of the regulations. Inspectors observed that further improvements to the existing building were urgently required and some amendments to the new extension were necessary and these are further discussed under regulation 17 Premises and regulation 28 Fire Precautions of this report.

Staff had received up-to-date training in COVID-19 precautions, prevention of the transmission of the COVID-19 virus and use of personal protective equipment (PPE). Practices and procedures reflective of the current national guidance on infection

prevention and control practices for managing an outbreak of infection were in place. This included monitoring all visitors and staff for signs and symptoms of COVID-19 on entry to the centre, compliance with guidance on visiting and provision of sufficient hand sanitisers and gels. However, considerable improvements in this area were required as detailed under regulation 27 Infection prevention and control.

Regulation 13: End of life

Residents had access to the local palliative care team and those receiving palliative care had the required medication prescribed to ensure their pain was kept under control and all comfort measures were in place. There was evidence that the residents' families were kept informed of their condition.

Judgment: Compliant

Regulation 17: Premises

The care environment and facilities available did not fully meet residents assessed needs in line with the centre's statement of purpose or conform to all of the matters as laid out in Schedule 6 of the regulations and the National Standards for Residential care settings for Older People in Ireland 2016 (the standards). Overall the premises required a programme of refurbishment to provide a comfortable environment for residents to live as follows:

In the existing building:

- dedicated safe storage areas for all cleaning chemicals and equipment was not available. Inspectors observed cleaning chemicals inappropriately stored in an unlocked utility room
- a number of fixtures and fittings required maintenance, repair and/or replacement
- the existing staff change area required review in terms of size, location and facilities.
- the laundry services were not suitable for their current purpose in that, there was insufficient space to separate clean and dirty laundry; a stainless steel sink with double drainer was not available and inspectors were not assured that all the domestic washing and drying appliances were of a sufficient standard or reached the required temperature to effectively wash soiled laundry. Furthermore, inspectors observed in both laundry containers, walls and ceilings were dripping with water caused by condensation due to inadequate ventilation. This presented a risk to water coming into contact with electrical outlets and equipment.

The provider had applied to the Chief Inspector to register 22 beds in a new

extension, however, inspectors observed that some support facilities, required by the regulations and the standards were not in place including;

- a nurses station
- a fully equipped laundry
- appropriate staff changing facilities
- an identified and separate dirty utility room for care and catering staff
- dirty utility rooms for use by direct care staff were available but did not include lockable storage for chemicals or racking/drying facilities for equipment
- lockable storage for residents' personal belongings were not available in residents bedrooms
- signage to orientate staff, residents or visitors was not in place

Judgment: Not compliant

Regulation 26: Risk management

Risk management processes were not fully established and/or were not embedded in practice including;

- arrangements for hazard identification and risk assessment.
- measures and actions required to control the risks identified.
- the risk register did not include all of the risks identified in the centre, measures in place to control the risks or an identified person responsible to ensure control measures were implemented
- examples where inspectors found risks not identified in the risk register included; risks associated with delegation of stock control; chemicals stored in unlocked storage areas, poor moving and handling practices, a wooden ramp at the door of the laundry and used to transport laundry in and out, was observed to be wet and slippery
- a complete cycle of identification, management, trending, learning and ongoing review to ensure improvement to care delivery was not in place.

Judgment: Not compliant

Regulation 27: Infection control

Infection prevention and control practices were not consistent with the National Standards for Infection prevention and control in community services in that;

- Cleaning schedules to ensure all communal equipment was cleaned in

between each use were not in place for all types of communal equipment and where they were in use (for example for commodes and shower chairs) they were not consistently being completed
- A monitoring process to ensure the implementation of every cleaning schedule, in particular to ensure the cleaning of communal equipment after each use, was not in use
- staff practice did not reflect the World Health Organisation's (WHO) five moments of hand hygiene
- significant risks associated with poor infection prevention and control practices were found in respect of the management of soiled laundry. Appropriate resources for the safe transportation and cleaning of soiled clothing and bed linen were not available to staff and an immediate action plan to rectify this was issued to the provider on the day of inspection.
- some items of equipment required to be repaired/replaced where covers were observed to be cracked or torn and could not be effectively cleaned, examples included mobility aids such as rollators and specialised chairs for residents.
- some aspects of the premises were cluttered with equipment and could not be effectively cleaned; these included a number of residents bedrooms and the worktop and floor in the nurses clinical room.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was not taking adequate precautions against the risk of fire:

- A fire safety risk assessment had been carried out by the provider's fire consultant on 3 November 2021 which had identified a number of high risks. Inspectors were not presented with evidence that these risks had been managed adequately by the provider.
- The main fire door into the kitchen, a room of increased fire risk, was in a state of disrepair and was wedged open due to the floor covering. This required urgent attention and the provider was issued with an urgent action plan and requested assurances on what mitigating measures would be put in place until a fire door assessment and the scope of works relating to fire doors would be complete.
- A fire blanket stored in the external smoking shed was undersized for its intended use as a fire blanket for residents. Further review of the management of residents who smoke was required.

The inspector was not assured that adequate means of escape, including emergency lighting was provided throughout the centre:

- The compartment boundaries used for phased evacuation were not clearly defined and the extent of fire compartments were not fully known by staff

which could cause a delay and confusion in the event of a fire evacuation.
- A fire exit had been decomissioned as a result of current construction work without an appropriate assessment or consultation with a fire professional. Fire signage was still present above the exit.
- Adequate emergency lighting had not been installed along external escape routes.

Adequate arrangements were not in place for maintaining all fire equipment and means of escape:

- While a fire safety risk assessment had been completed that included identified deficiencies relating to breaches in compartments, fire doors and glazing, there was a delay in completing the recommendations of this assessment.
- While weekly checks of fire doors were taking place and faults were recorded, not all faults had been identified. For example some fire doors were missing a door closer and screws were missing in some hinges.

Adequate arrangements were not in place for staff of the designated centre to receive training

- Staff participated in fire warden training however, the content of the training was not available to inspectors on the day of inspection. Inspectors were not assured that fire training for all staff included the requirements under regulation 28 (1)(d).

From a review of the fire drill reports, the inspector was not assured that adequate arrangements had been made for evacuating all persons from the centre in a timely manner with the staff and equipment resources available. For example:

- Some drills lacked detail to inform practice, and there had been no fire drills completed since the previous inspection in May 2021, despite monthly fire drills required as per the local policy.

Adequate arrangements had not been made for detecting fires:

- The centres policy stated the fire detection and alarm system was an L1 category, however the documentation for the fire detection and alarm system identified the system as a type L2/L4 system and did not meet the required L1 system. Additional detection was required in some areas, for example the sluice room had no smoke sensor.

Inspectors were not assured that adequate arrangements were in place for containing fires

- The majority of fire doors had gaps around the fire doors and frames, had inadequate ironmongery fitted, had signs of damage which reduced the integrity of the fire door; some fire doors had been re-purposed and modified where a non-fire rated vent had been fitted to a fire door.
- The provider's fire consultant recommended that a full assessment of

compartments in the centre was required. The provider was issued with an urgent action plan to engage with a competent fire consultant to carry out this assessment of compartments.

The person in charge did not ensure that procedures to be followed in the event of a fire were displayed in a prominent place in the designated centre:

- Drawings displayed included pertinent information, including the primary and secondary escape route. They did not show the extent of compartment boundaries to inform the identified evacuation strategy of horizontal evacuation. Inspectors were informed that floor plans were in the process of being updated.

At the time of inspection the provider had applied to the Chief Inspector to register 22 beds in a new extension, however, inspectors observed some non-compliances relating to fire precautions including;

- Ceiling attic hatches were not fire rated
- Smoke alarm dust covers had not been removed
- Floor plans for the new extension did not accurately reflect the current layout of the new extension observed by inspectors. For example a large day room had been divided into two separate rooms and a store room had been added on.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors looked at a sample of nursing assessments and care plans in place for residents. Considerable improvements were required to ensure that residents were receiving a high standard of evidence-based practice. For example:

- A risk assessment and care plan was not in place for every identified care need, the information included on the nursing assessment was not always used to inform the care plan
- care plans were not reviewed as needs changed, for example when residents return to the centre following a period of acute care in hospital, inspectors found care plans were not updated within 48hours
- Where care plans were in place, these was little evidence that these were fully implemented by staff. Examples included repositioning of residents at risk of developing pressure ulcers and care interventions for personal hygiene.
- although some daily nursing care records were person-centred and included some details on residents mood and well being, most were focused on basic care needs and did not give sufficient insight into the overall health and well-being of residents

Judgment: Not compliant

Regulation 6: Health care

It was found that residents were provided with medical care and allied health professional interventions as they required in a timely manner.

Judgment: Compliant

Regulation 9: Residents' rights

A designated activities staff person was observed delivering a programme of activities to groups of residents in the main sitting throughout the day. Residents were observed to enjoy the activities provided, however, it was noted that many residents spent a considerable amount of time in their own bedroom without meaningful stimulation. Inspectors heard that staff tried to spend time with residents in their rooms and to engage with them in their individual interests, but the time available was varied.

Inspectors found that some improvements were required to create a culture where residents are supported to make choices about their daily life in a way that reflects their preferences and human rights. Some care practices and the use of institutional language observed on inspection did not demonstrate respect for residents as individuals.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Inspectors observed that some bedrooms did not facilitate residents' functional activity or promote their independence in that;

- access to the wardrobe in some bedrooms was restricted due to the proximity of the bed or due to their location behind the bedroom door. The doors of the wardrobe faced the end of the bed and although the doors could be opened fully, access was limited due to lack of space. Similarly, where wardrobes were located behind the bedroom door access to the wardrobe was restricted. This meant that residents who were not fully mobile and required the use of assistive equipment, could not easily, or independently, access their wardrobe space.

• inspectors saw several bedrooms both twin and single rooms where residents did not have sufficient storage space to store personal belongings and items such as books, bags of clothing and in one instance boxes of nutritional supplements were stored on the floors of these bedrooms
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant

Compliance Plan for Kilminchy Lodge Nursing Home OSV-0000052

Inspection ID: MON-0034391

Date of inspection: 13/12/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 4: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: The statement of purpose and floorplans have been reviewed and revisions made to ensure there are no discrepancies between the two documents.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training records were reviewed and updated where required for all staff. Following the inspection, update training was provided to staff by the centre's trainer in conjunction with the regional management team in relation to moving and handling, hand hygiene, infection prevention and the control and management of laundry. The application of this training is monitored by the local management team and reinforced through daily safety pauses. Assurance on the effectiveness of the training is being assessed by the Regional Director with internal audit being carried out by national quality team. In addition, an external provider has been commissioned to deliver update training in relation to person-centred care (all staff) and to nursing and care staff in relation to their roles within the centre. In addition to the Person in Charge, the centre now has two ADONs who will provide clinical oversight and supervision on day-to-day practice thereby ensuring that the training provided to staff manifests in improved outcomes for residents.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A comprehensive review of the governance and management arrangements within the centre was immediately carried out following the inspection. This review and the subsequent work programme was initiated by the regional operations team, the national quality team and the national facilities team. The immediate actions undertaken in relation to inspection findings included the following:

• Comprehensive review of the physical environment of the centre (including the new extension) to ensure that the premises are in accordance with the requirements of the regulations.
• The roles and responsibilities of the operational management team have been clearly defined for all staff and revised processes have been introduced within the centre to ensure robust ordering and stock control.
• All staff have been updated on the reporting arrangements and each individual member of staff is clear on who they report to on a day to day basis including escalating to the nurse in charge as required.
• A nurse lead is identified on all shifts
• An external provider has been commissioned to provide additional training to the nurses to further enhance their roles.
• An updated agency induction process has been introduced and additional staff pauses have been initiated throughout the day to further enhance and facilitate communication among staff on the care being delivered and the current status of the residents.
• All care plans are now audited during the admission process and on an ongoing basis to ensure they fully reflect resident's assessed needs and reflect hospital transfers, incidents or accidents.
• All carer documentation is to be migrated to the same electronic record management system used by the nursing staff to improve coherence of care planning and record keeping
• Weekly dedicated team meetings with representation from all departments to ensure improved communication and local governance; and to ensure clarification of roles and responsibilities of all staff
• Reinforcement in staff through daily handovers and safety pauses to report any issues of concern or perceived risks immediately to the DON (or her delegate) on matters such as fire safety, infection prevention and falls management for example.
• Updated training to the DON, ADONs and senior staff on the manageement of complaints in accordance with regulations, best practice and the home's policies and procedures. A comprehensive review of complaints has been carried out and all open complaints have/are being addressed
• Actions outstanding from the independent fire safety consultant are being implemented

• The areas of improvement identifed by the inspector in relation to fire doors, containment and the overall management of firer risk are being addressed.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A comprehensive review of the management of complaints was carried out by the national quality team and a dedicated quality improvement plan was provided to the local and regional operational management teams. All outstanding complaints are being addressed and closed off following consultation with complainants and records are being updated to reflect the outcome including whether the complainant is satisfied or not.

Dedicated templates for letters and investigation reports were provided to the DON & ADONs to ensure the adoption of a consistent approach and to make sure complaints are managed in accordance with regulations and standards and the centre's policies and procedures.

Dedicated training has been provided to the DON & ADONs in relation to complaints management and is being provided to all other staff on how to respond to a complaint.

The management of complaints (including responses and timelines) is discussed weekly at the local maangement meeting and monthly at the governance meeting with the Regional Director.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A comprehensive review of schedule 5 policies and related procedures is currently underway within the centre in conjunction with an external service provider. It is intended that the revised documents will be implemented by 31 March 2022 in conjunction with dedicated training for all staff. An external audit will be undertaken in Q2 to assess adherence to the policies. In the interim, all staff have been familiarized with local policies; these are now located at nurse station 1 and all staff made aware of this.

The national quality team have worked closely with staff to ensure all local policies have

been actioned and all staff have appropriate knowledge, these areas included IPC, the management of laundry and the management of clinical waste.

The national quality team have also audited resident daily documentation, including care plans. Critical areas found from audits have been fully reviewed and corrective measures immediately put in place. The DON & ADONs ensure oversight and compliance going forward.

Training has been provided to staff in relation to fire safety management in accordance with the policy and fire drills are ongoing within the centre.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
On the day of inspection, all chemicals were stored securely in a locked facility and staff were advised on the importance of maintaining a safe environment. Staffing changing facilities have been reviewed and dedicated rooms are now available for care and catering staff.

The refurbishment programme will on a phased basis fully address the failings identifed by inspectors in relation to the existing centre. A new dedicated laundry has been commissioned and this should be available in Q2. All laundry, currently outsourced during the refurbishment programme will be managed in-house. The schedule of work planned for the centre has been included in the statement of purpose and is due to be completed by the end of Q2, 2022.

A revised statement of purpose and floorplans was provided to the Authority following the inspection that addressed the issues during the inspection in relation to the new extension including the provision of an additional nurses station, appropriate staff changing facilities, separate utility facilities for catering, care and houskeeping including appropriate racking and drying facilities for equipment. Appropiate signage to orientate residents, staff and visitors has been sourced for the new extension. Lockable storage is now available in all bedrooms.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Following the inspection, a comprehensive review of risk management within the centre

was carried out. Weekly and monthly governance meetings are now in place which include a specific health and safety agenda item. The risk register has been updated with control measures in place where required including identification of persons responsible for implementing these measures. Examples of updated risks include moving and handling, stock control and IPC. The approach to stock control has been revised with weekly oversight by DON/PIC to ensure good management of stock, and early escalation if stock required. The issues associated with the laundry have been resolved. The revised approach to risk management now includes incident analysis and triangulation of findings to inform learning and future training within the centre.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Immediate training was provided to all staff in relation to infection control and further enhanced training is to be provided by an external provider in Q1, 2022.Cleaning schedules have been revised to be more consistent, thorough, and the responsibilities have now been clarified to all staff. Auditing/Monitoring of this is being undertaken by the management team within the centre. "I am clean stickers" has been re-introduced to evidence cleaning of equipment and refresher training has been provided to staff on "5 moments of hand hygiene" and the trainer has worked alongside staff to ensure compliance. A dedicated Laundry SOP was introduced on the day of inspection and update training is ongoing with staff. A new laundry facility will be in place in Q2, 2022 and all resident laundry and linen has been outsourced in the interim. A full review of equipment has been completed and new items are on order. The centre has been decluttered for easy access for cleaning and storerooms have been cleared of obsolete items.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Remedial works to the fire doors into the kitchen have been carried out and replacement doors are currently on order. In the interim an additional member of staff has been rostered to support fire safety within the centre while all remedial works are being concluded.

The fire blanket in the external shed has been replaced with a larger model and the management of residents who smoke has been revised by the DON/PIC.

Compartment boundaries have been clearly defined and updated fire safety training has been provided to staff. The independent fire consultant has been involved in informing fire safety within the centre and the issues in relation to fire signage and emergency lighting are being addressed.

Adequate arrangements are now in place and outstanding actions from the fire safey consultant are in progress and will be fully addressed. Weekly fire safety checks continue with immediate remidial action now taken to address any noted areas for improvement.

Updated training in relation to fire safety (including fire warden training) has been provided to all staff. Fire drills are also being carried out and include the simulated evacuation of residents from the largest compartment in the centre with nighttime staffing levels.

The fire detection and alarm system is to be fully upgraded as part of the refurbishment plan and additional detection has/is being installed where required.

A competent fire consultant carried out an assessment of compartments and remedial work has been undertaken to address the failings identifed.
The procedures to follow in the event of a fire are prominently displayed throughout the centre and contain all the requisite information.
All issues identifed in relation to the new extension have been addressed including fire rating of ceiling hatches and removbal of udst covers on smke alarms. Floorplans have been updated to reflect the final layout of the extension.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The clinical oversight of care provided in the home has been reviewed. The nurse management team in conjunction with nursing and care staff now ensure that all care provided is fully reflective of the assessed needs and wishes of residents and is updated as required to reflect any change in the status of a resident. A new checklist has been introduced in relation to hospital transfers that will further enhance the standard of record keeping in this regard.

Update training for staff in relation to care planning has been provided by the Person in Charge in conjunction with the regional management team to ensure that the standard of assessment and related documentation provides a sufficient overview of the overall health and wellbeing status of residents.

A comprehensive review of resident's care plans has been carried out and immediate action taken to address the shortcomings identified by inspectors. In particular, risk

assessment and care planning for residents fully reflects individual care needs and is based upon ongoing nursing assessments. A new checklist has also been introduced to inform risk assessment.

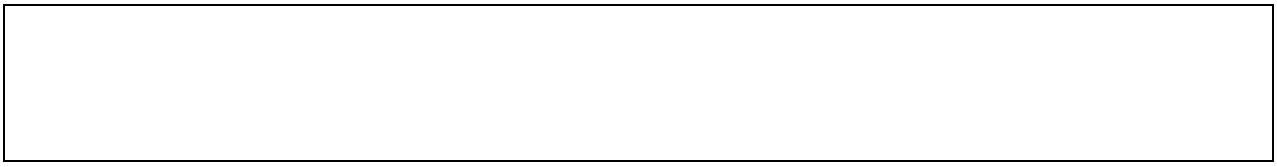
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The allocation of staff has been revised to maximize the time available to support and stimulate residents. In addition, the provision of activities and staff engagement with residents has been comprehensively reviewed following the inspection. Guidance has been provided to all staff in relation to activities and on the need for a more integrated approach with care staff working in parallel with the activity coordinator in the delivery of a programme that more fully meets the needs of all residents including those who exercise choice to remain in their bedrooms.

Person-centered training for staff has been commissioned through an external provider and as a result of this training and ongoing awareness raising within the centre, the promotion of practices and the delivery of care will more fully promote resident's dignity and respect at all times.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The major refurbishment plan currently ongoing within the centre includes a redesign of all existing bedroom spaces. Newly refurbished bedrooms will have repositioned beds, seating and integrated wardrobes/lockers thereby maximising the floorspace available to residents and more readily promoting enhanced independence and the use of assistive equipment where required. The size and design of wardrobes will provide residents with sufficient storage space for their clothing, personal belongings and other mementoes. Following the inspection, a review of all storage space in bedrooms was carried out and in conjunction with residents and where appropriate families', alternative storage was offered which has helped declutter rooms and promote additional space. Following registration of the newly constructed wing, 26 residents will be supported to relocate to new bedrooms to allow the next phase of the work to commence. The schedule of upgrade works to the centre should be concluded by the end of Q2, at which time, all residents will be residing in refurbished bedrooms.



Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	31/12/2021
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	30/06/2022

	and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/02/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Yellow	31/01/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	31/12/2021

	details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2022
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/01/2022
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	31/01/2022
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording,	Not Compliant	Orange	31/01/2022

	investigation and learning from serious incidents or adverse events involving residents.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	28/02/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	14/02/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	14/02/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	14/02/2022

Regulation 28(1)(d)	The registered provider shall 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.	Not Compliant	Orange	14/02/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	14/02/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Red	14/02/2022

	detecting, containing and extinguishing fires.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	31/01/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Substantially Compliant	Yellow	31/01/2022
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	31/01/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/03/2022

Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/01/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/01/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/01/2021
Regulation 9(2)(b)	The registered	Substantially	Yellow	30/03/2022

	provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Compliant		
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/03/2022