Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Killeline Nursing Home
Centre ID:	423
Centre address:	Cork Road Newcastlewest Co. Limerick
Telephone number:	069-22061
Fax number:	069-69837
Email address:	killelinenh@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Denis McElligott
Person in charge:	Marie O'Malley
Date of inspection:	6 July 2011
Time inspection took place:	**Start:** 15:00hrs **Completion:** 23:00hrs
Lead inspector:	Margaret O'Regan
Support inspector:	N/A
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meets the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Killeline Nursing Home is a 63 bedded two-storey residential centre. There are 36 beds in the general wing, 13 beds in the specialised unit, catering for residents with an acquired brain injury (ABI) and 14 beds in the unit designated for those with dementia. Forty seven residents were accommodated on the day of inspection.

Location

Killeline Nursing Home is situated in the town of Newcastlewest in Co Limerick. It is 40 kilometres from Limerick city.

Date centre was first established:	2007
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	16

Dependency level of current residents	Max	High	Medium	Low
Number of residents	0	13	13	21

Management structure

Killeline Nursing Home is run as a partnership between Patrick Kennedy and Denis McElligott. Denis McElligott is the person nominated on behalf of the business. Marie O'Malley is the Person in Charge and Marie Leahy is the Deputy Person in Charge. All staff report to the Person in Charge and the Person in Charge reports to the Provider, Denis McElligott.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2	9	2	3	2	1

Background

The Health Information and Quality Authority's Social Services Inspectorate first inspected Killeline Nursing Home on 6 September 2010 and 7 September 2010. It was an announced registration inspection. At that time the deputy person in charge was covering duties for the person in charge (PIC) who was absent. Subsequently, in October 2010, the PIC resigned and afterwards, in November 2010 the deputy person in charge resigned. As a temporary arrangement until the post of PIC was filled on 31 January 2011, the provider, who is a PIC in another centre assumed the responsibilities of the PIC in Killeline.

On 25 January 2011 a follow up inspection was conducted by the Authority, to assess progress with regards to the matters needing action as outlined in the September 2010 report. Inspectors found that little progress had been made and other significant safety issues came to their attention. In particular, issues with regards to staff training in fire prevention and elder abuse prevention. There were also concerns with regards to staffing levels and staff turnover. In general there was a lack of adequate governance and management in the centre. These concerns received attention from the provider as noted when an unannounced inspection took place to the centre a month later on 25 February 2011. At this point the newly recruited person in charge was four weeks in her post. Progress had been made on the actions set out in January 2011 and in particular there was evidence of a significant improvement in the management of the centre. Staff were receiving training and direction thus reducing the previously identified risk to resident safety. Initiatives had been set in motion for improvements to the overall quality of life for residents.

The purpose of this inspection, which took place on 6 July 2011, was to determine if progress made by 25 February 2011 was sustained and if further progress had been made with regards to the action plans set out in previous reports. The findings of the inspection, which was unannounced, are detailed in this report.

Summary of findings from this inspection

The appointment of the person in charge has had a positive effect on the overall management and leadership of the centre. This was apparent from the manner in which quality of life issues for residents had been addressed, in particular the activities provided, the risk assessments conducted and the support and mentoring provided to staff. Staff commented that her appointment provided them with direction and guidance, something which they appreciated.

Mandatory training was provided to staff; however, shortfalls remained. Clinical practices in relation to care planning, use of restraint and medication management had all improved, making the care delivered to residents safer. However, further improvements and greater attention to detail was required. The inspector found that 10 of the 18 action plans had been dealt with. Progress was made on another seven and one action, pertaining to recruitment, remained outstanding.

Actions reviewed on inspection:

1. Action required from previous inspection:
Adequate arrangements must be made for the maintenance of all fire equipment.

Adequate arrangements must be made for the review of fire precautions. Fire equipment must be tested at suitable intervals.

Arrangements must be made for persons working at the centre to receive suitable training in fire prevention.

Fire drills and practices must be conducted at suitable intervals to ensure that the persons working at the centre and, insofar as is reasonably practicable, residents are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

A record must be maintained of all fire alarm tests carried out together with the result of any such test and the action taken to remedy defects.

The inspector viewed records which showed that maintenance and testing of fire equipment was carried out on 2 February 2011.

The procedure to be followed in the event of a fire was typed, laminated and displayed. Also displayed was a framed layout of the building indicating where fire exits were.

Records were available to show that staff had received fire training on 16 February 2011, 17 February 2011 and 26 February 2011. This was facilitated by a private company. However, 13 members of staff were awaiting training. Eight of these had been added to the duty roster since February 2011.

The person in charge informed the inspector that practice fire evacuations had taken place on all units.

A system was in place whereby a staff member tested the fire alarms on a weekly basis and a record was maintained of these checks and any action taken to remedy defects.

2. Action required from previous inspection:
The numbers of staff and the skill mix of staff must be appropriate to the assessed needs of residents, and the size and layout of the centre.

The person in charge shall ensure that there is an appropriately qualified nurse on duty and in charge of the centre at all times and a record thereof maintained.

From examination of the duty roster and from conversations with staff, the inspector established the average staff to resident ratio was;

- 1:5.5 in the morning
- 1:5 in the afternoon
- 1:7 in the evening
- 1:11.75 at night time.

In January 2011 the levels were;

- 1:6 in the morning
- 1:6 in the afternoon
- 1:7 in the evening
- 1:11.75 at night time

In addition to the above, there were staff on kitchen duties, laundry duties, household duties and administrative tasks. The changes in ratios between January 2011 and July 2011 reflected an extra 50 hours of nursing provided for per week. The person in charge was outside this staffing complement and the staffing levels were further enhanced by the person in charge working over and above normal working hours, thus ensuring a level of supervision and support added to that reflected on the roster.

There had been changes to the manner in which staff resources were allocated. For example;

- a staff member was assigned to ensuring the dining room and mealtime for residents in the dementia unit was more satisfying
- outside personnel had been contracted to provide art therapy
- gardening activities were facilitated by volunteers
- staff at the leisure centre assisted residents to use the swimming pool.

A new management structure was put in place after the January 2011 inspection. A person in charge and a deputy person in charge were appointed, both on a full time basis. There had been no turnover of nursing staff since January 2011 and this had helped provide continuity of care. In addition, the nurses were now provided with guidance, mentoring and appraisals from the person in charge. Their skills and competencies had improved as a result.

Overall, the number and skill mix of staff had improved. However, considering the layout of the building, the complex and diverse needs of the residents and the fact that some nursing activities were not attended to in as complete a manner as should have been (such as medication practices - action 4, restraint assessment - action 7 and nutritional assessments - action 9), the current nursing and overall staffing complement warrants a further review.

3. Action required from previous inspection:
Ensure opportunities for meaningful fulfilment are provided for residents that reflect the resident's preferences, interests and abilities.

Changes and improvements had been made to the activities provided for residents. These included;

- the integration of residents from the three different units in activities
- the use of the main foyer area as the location for the organised activities
- the involvement of all staff in the daily activities. This is reinforced through the morning report which all carers and nurses attend.
- a change in culture from one of task based to sitting and talking with residents
- the provision of art therapy for 1.5 hours weekly. This was reported by staff to be working particularly well with residents from the acquired brain injury unit and residents from the dementia unit. Approximately 12 residents attended. There were plans in place to provide one to one art therapy where a need for same had been indicated. An exhibition of the art work created is to take place in the centre. A mural was painted on a boundary fence with the assistance of residents
- the conducting of bingo sessions twice weekly and prizes awarded for the winners. Staff reported this was well attended and creates much banter amongst residents and staff
- the reading of daily newspapers by staff for residents at a table in the foyer
- the use of the swimming pool in the leisure centre by four residents
- the creation of a vegetable and flower garden. Residents eat the produce produced and the hanging baskets made by the residents adorned the front of the building
- the production of personalised "Knowing me" folders for residents
- a greater emphasis around the social and pleasurable aspects of mealtimes, in particular in the dementia care unit
- the involvement of residents in interior redecorating projects
- the use of jigsaws and other cognitively stimulating tools for residents in the dementia care unit.

In addition to these new activities, the previous activities of music sessions, exercise sessions and reminiscence therapy continued on a weekly basis. The inspector saw residents using the secure outdoor area, some independently and others with the assistance of staff. Residents from the acquired brain injury unit were seen to go out for walks around the town and to the coffee shop in the company of carers.

4. Action required from previous inspection:

An Bord Altranais guidelines 2007 must be adhered to when a nurse transcribes a medication chart.

The registered provider shall ensure that the centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

The person in charge shall ensure that staff are familiar with such policies and procedures.

The centre's revised medication policy states that transcription of medical prescriptions is avoided where possible. This is in line with An Bord Altranais guidelines. The policy states that any transcription that is necessary must receive prior approval from the person in charge. While the medication charts examined by

the inspector were seen not to have been transcribed, it was noted that the policy was not clear in its guidance on this issue. It did not state that transcribed charts must be checked and signed for by two nurses, as per professional guidelines.

The pharmacist, general practitioner (GP) and nurse were involved in reviewing medication on a three-monthly basis and the documentation showed this. The pharmacist was involved in educational sessions and staff reported these were useful and informative. The inspector examined medication prescription charts and noted the GP's signature was on them. One resident who required his medicines to be crushed had written authorisation from his GP; however, the documentation relating to this was separate from the drug prescription chart and there was a potential for this information not to be properly relayed to the administering nurse. This was not in line with the centre's policy on crushed medication. Medication errors were recorded and one instance necessitated disciplinary action for non adherence to the centre's policy and non adherence to professional guidelines. There was a lack of clarity around one prescription as to whether the medication was to be administered routinely or as needed (PRN).

A system was in place whereby nursing staff indicated their understanding of the medication policy by signing once they had read and understood it.

5. Action required from previous inspection:
A system must be put in place for reviewing and improving the quality and safety of care provided to, and the quality of life of residents.

The person in charge spoke of her commitment to continuous improvement. Since the previous inspection a new incident/accident format was devised. All incidents were examined by the person in charge and recurring patterns identified. Corrective action was taken and for a number of residents there was a reduction in their number of falls. For example, one resident's incidence of falls reduced when his seating was changed, another when her footwear was altered. Others were referred for medical consultation.

Clinical audits had been conducted on the frequency of;

- infection – none at time of inspection
- pressure sores – none at time of inspection
- use of bedrails – number in use reduced and assessments carried out for those that were in use. Low low beds were used in preference to bedrails
- residents' pain – appropriate medical intervention given and ongoing assessment of the level of pain.

The person in charge has discussed the outcomes of these audits with nursing staff and was in the process of collating the findings and relaying the results to all staff.

The person in charge had also audited, through observation, the level of interaction between staff and residents in the dementia care unit. To improve communication between residents and staff the PIC provided in-house training and guidance for staff on how to relate more effectively. Staff were observed by the inspector to be at ease

with such communications and able to deal calmly with incidents of behaviour which was challenging.

There were some areas identified as needing more thorough auditing by the provider and the person in charge to ensure residents received quality and safe care. These included;

- audits of the mandatory training provided to staff. These are discussed in action 1 and action 16.
- audits of documentation held in relation to staff. This is further discussed in action 18.
- audits of medication practices. This is discussed in action 4 above.

6. Action required from previous inspection:
The complaints procedure must contain details of the independent appeals process.

The complaints policy was displayed in the foyer. It contained details of the independent appeals process.

7. Action required from previous inspection:
A record must be maintained of any occasion on which restraint is used, the nature of the restraint and its duration.

Records were maintained of occasions when restraint was used. Bedrails were removed from beds unless there was a specific indication that they were needed; an assessment for the use of bedrails was introduced and low low beds were used for some residents. These initiatives resulted in the number and frequency in which rails were used to reduce significantly. A system was in place where if restraint was used, it was checked on a two-hourly basis.

Consent was seen to have been sought for the use of restraint but in some instances this consent was from a next of kin which is not in line with national guidelines. In one instance the consent form did not clearly state the type of restraint to be used. There was a discrepancy noted on a resident's notes with regards to the reason why restraint (bedrails) were required; in the care plan it stated it was used for resident safety and on the restraint assessment document it stated the rails were used as an enabler. This suggested there was a lack of clarity on behalf of the assessors with regards to the reasons why bedrails were required.

8. Action required from previous inspection:
The resident's care plan must be kept under formal review as required by the residents changing needs or circumstances and no less frequently than at three-monthly intervals.

The care plan template had been revised since the January 2011 inspection. Six of these care plans were examined and seen to detail residents' healthcare needs and social care needs. The plans were reviewed on a three-monthly basis.

The person in charge was in the process of introducing, for each resident, a record labelled "knowing me". This document complemented the care plan mentioned above. It focused primarily on the social needs of residents and was written in a format that showed an understanding of residents' character and an understanding of their preferences, likes and dislikes. It was easy to access, read and understand and was available to all staff. It was written in conjunction with the resident and/or his/ her family. Approximately 50% of residents had this record in place at the time of inspection.

9. Action required from previous inspection:
Ensure residents weights are checked and recorded regularly and that all residents have an appropriate nutritional assessment.

Ensure infection control practices are in line with best practice.

A working sit on digital weighting was available as was a hoist scales. As a routine, residents' weights were checked on a monthly basis and recorded. This was an improvement on previous findings. However, it was noted that one resident who was underweight, did not have her weight recorded for the month of June 2011. In addition, there was no validated nutritional assessment on file for her. A food chart was in place for this resident but the detail recorded in it suggested greater attention needed to be given to her dietary intake.

Infection control measures were in place. These included the provision of;
- hand gel sanitisers throughout
- notices displayed regarding proper hand washing procedure
- alginate bags for infected laundry.

The person in charge reported there were no instances of infections such as Methicillin-Resistant *Staphylococcus Aureus* (MRSA) infection or clostridium difficile at the time of inspection.

10. Action required from previous inspection:
Adequate screening curtains must be provided in bedrooms to maintain residents' privacy and dignity.

Notices regarding resident care must be discreetly positioned to maintain privacy and dignity.

The inspector saw that screening curtains were in place in twin-bedded rooms.

No notices were observed in residents' bedrooms which could impinge on their privacy or dignity. Staff who spoke with the inspector were aware of the need to maintain residents' privacy.

11. Action required from previous inspection:
Chemicals must be stored in such a manner as to prevent the risk of an accident.

The person in charge introduced a system whereby all chemicals posing a risk to residents were kept in a container and taken by the housekeeping staff to the area where they were working. Housekeeping staff were briefed regarding keeping any chemicals under close supervision.

12. Action required from previous inspection:
A sink with double drainer, serviced with an instant supply of hot and cold water must be in place in the laundry.

A wash-hand basin must be in place in the laundry.

Suitable changing and storage facilities must be provided for staff.

The inspector saw that the laundry facilities had been upgraded. Two new washing machines and a dryer were installed in addition to a double draining sink and a wash-hand basin.

Changing facilities for staff were made available in an upstairs area.

13. Action required from previous inspection:
All policies should be dated, have a review date and be appropriately referenced.

Schedule 5 policies were updated. They had a review date and were appropriately referenced. Staff sign once they have read and understood a policy.

14. Action required from previous inspection:
A record must be kept of each resident's personal property signed by the resident and this record must be kept up to date.

Written operational policies and procedures must be in place and adhered to relating to residents' personal property and possessions.

A system was in place whereby each resident had a wallet containing his/her personal valuables and cash. Every resident had a sign off sheet in the wallet and any valuables or cash either placed in or removed from the wallet, was signed for by the resident if possible or alternatively by the administrator and witnessed by another staff member. The balance remaining in the wallet was recorded at each transaction.

A written policy was in place relating to residents' personal property and possessions.

15. Action required from previous inspection:
A statement of purpose must be compiled which includes all the items listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The statement of purpose and function must accurately describe the service that is provided and the manner in which it is provided. It must be clearly demonstrated that the statement of purpose is implemented.

The statement of purpose was updated in March 2011 and included the items listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The statement of purpose reflected the services provided in the centre.

16. Action required from previous inspection:
All necessary arrangements must be made, by training staff or by other measures, which are aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Arrangements must be made for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

All reasonable measures must be taken to prevent accidents to any person in the centre.

Training in elder abuse detection and prevention was provided for staff in February 2011. However, in July 2011 there were still a significant number of staff that had not received this training or had only part of the training completed. Staff with whom the inspector spoke with were aware of what to do if they had any concerns in this area.

Serious incidents were identified, recorded and investigated. These included an incident of a medication error and an incident of physical abuse of a resident. In both instances disciplinary action was taken and in one case a staff member was dismissed. Learning from the incidents highlighted the need for greater supervision by the person in charge of medication administration practices and the need to support staff when reporting concerns they have with regard to resident care.

Measures put in place since January 2011 to prevent accidents included;
- training in fire safety
- training in the detection, prevention and management of elder abuse
- training in moving and handling
- training in the use of psychotropic drugs
- risk assessments, including risk assessments for the use of restraint and the use of the swimming pool
- the use of low low beds to minimise accidents

- increased supervision and guidance to staff
- improved practices in relation to the management of residents' finances
- greater awareness amongst staff of the need to store chemicals in a safe manner.

17. Action required from previous inspection:
Staff members must have access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.

All staff must be supervised on an appropriate basis pertinent to their role.

All staff members must be made aware of the provisions of the Health Act 2007 and all regulations and rules made hereunder, commensurate with their role, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents.

The training record showed that since January 2011 members of staff had undertaken training in;

- fire safety
- moving and handling
- elder abuse prevention
- nutritional assessment
- psychotropic medication
- diabetes.

However, in the January 2011 report the need for staff training in the area of acquired brain injury was identified. The provider in his response indicated training would be provided in dementia care and acquired brain injury but the records did not show that this had taken place. The person in charge had provided support and guidance to staff in these areas, but the need for a structured training programme remained.

Staff were supervised by the person in charge and this was confirmed by staff to the inspector. Regular staff meetings took place and this was confirmed by staff.

18. Action required from previous inspection:
A person must not be employed until such time as the documents specified in Schedule 2 have obtained and until such time that the provider is satisfied on reasonable grounds, as to the authenticity of the references referred to in Schedule 2 in respect of that person.

Evidence of each nurse's registration status must be maintained and available for inspection by authorised personnel.

On examination of files the inspector noted that since January 2011, staff were employed before such documents specified in Schedule 2 of the Health Act 2007

(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) had been obtained. These included references and medical certificate of fitness. In addition references that were not there in January 2011 had not been obtained in the interim.

Report compiled by:

Margaret O'Regan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

15 July 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
6 September 2010 and 7 September 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
25 January 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☒ Announced ☐ Unannounced
25 February 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre:	Killeline Nursing Home
Centre ID:	0423
Date of inspection:	6 July 2011
Date of response:	2 August 2011

Requirements

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

1. The provider has failed to comply with a regulatory requirement in the following respect:

New staff had commenced employment in the past number of months and there was no record that they had been provided with fire training. In addition, the records showed a number of longer term staff had not received fire training either.

Action required:

Arrangements must be made for persons working at the centre to receive suitable training in fire prevention.

Reference:

Health Act 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

* 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 with timescales:	**Timescale:**
Provider's response: Fire training is scheduled for Wednesday 10 August 2011. This session will complete fire training for all staff employed in Killeline Nursing Home.	10 August 2011

2. The provider has failed to comply with a regulatory requirement in the following respect:

One resident, who required his medicines to be crushed, had written authorisation from his GP. However, the documentation relating to this was separate from the drug prescription sheet. Medication practices must be safe and in this regard in line with the centre's own policy which states "the GP shall document that the medication is to be crushed on the prescription sheet".

There was a lack of clarity around one prescription as to whether the medication was to be administered routinely or as needed (PRN).

The centre's policy did not state that transcribed charts must be checked and signed for by two nurses, as per professional guidelines.

Action required:

The registered provider shall ensure that the centre has appropriate and suitable practices and written operational policies relating to the prescribing and administration of medicines to residents.

Action required:

There must be clarity around all prescriptions as to whether the medication is to be administered routinely or as needed (PRN).

Action required:

The centre's medication policy adheres to An Bord Altranais guidelines in relation to transcription of medications.

Reference:

Health Act 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

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

Provider's response: In line with best practice general practitioners are currently being requested to document clearly requirement to have medication crushed and clarify use of PRN medication. The centre's policy has been updated, stating clearly the requirement of transcribed charts to be signed by two nurses.	 30 August 2011

3. The provider has failed to comply with a regulatory requirement in the following respect: Consent for restraint was obtained from the next of kin. This is not in line with national guidelines. In one instance the consent form did not clearly state the type of restraint to be used. There was a discrepancy noted on one resident's notes with regards to the reason why restraint (bedrails) were required. This suggested there was a lack of clarity on behalf of the assessors with regards to the reasons why bedrails were required.	
Action required: Families should be involved in discussions around the use of restraint but consent for it must adhere to the national guidelines.	
Action required: Documentation around restraint must clearly identify the nature of the restraint used.	
Action required: Staff must receive training on the proper assessment for the use of restraint and training on the implementation of national guidelines.	
Reference: Health Act 2007 Regulation 25: Medical Records Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following training with the Health Service Executive (HSE) on 22 July 2011 on latest policy and guidelines on use of restraint a full programme of training will be delivered to all staff by Denis McElligott and Margaret Keane RN.	 1 September 2011 to 31 October 2011

4. The provider has failed to comply with a regulatory requirement in the following respect:

Deficits were noted in the quality of reviews. These included;

- the provision of mandatory training for staff.
- the documentation held in relation to staff
- the medication records and practices.

A more robust system must be put in place to ensure matters arising in relation to these are dealt with and followed up upon appropriately.

Action required:

The provider must conduct ongoing reviews of:

- staff training
- staff files and documentation
- staffing levels
- medication practices.

A report on these reviews must be made available to the Authority on a monthly basis until such time as the Chief Inspector is satisfied that the system for review of these matters is satisfactory.

Reference:

Health Act 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Progress is ongoing on all areas identified and a monthly report will be made available to the Authority as requested.	31 August 2011 and ongoing on a monthly basis

5. The provider has failed to comply with a regulatory requirement in the following respect:

One resident did not have her weight recorded for the month of June 2011. In addition, there was no validated nutritional assessment on file for her. A food chart was in place for this resident but the detail recorded in it suggested greater attention needed to be given to her dietary intake.

Action required:

A high standard of evidence based nursing care must be provided for all residents.

Reference:

Health Act 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The MUST tool has been completed for this resident. The resident is receiving nutritional supplements and is discussed as part of the 'red list' of priorities at all reports. Weight gain of over 1 kg has been achieved. A review with the resident's doctor in respect of further investigation has occurred.	1 August 2011

6. The provider has failed to comply with a regulatory requirement in the following respect:

Staff had been recruited before the proper documentation in relation to them had been obtained. These included references and medical certificates of fitness.

Action required:

A person must not be employed until such time as the documents specified in Schedule 2 have obtained and until such time that the provider is satisfied on reasonable grounds, as to the authenticity of the references referred to in Schedule 2 in respect of that person.

Reference:

Health Act 2007
Regulation 18: Recruitment
Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: No staff are now employed in Killeline Nursing Home until all documents specified in Schedule 2 are obtained and that the provider is satisfied on reasonable grounds as to the authenticity of references.	20 July 2011

Any comments the provider may wish to make:

Provider's response:

Killeline Nursing Home is committed to providing quality person-centred care. I feel the findings from the Health Information and Quality Authority inspection are a fair reflection of current practice and we welcome all recommendations in the context of continuous quality improvement and learning.

Provider's name: Denis McElligott

Date: 2 August 2011