Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Mount Tabor Nursing Home
Centre ID:	0071
Centre address:	Sandymount Green
	Sandymount
	Dublin 4
Telephone number:	01-2605772
Email address:	info@dcmiss.ie; jane.butler@dcmiss.ie
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	Mount Tabor Ltd.
Person authorised to act on behalf of the provider:	David Reynolds
Person in charge:	Jane Butler
Date of inspection:	25 February 2013
Time inspection took place:	**Start:** 09:15 hrs **Completion:** 18:30 hrs
Lead inspector:	Angela Ring
Support inspector(s):	N/A
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	44
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

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

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

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

This was the third inspection of this centre and its purpose was to continue to monitor the care and governance at the centre. Overall, the inspector found that although residents appeared to be well cared for, improvements were required in keeping records updated and in care planning.

Improvements also included updating the complaints procedure, risk management policy and the staff files. These issues are detailed in the Action Plan at the end of the report.

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

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

Theme: Leadership, Governance and Management

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

Outcome 1

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found that the statement of purpose accurately described the service that was provided in the centre and it was updated to describe the details of registration. The inspector was satisfied that the service met the care needs of residents, as outlined in the statement of purpose which was kept under review by the provider.

Outcome 3

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

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge was present in the centre on the day of inspection. The inspector found that she was well known to residents and staff. She demonstrated a good knowledge of residents needs and had good organisational skills. She was supported in her role by two clinical nurse managers (CNM's) who deputised in her absence. She demonstrated a commitment to ongoing continuous professional development by attending several relevant study days and there was documentary evidence to support this.

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

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

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

Outcome 6
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

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

The inspector reviewed the centres policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse and the procedures for reporting and investigating an allegation of elder abuse.

The person in charge was responsible for providing training to staff on the prevention, detection and response to elder abuse. There were records to indicate that staff had received training on identifying and responding to elder abuse. Staff

were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the person in charge. Residents spoken to confirmed that they felt safe in the centre.

The management of residents' finances was reviewed in detail at the last inspection in January 2012 and was found to be satisfactory. It was therefore not reviewed at this inspection but will be reviewed on future inspections.

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

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

Action(s) required from previous inspection:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Inspection findings

The inspector found that practices in relation to the health and safety of residents and the management of risk generally promoted the safety of residents, staff and visitors. However, some improvements were required in relation to maintaining accurate and updated care plans for residents who had frequent falls. This had been identified at the last inspection and had not been adequately addressed.

The inspector found that the risk management policy did not adequately cover the system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The inspector reviewed the number of incidents that occurred in the previous months and found that there were several falls with a small number resulting in injury. Two residents in particular were identified as being at very high risk of falls and had sustained several falls. The inspector found that there was no formal plan in place for the monitoring and supervision of these residents and the care plans had not been updated for a year. This was identified as an area for improvement at the last inspection and had not been adequately addressed. Residents were risk assessed for falls and care plans were developed for residents who had a fall, however the care plans were not regularly updated and did not describe the preventative strategies in place to prevent further falls. Incidents forms were completed when a fall occurred and a post falls analysis was completed for residents who had frequent falls. However, this review was not linked to the care plan. The inspector found that there was a variety of procedures and equipment used to prevent falls and reduce injuries from falls such

as hourly checks at night, bed and chair sensor alarms, crash mats, low beds and a medication review by the residents' doctor. The inspector spoke with several staff and all were found to be knowledgeable of falls preventative strategies and neurological observations were carried out for unwitnessed falls. The inspector found that some analysis was being carried out on the timing and location of falls. However, it was not comprehensive enough to find out the root causes for the number of falls.

The inspector reviewed the emergency plan and found that it was sufficient to guide staff on the procedures to follow in the event of an emergency.

The provider had failed to ensure that all reasonable measures were taken to prevent accidents to any person in the designated centre. Although there were records to indicate that staff received training in manual handling, the inspector observed three separate occasions where poor manual handling practices were carried out by staff. This posed a potential risk of injury to both residents and staff.

There was a comprehensive health and safety statement in place which was updated in August 2012 and it related to the health and safety of residents, staff and visitors. There was an overall risk management policy in place with specific risk management issues addressed in the risk register. These included the risks associated with violence and aggression, assault and accidental injuries to residents and staff and residents going missing with the exception of self harm. There was evidence that safety issues were discussed and addressed at regular health and safety meetings.

There was safe floor covering and hand rails throughout the centre. The inspector saw records to indicate that the lift and hoists were recently serviced. The inspector noted that infection control practices were adequate. Wall mounted dispensers containing hand sanitising gel were located at the entrance door and throughout the building. There were several policies developed for infection control to guide staff.

There were inadequate arrangements in place for testing fire equipment at suitable intervals as identified in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The procedures for fire detection and prevention were in place. The inspector reviewed service records which showed that the fire alarm system and fire equipment were regularly serviced. However, the inspector noted that the emergency lighting had not been checked for the previous three years, this was brought to the immediate attention of the provider who addressed it on the days following the inspection. The inspector was also not assured that adequate arrangements were in place for the detection, containing and extinguishing of fires. The inspector requested the provider to review the types of fire extinguishers that should be available in the centre.

The inspector read records which showed that regular inspections of fire exits were carried out. There were training records which confirmed that most staff had attended training on fire prevention and response and fire drills were carried out regularly. However there was one staff member who had not received training and the CNM agreed to address this immediately. The inspector found that staff spoken with were clear about the procedures to follow in the event of a fire. Fire procedures were prominently displayed throughout the centre.

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Overall, the inspector found evidence of good medication management practices with one area for improvement identified.

There was a medication management policy in place which provided guidance to staff; however, the inspector noted that some improvements were required in the medication management policy as it did not address the procedures to follow for medication that required to be crushed and it was not individually prescribed as such.

The inspector found that each resident's medication was reviewed regularly by their general practitioner (GP) and there was documentary evidence to support this.

Although, the inspector observed nursing staff using good practice for administration of medication, there was no evidence of regular audits being carried out to ensure that medications were being administered as prescribed. The CNM agreed that audits had not been carried out in recent months and had plans in place to recommence them.

Medications that required special control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. 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.

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Practice in relation to notifications of incidents was satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of the inspector all relevant incidents had been notified to the Chief Inspector by the person in charge.

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

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

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The healthcare needs of residents appeared to be met. However, significant improvements were required in ensuring that residents' care plans were kept updated to reflect each resident's individual needs.

Residents had good access to medical and allied health professionals. There was documentary evidence of residents being reviewed by medical practitioners, psychiatry of old age and physiotherapy. The person in charge explained that the GP's visited regularly and there was documentary evidence to support this.

The inspector reviewed a sample of residents' care plans and found that they were not kept updated to include all residents' identified needs and residents were not routinely reassessed every three months or when there was a change in the residents' condition. Several of the nursing records were not dated or signed which was not in line with professional guidelines for best practice. There was also some evidence of the involvement of residents and their families in the development and review of their care plans.

There was a record of the residents' health condition and treatment given, completed on a daily basis.

There were a small number of residents with wounds on the day of inspection. The inspector found that there was a wound management policy in place and some of the nursing staff had attended a recent study day on best practice in wound care. There was also access to a wound specialist nurse when required. There were assessments completed for each wound and a treatment plan in place. Specialist pressure relieving equipment was in place for residents where necessary.

The inspector found that residents' weights were recorded each month and the nursing staff monitored any changes such as significant weight loss. Nutritional risk assessments were used to identify residents at risk. Records showed that residents' food was being supplemented where necessary.

The inspector found that there were a number of residents with behaviours that challenged on the day of inspection. Staff were seen responding well to residents with behaviours that challenged. There was also documentary evidence to demonstrate that these residents were being regularly reviewed by Psychiatry of Later Life and a Geriatrician. The inspector found that there was a policy on managing behaviour that challenged in place to guide staff but it was not being carried out in practice. There was inadequate documentation of the triggers to the residents' behaviour and the strategies used to address the behaviour and meet the residents' needs.

The inspector found that improvements were made in reducing the use of restraint since the last inspection. There was a relatively low number of bedrails used and no lap belts. The centres policy on restraint was comprehensive and provided guidance to staff. There was evidence to demonstrate that alternatives to restraint were available and in use.

The inspector found that there were arrangements in place for the provision of meaningful engagement for residents. The inspector found that there were opportunities for residents to participate in activities appropriate to their interests and capacities and records were maintained on the social activities that residents engaged in. The inspector observed residents in communal settings; some were seen engaged in activities such as art, music and reading. There was evidence that

residents engaged in activities such as knitting, crosswords, art, relaxation and music. Residents told the inspector that there were a number of activities for them to partake in during the day.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The inspector found that the centre was safe, clean and warm. As identified in the last report, the inspector found that robust security measures were in place, with a receptionist on duty during the day.

Staff had access to assistive equipment to meet residents' needs, such as hoists, specialised beds, mattresses and chairs.

There were two multi occupancy bedrooms, the inspector found that the provider had plans in place to reduce these bedrooms to twin bedrooms in the coming months and there was documentary evidence to support this. The provider informed the inspector that building work was planned to commence in the coming months.

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

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

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The management of complaints required improvement.The inspector found that the centre's complaints procedure was displayed in a prominent place. However, it did not include the name of the independent appeals person who could be contacted should the complainant be dissatisfied with the outcome of their complaint. The complaints policy failed to identify a person to ensure that all complaints were appropriately responded to and that the person nominated to respond to complaints maintained the records identified in the regulations.

The inspector reviewed a sample of the complaints in the log that was used to record complaints from residents and relatives and found that there were adequate records maintained of complaints detailing the investigation and outcome of the complaint however more information was required on whether or not the complainant was satisfied.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There were no residents receiving end-of-life care on the day of inspection. The inspector found that there were adequate procedures in place to ensure that appropriate end-of-life care could be provided when necessary. There was a policy on end-of-life care and the person in charge explained that they accessed the services of the local palliative care team who provided support and advice. There was documentary evidence of the person in charge receiving training on end-of-life care in 2012.

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

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

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

Action(s) required from previous inspection:

The action required from the previous inspection was not satisfactorily implemented.

Inspection findings

The inspector found that the provider was mostly compliant with issues relating to staff recruitment, training and maintenance of files, however some improvements were required.

The inspector found that staff knew residents well and could describe the care required by and given to residents. The inspector saw staff responding to residents' needs in a respectful manner. Staff told the inspector that they were supported by the person in charge.

The inspector reviewed the roster and found that there appeared to be adequate staffing levels on duty to ensure that residents' needs were met. A total of 5 nurses and ten care assistants were on duty on the day of inspection. However, some residents and a small number of staff told the inspector that there were inadequate numbers of staff on duty. The inspector observed the staff being very busy and call bells were ringing continuously during the day. This was discussed with the provider and person in charge who agreed to continually review the staffing level and skill mix of staff to ensure that residents needs were met at all times.

The inspector examined a sample of the files of staff members and found that one file did not contain all of the information required by the regulations. The inspector reviewed the recruitment policy and found that it detailed the requirements in the regulations.

The inspector found that nursing staff had up to date registration with the Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) 2013.

The inspector carried out interviews with staff members and found that they were knowledgeable of the residents' individual needs, the centre's policies, fire procedures and the guidelines for reporting alleged elder abuse. Additional training had been provided to staff on infection control and food safety.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, and the nurse manager to report on the inspector's findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

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

Report compiled by:

Angela Ring
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

27 February 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Mount Tabor Nursing Home
Centre ID:	0071
Date of inspection:	25 February 2013
Date of response:	14 March 2013

Requirements

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

Theme: Governance, Leadership and Management

Outcome 7: Health and safety and risk management

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

The risk management policy did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

There were inadequate arrangements in place for reviewing and testing fire equipment, at suitable intervals such as emergency lighting.

In relation to manual handling, the provider failed to ensure that all reasonable measures were taken to prevent accidents to any person in the designated centre.

The risk management policy did not adequately address the precautions in place to control the risks associated with self harm.

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

A small number of staff had not received fire training. The inspector was not assured that adequate arrangements were in place for the detecting, containing and extinguishing of fires.	
Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents	
Action required: Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.	
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
Action required: Ensure that the risk management policy covers the precautions in place to control the risks associated with self harm.	
Action required: Provide suitable training for staff in fire prevention.	
Action required: Make adequate arrangements for detecting, containing and extinguishing fires.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will audit and review manual handling practices to ensure continued compliance. This will include ensuring all staff members have attended manual handling training, receive	up to December 2013

refresher courses on Mount Tabor specific equipment, and spot checks are carried by our manual handling instructor	
A programme of improvement for Care Plans has been set in place as outlined in our response to Outcome 11, Action Required. This will include updates following any further incident such as a fall. A falls diary will immediately be updated and following a first fall a falls risk assessment carried out. Evaluations in Care Plans will record any appropriate possible improvements in care which could prevent a similar occurrence. The Care Plan will be updated to reflect this. Recording of supervision for those residents at very high risk of falls will be carried out appropriately.	Completed
A check of falls and adverse incidents is reviewed each Tuesday and discussed at a weekly meeting with the nursing and care staff on duty. Minutes of this meeting are held at the nurses' station for staff to read and sign. The Director of Care carries out a monthly audit to further investigate any adverse events involving residents.	Completed
The Risk Management Policy is also being amended to clarify current procedures in place to investigate and learn from serious or untoward incidents.	17 March 2013
Risk Management Policy has been amended to cover the precautions in place to control the risks associated with self-harm.	Completed
We will review our training records and ensure that all staff have received fire training.	12 April 2012
A full test has been carried out on the emergency lighting system and identified faults rectified. We have commissioned a full re-survey of the building against IS 3217:1989 and IS3217:2008, together with a formal plan for ongoing testing.	30 June 2013
A comprehensive automatic Category L1 fire detection and alarm system is installed and quarterly inspections are recorded on file. Installed fire extinguishing equipment is inspected regularly and certified as conforming with IS291:2002.	Completed

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: There were inadequate written operational policies relating to the prescribing of medication that was crushed.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the prescribing of medication and ensure that staff are familiar with such policies and procedures.

Reference:

Health Act, 2007
Regulation: 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management
Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A policy relating to the prescribing of medication that was crushed has been added to our Medication Management Policy.	Complete

Theme: Effective care and support

Outcome 11: Health and social care needs

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

Resident's care plans were not kept under formal view as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.

Several records were not dated and signed by nursing staff.

The documentation of residents with behaviours that challenged was not in line with the centres policy or evidence-based nursing practice.

Action required:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.

Action required:

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

Action required: Provide a high standard of evidence-based nursing practice.	
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: Individual Care Plans are being rewritten for each resident using a revised document which will allow for clarity with regard to date and time of any update and last review. These were unclear within the previous format. The Care Plans will be updated on a daily basis relating to any change in the resident's condition. This will happen on a three monthly basis if there is no evidence of change. Care Plans will continue to reflect in detail the health and social needs of the resident. As is established practice in Mount Tabor, all Care Plans will be discussed with the resident or their representative, and their input included. This will be done on a phased basis as follows:	
Care Plans will be rewritten and new system of daily updating implemented over this period. We are commencing in this area as residents there have higher levels of dependency.	14 April 2013
There will then be a two week period for staff review and audit, to allow for any fine tuning.	30 April 2013
Care Plans for other residents will then be rewritten and integrated into the new system.	30 June 2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: The complaints policy failed to identify a person to ensure that all complaints are appropriately responded to and that the person nominated to respond to complaints maintains the records identified in the Regulations.

The complaints procedure did not contain an independent appeals process.

There were inadequate records maintained of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An independent person (our CEO) is already available to ensure that all complaints are appropriately responded to in line with regulations 39 (5) and 39 (7) Mount Tabor will identify suitable outside independent persons and document this in our Complaints policy and procedure. Our documentation will also be revised to bring clarity around the investigation and outcome of the complaint, and whether the complainant was satisfied with the resolution.	 Complete 1 June 2013

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect:	
Some staff files did not contain the documents required in Schedule 2 of the Regulations.	
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.	
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: Mount Tabor will undertake an audit of files for staff who have joined in the last six months and use this to identify and rectify any procedural issues.	30 April 2013

Any comments the provider may wish to make[1]:

Provider's response:

Mount Tabor seeks to provide all appropriate care, in accordance with the needs of each resident, in a safe and comfortable environment. We appreciate the support provided to us by the Inspector and the inspection process, and are always open to opportunities for further improvement.

Provider's name: David Reynolds on behalf of MountTabor Ltd
Date: 14 March 2013

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