Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Mount Carmel Community Hospital (Short Stay Beds)
Centre ID:	OSV-0005337
Centre address:	Braemor Park, Churchtown, Dublin 14.
Telephone number:	01 491 8000
Email address:	mountcarmel@mowlamhealthcare.com
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Samantha Rayner
Lead inspector:	Deirdre Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	62
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 July 2016 09:30	05 July 2016 18:30
06 July 2016 09:30	06 July 2016 13:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to follow up on matters arising from a registration inspection that was carried out on the 21 and 22 March 2016 and to monitor progress on the actions required.

As part of the inspection, the inspector met with residents, family and staff members, observed practices and reviewed documentation such as policies and procedures care plans, medical records and fire safety procedures.

The inspector found the provider had made progress to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The designated centre is now registered as per the Health Act 2007 and the registration certificate was displayed in the reception area on the ground floor of the centre.

The inspector found evidence that the provider was implementing the action plan to address the issues identified at the previous inspection. There were improved fire safety procedures in place along with regular staff training and drills. The staff were familiar of the fire safety procedures in place.

There was a new dining room available to residents in one unit of the centre, and the garden had improved access to it. The complaints procedures were prominently displayed throughout the centre, and there was evidence of action taken and detailed records of investigations carried out.

There was an adequate number of staff and skill mix to meet the assessed needs of the residents. A range of training was taking place and scheduled throughout 2016.

However, improvements were still required to be in compliance with the regulations and ensure positive outcomes for the residents. These related to outcomes on: governance, health and social care needs, safeguarding and safety and documentation.

There were 21 actions at the previous inspection that the inspector followed up on. Fifteen of the actions were fully addressed, 2 were in progress and 4 were not completed.

There were 7 actions required at this inspection. The action plan at the end of this report identifies a number of areas where improvements are required to meet the requirement of the regulations and national standards.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is 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.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector reviewed the statement of purpose and function for the centre, which contained the information required as set out in the regulations. The action from the previous inspection had been addressed and the practices in the centre reflected the statement of purpose and function.

The statement of purpose had been reviewed since the last inspection. The admissions criteria for residents requiring short stay care was now implemented in practice. There was a written agreed and signed discharge plan for each resident. The plan was completed in advance of the resident being admitted to the centre and it outlined the proposed transition plan for the resident after their stay. The contracts of care read for a sample of residents included an agreed discharge date.

The statement of purpose outlined the criteria for respite residents to be admitted into the centre.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The provider had made progress to improve the governance and systems in place to ensure the effective delivery of care to residents. However, the system of auditing practice to assess compliance with the regulations and standards and to bring about positive outcomes for residents requires improvement.

The designated centre is operated by the Health Service Executive (HSE). It is now registered as per article 46 (1) of the Health Act 2007. This was a non compliance from the previous inspection and has been addressed. The registration certificate was displayed in the reception area.

There was a clearly defined senior management team that included the person nominated on behalf of the HSE (the provider), the person in charge and a representative of the service provider. The senior management team met every month. There was a standard agenda and minutes of the last meeting read confirmed a range of matters were discussed. The person in charge also presented a report of key performance indicators (KPI) at each meeting for the previous month.

The person in charge held monthly clinical nurse manager meetings, which reviewed the KPIs, incidents and accidents, staffing levels and clinical risk. There were minutes of the meetings on file the most recent meeting was read. There was evidence of actions that had been decided on agreed and these were followed up by the person in charge.

The provider had improved the systems in place to ensure effective governance of the centre. There were regular internal and external audits carried out. The inspector read a number of audit reports that were completed since the last inspection. These included infection and hygiene control, medicines management, health and safety, clinical documentation and care standards. However, improvements were identified as there was limited evidence to show what improvements and change had been brought about to address issues identified. For example, the inspector found evidence of poor outcomes for residents in relation to aspects of healthcare and the care planning that had not been picked up by the audits. These are further discussed in Outcome 11 (health and social care needs).

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found the actions from the previous inspection in relation to the residents guide and the contract of care had been fully addressed.

There was a guide to the centre which was available to all residents and it was on display in the centre. The guide had been updated since the last inspection and it provided information on the complaints procedures including how and to whom to make a complaint.

The inspector reviewed a sample of residents' contracts of care. These now met the requirements of the regulations. Each contract reviewed was agreed and signed by the resident or a representatives if required, on their admission. In addition, a representative of the provider had also signed the document.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector found progress was made in relation to policies and records to be maintained for residents. The actions from the previous inspection were reviewed. The action relating to policies in the centre from was not fully addressed.

There were records of wound care assessments were now maintained for residents. This

was an action from the previous inspection and addressed.

The actions in relation to the falls and nutrition policies were addressed. The action regarding residents' property lists had also been addressed since the last inspection. These documents were reviewed during the inspection.

Another area of improvement was identified. The policy on the management of restrictive practices did not fully guide staff practice. For example, the assessment and monitoring of the use of bedrails in the centre were not included.

There were gaps in the documentation of residents' dietary intake, as identified in Outcome 11 (health and social care needs). A 3 day food charts was not fully completed and it did not guide care.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The actions in relation to the use of restrictive practices in the centre were followed up. There was some progress required to bring about improvement in this area.

It was evident that the National Policy "Towards of Restraint Free Environment" was being implemented in the centre but not comprehensively. The inspector reviewed files of residents' who required bedrails and personal alarms to minimise the risk of wandering. There were regular assessments carried out. However, the alternatives to the use of bedrails were not consistently documented. There was also a policy on the use restrictive practices. But it did not fully guide practice in this area. There were 17 residents who required bedrails but procedures to assess and monitor bedrail usage or monitoring wandering behaviours were not included. The completion of care plans for residents at risk of wandering also required improvement to guide staff practice.

The person in charge told the inspector she regularly reviewed bed rail usage and residents, where possible, were encouraged to remove bedrails. The use of restrictive

practices was mainly in the form of bedrails and monitoring alarms for wandering behaviours.

The inspector reviewed a policy on the management of responsive behaviours which guided staff practice. At the time of inspection a small number of residents presented with responsive behaviours. There were regular assessments completed for residents and care plans were developed to guide the care to be delivered. An area of improvement in relation to the care plans read is outlined in Outcome 11. Staff informed the inspector how they would handle certain situations with residents'. They used evidenced based tools to record incidents when required.

The inspector spoke to a number of residents who said that they felt safe and secure in the centre. Residents stated that they attributed this to the staff who they said they were caring and trustworthy. There was a secure entrance to the centre, with a reception staffed 24 hours a day. A visitor's book was in place.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The actions from the previous inspection were fully addressed. The provider had put adequate arrangements were in place to review fire safety precautions and ensured staff were fully aware of the procedures to be followed in the event of a fire.

The fire safety evacuation procedures had been updated since the last inspection. The revised fire evacuation procedures were also displayed prominently throughout the centre. Since the last inspection fire drills were taking place at regular intervals. There had been eight fire drills to date, with more planned. The records of a sample of drills were read. The records included the length of time, the outcome and any issues that arose during the drill that were to be followed up. The inspector spent time discussing the new procedures with the person in charge who stated they now enhanced the procedures in place to evacuate residents in the event of a fire.

The inspector spoke to members of staff who were knowledgeable of the fire evacuation procedures. Staff informed the inspector they had taken part in the fire drills to practice the new procedures also. The staff had been provided with additional fire safety training on the new procedures. A number of new staff had commenced work recently in the

centre. They were given an overview of the fire evacuation procedures. There was fire safety training scheduled to capture new staff. The next fire safety training was on the 4 August 2016. For agency staff working the centre a fire safety checklist was to be completed and signed that confirmed that they were familiar with the fire evacuation procedures for the centre.

Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits, which had weekly checks, were unobstructed. A weekly fire test of the alarm system took place, with records of the tests maintained.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The action from the previous inspection was fully completed. The inspector found residents were protected by the centre's policies and procedures for medicine management.

The inspector reviewed a sample of completed prescription and administration records with a nurse. The action regarding the crushing of residents' medicines was followed up and it was addressed. The general practitioner (GP) along with the pharmacist reviewed the medicines of residents' recommended to be crushed. There was evidence that the GP individually prescribed the medicines that were to be crushed along with the review.

There were systems in place to review safe medicine management practices. There were internal medicines audits completed. The most recent audit report read from June 2016 was read. It included detailed findings and recommendations from the audits. The pharmacy service also completed audits with the most recent report from April 2016 read.

There was a system in place for monitoring safe medicine management practices. All nurses had completed medicine management training. There was further training scheduled for July and August 2016 for all nursing staff.

Judgment:
Compliant

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

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector followed up on the actions from the previous inspection. While some progress had been made, improvements were still required in the management of residents' assessed healthcare needs and the documentation of care plans. Two actions had not been fully addressed.

Nutrition Management:
There were improvements required in the management of residents nutrition in terms of weight loss. The inspector reviewed the files of residents identified as at risk of weight loss. However, the monitoring of one resident required improvement:
- a three day food chart for the resident was not fully completed for one day and quantities of food not clearly documented in the food charts,
- an oral supplement drink recommended by the dietician was not prescribed,
- the care plan did not provide sufficient guidance for example, the dietician and speech and language therapy recommendations were not updated.

The inspector requested action to be taken in relation to the management of the resident's nutritional needs. The resident was reviewed by a dietician that day, a revised food chart was put in place and the nutritional care plan was updated. This was an action at the previous inspection and was not fully addressed.

Since the last inspection appropriate action had been taken to ensure residents had good access to dietician services. Any resident who had experienced significant weight loss or if they were assessed as risk of malnutrition were being referred to the dietician services. There was documented evidence to confirm the dietician reviews of residents. There was evidence that referrals to the dietician were happening in practice. A nutrition management policy was in place.

Falls Management:
There were improved practices in the management of falls. The falls policy had been updated since the last inspection. It provided clear direction to staff on the post fall procedures. The inspector spoke to a number of staff who were familiar with the falls

policy in place. Records read confirmed where residents fell an accident form was completed. There was evidence that neurological observations were completed for residents if they had a suspected head injury following a fall. However, neurological observations were not completed for one resident following a fall that resulted in a head injury. There was evidence that each was resident was assessed post fall. There were care plans in place. However, one care plan stated a resident was at low risk of falls, although the file reviewed showed they had experienced a number of falls and were assessed as being high risk. The action from the previous inspection had not been fully addressed.

Wound care management:
There was evidence of good practices in relation to wound-care management, with an area of improvement identified. Where a wound occurred, there were assessments completed, photos taken and a care plan was commenced. There was access to tissue viability nursing staff to provide additional support if required. The inspector reviewed the records of two residents' with wounds. There were records in place that charted the progress of each resident's wound. However, the assessments completed for one resident with multiple wounds were unclear and incomplete in order to track their healing. In addition, the wound care plan did not clearly outline the treatment regime or the frequency of the dressing changes for each wound. This was brought the attention of the person in charge who assured the inspector appropriate action would be taken.

Assessment and Care Planning:
There were care plans developed for all residents' where an assessed healthcare need was identified. However, as outlined above some care plans did not consistently guide the care to be delivered. For example, weight loss, wound care, prevention of falls, wandering behaviours and responsive behaviours. These matters were brought to the attention of the person in charge, and prior to the end of the inspection, confirmed that additional training on care planning was to be arranged for the nursing staff. This had been an action at the previous inspection and still required improvement.

There was evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans.

The inspector found each resident was comprehensively assessed on admission to the centre. There were recognised tools used to assess residents' clinical needs including the MUST. Inspectors found residents' information was documented clearly on a daily basis in their nursing notes or within the vital signs records completed on a monthly basis for example, body mass index, weight, blood pressure, temperature.

General Practitioner and Allied Health Services:
Residents healthcare needs were supported by good access to a full time medical officer. There was an out-of-hours GP service was available. There was good access to a range of allied health professionals for example, psychiatry of old age, dietician, chiropody, and speech and language therapist. A full time physiotherapist was employed by the service, and she met the inspector and outlined her role in the centre.

Letters of referrals and appointments were seen on residents' files. The recommendations of allied health professionals were incorporated into care plans, apart

from the area of improvement outlined above.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The action from the previous inspection were addressed. The action related to the provision of dining space in one unit of the centre and access to the garden.

A dining room was provided in the Hazel unit for the residents meals. An unused room had been converted into the dining room. It was nicely decorated and suitably furnished. During the lunchtime meal the inspector visited the residents having their lunch and found there was adequate space provided for the residents who were there at that time. An area at the back of the room was provided to make a small sitting area for the residents to use. The inspector spoke to a number of residents who said they enjoyed going to the dining room for their meals.

The provider had improved accessibility to the garden. A clearly marked and sign posted path led to the garden from the centre, via the car park. A step remained into the grassy part of the garden but, residents could access a paved area adjacent to the garden which was provided with comfortable seating. The person in charge told the inspector that residents would go outside with family members or with staff on request.

Judgment:
Compliant

Outcome 13: Complaints procedures
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.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The three actions in relation to the complaints procedures had been fully addressed. The inspector found the provider taken appropriate action to address complaints management in the centre.

There were policies and procedures in place for the management of complaints that met the requirements of the regulations. The procedure was now displayed throughout the centre, which was an action at the previous inspection and now addressed. There was a nominated person was responsible for investigating complaints and this person's details were reflected in the complaints procedure.

There was a nominated person responsible for ensuring that all complaints were appropriately responded to and that records are maintained. An independent person was available if complainants wished to make an appeal.

The inspector reviewed records of complaints received in the centre. The documentation included details of each complaint, the action taken in response to complaints and how the complaints were resolved. The satisfaction of the complainant with the outcome of the complaint was also recorded.

Verbal complaints were recorded electronically by staff and were then reviewed by the complaints officer. This was also an action from the previous inspection and now addressed. The policy in the centre was to resolve complaints locally with reports maintained of when they were actioned.

The inspector spoke to various residents and staff members, and found that they were aware of the complaints procedure. This had been an action at the previous inspection and was addressed.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The action from the previous inspection were addressed regarding the range of training available to staff working in the centre. The provider ensured there was an adequate staff number and skill mix to meet the assessed needs of residents in the centre.

The action from the previous inspection regarding the provision of training for staff to meet the assessed needs of residents. The inspector discussed the training with the person in charge. The training to date included dysphagia and falls prevention. There were training dates scheduled for wound-care, nutrition and hydration and care planning. The person in charge said she anticipated this would improve staff knowledge of the policies and practices in this area.

An examination of the training records demonstrated staff had access to on-going mandatory training and other training pertinent to the needs of the resident population. All staff had up-to-date training in fire safety management, and the prevention, detection and reporting of abuse. There were regular dates planned for this training throughout the year to capture new staff and staff who required refresher courses.

The inspector reviewed an actual and planned staff roster for the centre and from observation was satisfied a sufficient number and suitable skill mix of staff on duty. Depending on the days of the week, between 4 to 5 nurses were on duty from 8am until 8pm each day. The person in charge and an assistant director of nursing (ADON) were supernumerary and available Monday to Friday. There were up to 9 health care assistants on duty from 8am to 8pm. There were 4 healthcare assistants and 3 nurses on duty overnight from 8pm. There was no evidence of nursing staff working 2 consecutive shifts to cover staff shortages which was an issue at the previous inspection. There was evidence of regular review of staffing levels.

The person in charge said they were recruiting new nursing staff and a number of nurses had recently commenced work in the centre. On the day of the inspection, two nurses had started their induction programme. An additional clinical nurse manager was on duty to facilitate their induction. The inspector met one new nurse who had recently been recruited. The nurse was familiar with the residents and key operational policies. The person in charge told the inspector that when new staff commenced in the centre, they were scheduled to attend mandatory training such as fire safety training and prevention of abuse training as set out on the training calendar.

A number of agency staff were required to fill in some nursing and health care staff shifts. A service level agreement was in place with the agency that confirmed the documentation required by the regulations was in place for each staff.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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[1]

Centre name:	Mount Carmel Community Hospital (Short Stay Beds)
Centre ID:	OSV-0005337
Date of inspection:	05/07/2016
Date of response:	19/08/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place to ensure care was continuously and monitored were not fully effective for example, how to bring about improvement or changes in the care delivered to residents.

1. Action Required:

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

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
There are now systems in place to ensure that care is continuously and effectively monitored. Care plans are regularly reviewed according as the needs of patients change. All changes in the plan of care for each patient are documented. Clinical documentation audits are undertaken on a monthly basis and they include action plans to address areas requiring improvement.

Proposed Timescale: 10/08/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The restrictive management practices policy did not fully guide practice.

2. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The PIC has reviewed the clinical documentation of restraint for patients who require bedrails and has ensured that the assessment and monitoring of the use of bedrails is appropriately documented in accordance with the National Policy on the use of restraint. In conjunction with the ADON and CNMs, the PIC will ensure that clinical documentation on restraint consistently guides staff practice in relation to the use of bedrails and that there is sufficient documentation in place to demonstrate that restraint is a measure of last resort, used only after other alternatives have been explored and that a full assessment is documented for each patient.

The documentation of dietary intake has been reviewed for all patients at risk of weight loss. The care plans guide staff in monitoring nutritional intake and outline appropriate interventions in the event of poor nutritional intake or weight loss. The procedure on management of nutrition has also been updated to guide staff about when to commence appropriate interventions following assessment of patients at risk of weight loss. This includes the requirement to complete a 3 day chart recording all intake and output; referral to dietician and/or doctor, and the need to document decisions regarding individual residents following weekly MDT meetings. Nursing and care staff have been educated by the CNMs on how to accurately record intake and output and the CNMs are responsible for ensuring that documentation is completed accordingly.

during handovers, mid-day reporting and compliance with highlighted on the CNM The PIC will ensure that staff are aware of all patients at risk of weight loss; this will be documented on each patient's care plan and will be discussed and reviewed at handover and multi-disciplinary team meetings.

Proposed Timescale: 10/08/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The completion of nutritional food charts for residents requires improvement.

3. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
A review of all patients at risk of weight loss has been undertaken. Food charts are in place and completed fully for patients whose nutritional intake requires close monitoring. The food charts are completed as part of the plan of care to inform and guide staff about appropriate interventions to be followed for those at risk of weight loss.

Proposed Timescale: 10/08/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The alternatives to the use of bedrails were not consistently documented or otherwise evidenced.

4. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
As previously outlined under Outcome 5, the use of bedrails is assessed on an individual basis in accordance with the national policy on the use of restraint. The centre's policy on the use of restraint is in accordance with the national policy. The centre is working towards a restraint-free environment and there a reduction in the number of bedrails in use. This has been a challenge for staff because the majority of patients admitted to the centre have been transferred directly from the acute setting where and they have

been accustomed to having bedrails on their hospital beds, so some patients and their families are reluctant to considering alternatives to bedrails.

There is now documented evidence that alternatives to the use of bedrails are being explored as part of each patient's assessment. The centre is seeking to use 'grab-rails' as an alternative to bedrails for those patients who wish to use the bedrail to assist them in changing position in bed. A number of grab-rails have been ordered and it is expected that they will be introduced as an alternative by mid-August 2016.

The care plans of patients who have a tendency to wander have been reviewed and they now fully guide practice.

Proposed Timescale: 31/08/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not revised or updated as residents assessed care needs changed.

Care plans did not fully guide the care to be delivered e.g. weight loss, wound care, prevention of falls, wandering behaviours and responsive behaviours.

Care plans were not updated with the most up-to-date recommendations from allied health services e.g, dietician and speech and language therapy.

5. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
All care plans are revised as the assessed needs of patients change and at a minimum every 4 months for any longer term patients. A comprehensive review of all care plans is being undertaken to ensure that they fully guide the care to be delivered. This review will be completed by the 30th September 2016. The PIC will ensure ongoing compliance with expected standards of clinical documentation.

Nutrition Management: The PIC will ensure that all nursing and care staff are aware of the procedures to be followed for all patients at risk of weight loss. This includes instruction on how to accurately complete a 3 day food chart, documentation of referral to dietician, documenting dietician's recommendations in the patients' care plan. The PIC will monitor compliance with clinical documentation procedures in conjunction with the ADON and CNMs The PIC will ensure that the Resident Medical Officer's recommendations are also documented in the patients' care plan.

All care plans will include up to date recommendations from allied health professionals where appropriate.

Falls Management:
The PIC will ensure that all nursing staff are fully aware of the correct procedures to be followed in the event of an unwitnessed fall or suspected head injury, including the completion of neurological observations and documenting rationale on discontinuation of observations. Adherence to the correct procedures will be closely monitored by the POC, ADON and CNMs via a weekly falls summary report.

Wound Management:
The PIC will ensure that all nursing staff are instructed in the correct and appropriate documentation of wound reassessments completed after each dressing change. This will be done as part of staff induction and through regular in service training and education. In the event that a patient has more than one wound or dressing type, the PIC will ensure that nursing staff are aware of their responsibility to provide clear and concise documentation with reference to dressing regime of each wound. Further dates have been scheduled for staff education sessions on pressure area care and wound management.

Proposed Timescale: 30/09/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of residents healthcare needs requires improvement for example, wound care management, weight loss and falls prevention.

6. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
A nursing assessment of patients' care needs is undertaken prior to admission and on admission; the multi-disciplinary team undertakes a review of the care needs of patients on a weekly basis and as required. The PIC will ensure that there is a consistent focus on all healthcare needs to ensure that all patients receive a high quality of care.

The PIC has scheduled care plan workshop sessions for all staff nurses and there will be a review of 2 nursing care plans each week to ensure that a consistently high standard of clinical documentation is in place.

Proposed Timescale: 30/09/2016