

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people



Centre name:	Kinvara House
Centre ID:	0054
Centre address:	3/4 Esplanade
	Strand Road
	Bray, Co. Wicklow
Telephone number:	01 2866153
Fax number:	01 2864353
Email address:	kinvarahousebray@eircom.net
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered providers:	Kinvara House Limited
Person in charge:	Mary Mangan
Date of inspection:	1 November 2011
Time inspection took place:	Start: 09:15 hrs Completion: 18:15 hrs
Lead inspector:	Linda Moore
Support inspector:	N/A
Type of inspection:	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced
Purpose of this inspection visit:	<input type="checkbox"/> Application to vary registration conditions <input type="checkbox"/> Notification of a significant incident or event <input type="checkbox"/> Notification of a change in circumstance <input type="checkbox"/> Information received in relation to a complaint or concern <input checked="" type="checkbox"/> 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 meet 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

Kinvara House is a four-storey building which consists of two adjoining houses with an extension to the rear. Accommodation is provided over the four floors for 36 people including some residents with dementia.

There are two single en suite bedrooms with wash-hand basin toilet and bath, and four single en suite bedrooms with wash-hand basin and toilet on the ground floor. The residents' dining room, the main kitchen, laundry, hairdressing room and an assisted bathroom with toilet shower and bath also located on this floor. Other facilities on this floor include the staff cloakroom.

The main entrance is located on the first floor which leads to the lobby. There is one large sitting area to the right of the main lobby with direct views onto the promenade and the sea. There is a lounge to the left of the lobby which overlooks a secure, well maintained courtyard accessible to residents. There are eleven single en suite bedrooms with wash-hand basin and toilet and three single en suite bedrooms with wash-hand basin, toilet and bath on this floor. There is also a separate bathroom with an assisted bath, assisted shower and toilet. There is an oratory and offices for the person in charge and staff. There are separate toilet facilities for residents, staff and visitors on this floor.

Four single en suite bedrooms with a wash-hand basin and toilet and four single en suite bedrooms with a wash-hand basin, toilet and bath are on the second floor.

Accommodation on the third floor includes four single en suite bedrooms with wash-hand basin and toilet, and four single en suite bedrooms with wash-hand basin toilet and bath. Shower and toilet facilities for catering staff are also located on this floor. All floors have adequate storage space for linen and equipment. All floors are accessible by stairs and lift.

There are closed-circuit television cameras (CCTV) in place outside the building and a keypad locking system on the front door.

Location

Kinvara House is located on the sea front in Bray, Co. Wicklow. It is a two minute drive from the dart station and close to local churches, shops and amenities. There is pay parking on the street directly outside the centre.

Date centre was first established:	1 September 1990
Number of residents on the date of inspection:	35
Number of vacancies on the date of inspection:	1

Dependency level of current residents	Max	High	Medium	Low
Number of residents	0	17	8	10

Management structure

Mary Mangan is the nominated person on behalf of the Provider and Person in Charge. She is also a Director of Kinvara House Ltd and her husband, Denis Mangan is the Managing Director and Chief Executive Officer. She will be referred to as the provider throughout the report. Gillian Mangan is currently Learning and Development Manager and is being mentored by Mary Mangan to take on the role of provider in the future. The Provider is supported by a full-time administrator who reports directly to her. The staff nurses on duty and the household staff all report directly to the Provider and the care staff report to the staff nurse on duty. The catering assistants report to the Chef who in turn reports to the provider. An assigned staff nurse deputizes for the Provider when required.

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	1	7	2	3	1	1 Trainee

Background

Kinvara House was first inspected by the Health Information and Quality Authority on 2 and 3 February 2010. This was a registration inspection. The provider did not meet all of the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Inspectors had serious concerns about the care, management and safety of three residents. The provider was asked to submit immediate action plans to address these issues. The information was received and reviewed by inspectors who found it to be satisfactory. During that inspection residents reported a high level of satisfaction with their lives and said their health care needs were met.

The operational policies in place were inadequate to promote a consistent approach to the management of health and safety practices and the management of incidents and accidents was ineffective. The clinical policies and staff training in place were not comprehensive enough to guide staff in the delivery of a high standard of evidenced-based practice.

An announced follow up inspection was carried out on 23 June 2010. Inspectors reviewed the actions taken and progress made since the previous inspection and noted that the provider had addressed some of the actions fully while others improvements were still in progress. Many staff had attended training and additional training was scheduled throughout the year. Environmental risks were addressed and monitored on a regular basis. The provider had implemented a schedule of activities for residents with communication difficulties and dementia.

The previous action plan from inspection 23 June 2010 identified areas where improvements were required to comply with the requirement of Regulations and *the National Quality Standards for Residential Care Settings for Older People in Ireland*, such as:

- training was not provided in specific clinical areas such as wound management, falls management, pain management, assessment of needs, clinical risk assessment and care planning
- the risk management policy was a work in progress and had not yet been implemented
- medication polices were not specific to the practices in the centre
- there was no system in place to analyse or monitor the number, nature, cause or severity of incidents and accidents and subsequent outcomes for residents
- care planning process was not robust or consistent in assessing or detailing residents care needs
- there was no photographic evidence of identity or evidence of mental or physical fitness of staff as required by the Regulations
- not all staff were familiar with the emergency policy in place relating to the arrangements for the evacuation and relocation of residents in the event an emergency
- there was no dedicated wash hand basin for nursing staff to wash their hand prior to a procedure requiring aseptic techniques such as wound dressings.

The inspection reports can be found at www.hiqa.ie under centre number 0054

This additional inspection report outlines the findings of a follow up inspection that took place on 1 November 2011. The inspection was unannounced and focused on the actions of the inspection of 23 June 2010. The inspector met the provider and a number of staff, residents and relatives.

Summary of findings from this inspection

This was an unannounced follow up inspection which focused on areas identified for improvement at the follow up inspection in 23 June 2011 and to monitor compliance with the Regulations.

The inspector found that the provider had responded to the action plan from the previous inspection but there were considerable improvements still required. Two of the nine actions identified had been fully completed, six had been partly met and one action had not been completed.

All of the outstanding items were not completed within the time specified or were ongoing issues.

Improvements made by the provider since the previous inspection included:

- provision of training in medication management
- improved staff awareness of the emergency procedure
- additional hand washing facilities
- the provision of a risk management committee
- vetting of volunteers

The inspector met residents, relatives, the provider and staff on duty. Records were examined including care plans, medical records, staff records including training records, staff files and policies.

Overall, the inspector had difficulty assessing documentation. The provider was not aware of the location of a number of documents and considerable time was spent waiting to access documentation. The inspector found that accountability and responsibility for the service needed to be strengthened in relation to meeting the requirements of the Regulations and driving forward the actions required within the time frames agreed.

The provider had not notified the Authority when a resident sustained fractures from two separate falls. These notifications were subsequently submitted to the Authority. The provider said she was not aware of the requirements of Schedule 2 of the Regulation.

Improvements were still required in the management of falls, care planning, restraint and risk management. Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Issues covered on inspection

Statement of Purpose

The statement of purpose was not in line with the Regulations. The inspector was satisfied that the statement of purpose accurately described the services that was provided in the centre but did not meet the requirements of Schedule 1 of Regulations. Mary Mangan the person nominated to act on behalf of the provider was identified as the provider as opposed to the name of the company and the registration status had not been amended in the statement. The statement was not reviewed after the registration inspection and while it was made available to residents on admission, it was not freely available. The CEO said he was planning to review this.

Complaints Management

The inspector found evidence of good complaints management practices but the policy required some improvements.

Management of complaints was comprehensive and learning from complaints was reflected in practice. The complaints policy was read by the inspector and details of the complaints procedure were posted publicly and described in the Residents' Guide and the statement of purpose. The procedure provided guidelines on how to make a complaint or express a concern, and how these would be addressed. A named complaints officer was identified. However, the policy did not identify an appeals process in the event that a complainant was not satisfied with the outcome. The provider confirmed that she met with residents and relatives on a daily basis and usually resolved any issues which arose before they became a source of discontent. Residents and relatives agreed that this was the case and records showed the number of complaints to be very low. The inspector reviewed the complaints log, which showed details of how complaints had been resolved, including details of the complainant's level of satisfaction with how the complaint was managed.

Protection

Overall, the inspector was satisfied that measures were in place to protect residents from being harmed or suffering abuse, but there were areas for improvement in relation to the policy on the protection of vulnerable adults. Although the centre had a policy on safeguarding of residents, this required to be more specific to guide practice and inform staff. The provider said all staff had attended training on identifying and responding to elder abuse. However, the records were not available for the inspector to view. The staff spoken to displayed sufficient knowledge about different forms of elder abuse and they were clear on reporting procedures. Residents spoken to confirmed to the inspector that they felt safe in the centre. They primarily attributed this to the staff being available to them at all times and the locking system on the entrance doors. The provider was accessible to all residents as she visited residents each time she was in the centre and enquired about their well-being and if they had any concerns or complaints. The inspector saw this happening and residents confirmed that they were visited frequently and could discuss any issues or worries.

Health and safety

The provider had taken adequate fire precautions. Fire extinguishers and equipment were kept in good working order and were serviced regularly. Records showed they were last serviced in August 2011. Fire notices and the evacuation plans were posted prominently on all corridors. There was a record of fire drills and evacuation training. The most recent evacuation training had been on 29 August 2011 and a fire drill took place on 15 July 2011 and staff were fully aware of what to do in the event of a fire. The CEO checked the fire exits weekly and he said that all staff were aware to check exits daily to ensure they were not blocked.

Residents' Register

The inspector read the register and noted that it was up-to-date. There was also a current list of residents available, which may be necessary in the event of fire.

Review of Quality and Safety of Care and Quality of Life

The inspector was satisfied that the experience of the residents was monitored and developed on an ongoing basis as the provider met the residents almost daily and listened to their feedback. However, the organisation lacked a formal system to review the quality of care. The provider said she used the risk management committee to review the quality of care delivered, but this committee had only met once. The provider had audited the medication charts and she said she informally audited the care plans but did not record this. There was also no system in place to collect clinical data to identify possible trends and for the purpose of improving the quality of service and safety of residents.

Operating Policies and Procedures (Schedule 5)

Inspectors read a number of the centres policies as outlined in Schedule 5 of the Regulations and noted that these were general documents and guidelines and not policies as they did not guide practice. A considerable amount of work was required in this area. The policies did not include the date of development or a review date. The behaviours that challenge policy included the aggression and violence and there was missing person policy, but there was no policy on self harm or assault as required under the Act. The restraint policy, protection of vulnerable adults policy, recruitment policy and risk management policy were not sufficiently detailed to guide care. There was also no evidence that staff had read these policies. It was difficult to determine if the policies were available to staff as the provider and staff nurse could not locate the restraint policy and the administrator printed this for the inspector to review.

Actions reviewed on inspection:

1. Action required from previous inspection:

Put in place education and training to enable staff to provide care in accordance with contemporary evidenced practice.

This action was partially met.

The provider had arranged some additional training and facilitated staff attendance. The inspector reviewed the available training records for staff. Staff nurses had attended training on supra-pubic re-catheterisation, constipation management and medication management. The provider said the nurses had attended training on wound management, manual handling and elder abuse but the records of the training could not be located. The staff said they had attended the training. The provider said that training was planned on assessment and care planning for 7 November 2011. The inspector found that training in falls management had not been provided.

2. Action required from previous inspection:

Complete a comprehensive risk management policy to include environmental risk assessments and implement it throughout the centre.

This action was partially met.

In response to this required action the provider had established a risk management committee which included the provider, Chief Executive, the learning and development officer and the administrator. The minutes of the meeting on 10 August 2011 were reviewed. This included an annual audit of all risks and these were discussed at the meeting. This committee had only met once and the formal approach to identify and manage clinical and non-clinical risk was not embedded. This group developed a risk management policy, which was read by the inspector. It did not fully guide practice and it did not meet the requirements of the Regulations.

3. Action required from previous inspection:

Develop appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

Implement and train staff in the use of such policies and procedures.

Maintain accurate records of each drug and medicine administered giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drug in accordance with any relevant professional guidelines.

Make arrangements for the identification, recording, investigating and learning from untoward incidents or adverse events involving residents.

This action was partially met.

Staff received training in medication management since the previous inspection, Additional training on drug interactions, swallowing difficulties, crushing medication and pain management were delivered in July 2010. The nurse on duty told the inspector she found the training sessions very informative.

There was now a system in place to manage and record the monitoring of scheduled controlled drugs as required by legislative requirements. Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. These medications were counted at the time of administration and at the change of each shift. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift. The inspector checked a sample of the balances and found them to be correct.

The provider explained that the pharmacy had developed a policy in conjunction with the provider. The inspector noted that the medication policy did not guide practice and the nurse on duty was not familiar with the medication management policy.

The nurse told the inspector that transcribed medications were now counter-signed by a second nurse. This was verified by a review of residents' records. However, this system of checking was not robust. Records showed that a resident's medication was administered in accordance with the incorrectly transcribed medication on the prescription. A controlled drug was administered and the medication had not been transcribed from the previous prescription. A review of old prescription records indicated the resident received the medication as originally prescribed by the general practitioner (GP). The provider informed the inspector in writing that this had been addressed immediately after the inspection. The inspector found the poor transcribing and administration practices could result in an adverse outcome for residents.

The inspector reviewed the residents' medication administration procedure and records and found evidence of unsafe practices. The inspector observed that the staff member on duty did not refer to the prescription when administering Warfarin, but referred to a sheet which a nurse had written the dose of the Warfarin to be administered based on a telephone conversation with the doctor. The doctor had prescribed the medication "as per INR" and had not stated the dosage or signed the Warfarin prescription.

The nurse told the inspector that they used photographs to identify residents when administering medications but the inspector noted that a small number of the residents' photographs were missing. A lack of identification could result in negative outcomes to residents.

The inspector noted that the medication management policy included the arrangements for the identification, recording, investigating and learning from untoward incidents or adverse events involving residents. The policy stated that an adverse drug event form was used to record an adverse event, but, this was not the practice in the centre. The nurse said a small red book was now available to record errors and adverse events and that there had not been any errors in medication management since the previous inspection.

4. Action required from previous inspection:

Provide arrangements for the identification, recording, investigating and learning from serious or untoward incidents or adverse events involving residents.

Implement all reasonable measures to prevent accidents to any persons in the designated centre.

This action was partly addressed but required further improvement to ensure there is consistent practice in relation to the identification, recording, investigating and learning from serious or untoward incidents or adverse events involving residents.

The provider had collected and reviewed information on falls each quarter since the last inspection and she reviewed the incident reports to determine if the appropriate action was taken in response to the incidents. The provider also completed two audits of the falls in 2011 and she stated in the results of the audit that all appropriate action was taken to minimise the residents' risk of falling. The inspector noted that some of the incident and accident report forms included the preventative measures to minimize the risk of reoccurrence. For example, (resident name) told to call for assistance, the requirement for provision of suitable footwear. The provider had provided a bed and chair alarm for one resident and a door alarm for another resident but had not evaluated the effectiveness of these interventions and not all incident reports included preventative actions.

The information gathered by the provider was limited and the recorded data available could have been analyzed further. For example, the auditing system in place did not monitor the number, nature, cause or severity of all incidents and accidents and subsequent outcomes for residents.

The inspector noted there was some improvement to the risk management system to address the issue of falls assessment, prevention and management. This required further development. While there had been some improvement to the falls prevention and management policy, it was not evidence-based and would not guide staff in the prevention and management of falls. For example, the policy did not indicate what risk assessment tool was to be used to assess residents at risk of falling or how to respond if a resident fell.

The provider told the inspector that staff had still not received training in falls prevention and management. The inspector reviewed residents' files and noted that residents were not consistently reassessed following a fall. Some residents had a falls prevention and management care plan in place when identified as at risk of falls or following a fall. However, these needed to be more specific to guide a consistent approach to care. The inspector noted from analyzing the falls that there were 21 falls since August 2011 and of these, one resident had fallen five times. This resident had fallen in May and July 2011 and both of these falls resulted in fractures. These falls were not notified to the Authority.

5. Action required from previous inspection:

Review the residents care plan under as required by the residents changing needs or circumstances and no less frequently than at three-monthly intervals.

Maintain appropriate records of all nursing care provided to the resident including, but not limited to, wound care, pain assessment and falls management.

Devise individualised evidenced based care plans which are developed and agreed with each resident or where applicable with their significant other and make the care plan available to each resident. Revise the residents' care plan, after consultation with them, unless it is impracticable to carry out such a consultation and notify the resident of any review.

This action was not addressed.

The inspector found that the care planning process was still not robust or consistent in assessing or outlining residents care needs.

The inspector found there was still not a consistent approach to ensuring that nursing' assessments, risk assessments and care plans were implemented in line with the Regulations. There was no system in place to ensure that each resident had a comprehensive assessment undertaken and a care plan in place. Nursing staff had not received additional training on assessment, clinical risk assessment and care planning and this contributed to inconsistencies. For example, some residents were reassessed on a three to four-monthly basis but their assessments and care plans were not reviewed or amended when their condition changed. The inspector found where risk assessments were completed on a regular basis there was no evidence that this information was being utilised to formulate specific care plans for residents. Nurses were now accountable for updating a number of care plans but these were not being used to guide the care. The inspector found a care plan for one resident in another resident's file.

It was not possible to gain an understanding of the residents' current needs from the care plans. This could result in an inconsistent approach to care provision and poor outcomes for residents. The inspector noted where one resident was receiving wound care for a chronic leg ulcer, the frequency of treatment prescribed was not recorded in a care plan. It was not evident from the documentation when the wound required dressing or how frequently the wound was to be reassessed. There was an

update of the wound care in the progress notes only. There was no improvement in this regard since the previous inspection.

The inspector reviewed the practice in relation to the use of restraint. From a review of residents' records and talking to staff, it was noted that restraint management required some improvement. The inspector observed that bedrails were in use for a number of residents. The provider told the inspector that none of the staff had attended the training on the national policy on the use of restraint and she did not have a copy of this policy for staff to refer to. Residents who had bedrails did not have a care plan to manage this. The inspector noted that monitoring of the use of bedrails at night time was not documented, the provider said that residents were checked hourly overnight but documented checks were not completed.

Residents had a consent form for restraint signed by the GP and family member. There were assessment forms for bedrails but these had not been consistently completed and the alternatives tried prior to using bedrails were not well documented.

6. Action required from previous inspection:

Update staff files to include all information as required in Schedule 2 of the Regulations.

This action was not completed.

The inspector read a number of the staff files and noted that they still did not include all information as required in Schedule 2 of the Regulations. There was still no photographic evidence of identity or evidence of mental or physical fitness of staff. Staff files still did not have the three references as required by the Regulations. The provider had a lack of awareness of these requirements of the Regulations.

7. Action required from previous inspection:

Implement a process of vetting volunteers appropriate to their role and level of involvement in the centre.

This action was addressed.

The provider had implemented a process to vet all volunteers appropriate to their role and the inspector read the agreements developed and signed by volunteers.

8. Action required from previous inspection:

Ensure all staff are aware of the emergency policy and procedures including procedures to be followed in the event of an emergency evacuation of residents.

This action was addressed.

The inspector read the emergency procedures which included the procedures to be followed in the event of an emergency evacuation of residents. This was available to staff on their notice board and the provider said that training had been provided to staff on these procedures. Staff spoke to were knowledgeable of the procedures.

9. Action required from previous inspection:

Provide sufficient number of hand washing facilities in appropriate places.

This action was partly addressed.

There was an additional dedicated wash hand basin for nursing staff to wash their hand prior to a procedure requiring aseptic techniques such as wound dressings. However, the inspector saw that this was blocked by a hoist and a large chair during the morning of the inspection. The staff nurse said that she used another sink in a bathroom upstairs to wash her hands.

Report compiled by:

Linda Moore

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

4 November 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	Type of inspection:
2 and 3 February 2010	<input checked="" type="checkbox"/> Registration <input type="checkbox"/> Scheduled <input type="checkbox"/> Follow up inspection <input type="checkbox"/> Triggered <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced
23 June 2011	<input type="checkbox"/> Registration <input type="checkbox"/> Scheduled <input checked="" type="checkbox"/> Follow up inspection <input type="checkbox"/> Triggered <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

Provider's response to inspection report *

Centre:	Kinvara House
Centre ID:	0054
Date of inspection:	1 November 2011
Date of response:	1 December 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 is failing to comply with a regulatory requirement in the following respect:

The risk management policy was not in line with the Regulations.

The arrangements for the identification, recording, investigating and learning from serious or untoward incidents or adverse events involving residents were not well established.

Action required:

Revise the risk management policy and implement it throughout the centre.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures.
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:
<p>Provider's response:</p> <p>A complete review of risk management policy within the centre: commenced by the learning and development manager with the assistance of an external risk management expert.</p> <p>Presentation of review to risk management committee.</p> <p>Updated policy to be completed.</p>	<p>12/12/2011</p> <p>16/12/2012</p> <p>31/01/2012</p>

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

Medication transcribing and the practice to take orders over the phone were not in line with the centre's policy.

Staff were not familiar with the medication management policy.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Action required:

Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Reference:

Health Act, 2007
 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
 Regulation 25: Medical Records
 Standard 14: Medication Management

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

Provider's response:	
Review of current practices with person in charge, nursing staff, general practitioner, pharmacy and independent consultant. Review has commenced and to be completed	16/12/2011
Recommendations made in updates required in current practices and written policy, followed by training and implementation.	31/01/2012
Auditing of medication management continue by Person in Charge.	Ongoing

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

A high standard of evidence based nursing practice was not delivered in relation to falls management, restraint and wound care.

Action required:

Provide a high standard of evidence based nursing practice in relation to falls management, restraint and wound care.

Action required:

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 17: Training and Staff Development
Standard 13: Healthcare
Standard 24: Training and Supervision

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

Timescale:

Provider's response:

Training in following areas to be delivered in January and February:

For all employees:

- Falls Management
- Restraint
- Challenging Behaviour

29/02/2012

For all Nursing staff: <ul style="list-style-type: none"> Care planning Pharmacy education training to continue 	Ongoing
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4. The provider has failed to comply with a regulatory requirement in the following respect:

Inspectors found that the care planning process was not robust or consistent in assessing or outlining residents care needs. The staff nursing said she had not received additional training on the care planning process.

Residents were not consistently reassessed on a three-monthly basis as a result the care plans were not reflective of the resident's current needs.

Action required:

Review the residents care plan under as required by the residents changing needs or circumstances and no less frequently than at three-monthly intervals.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 13: Healthcare

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

Timescale:

Provider's response:

Assessment and Care Planning Review:

Review Contributors - person in charge, development and learning manager, nursing staff, care staff, GP and pharmacy.

Stages of process:

- Baseline review
- Process Mapping to standardise documentation
- Training / Mentoring Sessions
- Trouble shooting and Audit
- Policy and Audit Tool Development

Completed
16/12/2011
29/02/2012
31/03/2012
31/03/2012

This will allow a complete review of current practices, written policies and update of all files in line with said review.

30/04/2012

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

There was no photographic evidence of identity or evidence of mental or physical fitness of staff as required by the Regulations.

Some staff did not have the required three written references on their file.

Action required:

Update staff files to include all information as required in Schedule 2 of the Regulations.

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:

An audit of all staff files.

Completed

Any files incomplete updated in line with Schedule 2 of the Regulations.

16/12/2011

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

There was a dedicated wash-hand basin for nursing staff to wash their hand prior to a procedure requiring aseptic techniques such as wound dressings but this was blocked by equipment and not in use.

Action required:

Provide sufficient number of hand-washing facilities in appropriate places.

Reference:

Health Act 2007
Regulation 19: Premises
Standard 26: Health and Safety

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

Timescale:

Provider's response: The area cleared of all equipment and notice in place to prevent reoccurrence.	Completed
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7. The provider is failing to comply with a regulatory requirement in the following respect:

The centres policies as outlined in Schedule 5 of the Regulations were general guideline documents and not policies as they did not guide practice. This included the complaints policy, elder abuse policy, restraint policy.

Action required:

Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

Reference:

Health Act, 2007
Regulation 27: Operating Policies and Procedures
Standard 29: Management Systems

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

Timescale:

Provider's response:

A review of all the centres current polices.

31/12/2011

Updates in written/operational policies as listed in Schedule 5 of the Regulations for completion and in line with other processes currently underway within the centre.

29/02/2012

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

The statement of purpose did not consist of all matters listed in Schedule 1 of the Regulations.

The Statement of purpose was not kept under review.

Action required:

Review the Statement of purpose to ensure it consists of all matters listed in Schedule 1 of the Regulations and reflects the current registration.

Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Statement of purpose reviewed and changes made.	Completed

9. The provider has failed to comply with a regulatory requirement in the following respect: There was no formal system in place to review the quality and safety of care provided to residents.	
Action required: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.	
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: A draft quality assurance review drawn up. Review by risk management committee New quality assurance review commenced	Completed 16/12/2011 31/01/2012

Any comments the provider may wish to make:

Provider's response:

None

Provider's name: Kinvara House Ltd

Date: 1 December 2011