

**Health Information and Quality Authority
Regulation Directorate**

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



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):	Gearoid Harrahill;Sheila McKevitt
Type of inspection	Announced
Number of residents on the date of inspection:	58
Number of vacancies on the date of inspection:	7

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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 March 2016 09:30	21 March 2016 18:30
22 March 2016 08:00	22 March 2016 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The provider had applied for registration for 65 places. This report sets out the findings of the inspection. As part of the inspection, inspectors met with residents', relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

People attending this service were referred to as patients by staff and in all of the documentation in the centre, but they are referred to as residents in the report.

Inspectors found that there were a number of areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The provider and person in charge were required to take immediate action to address fire safety risk and an aspect of residents healthcare needs.

Mount Carmel Community Hospital (Short Stay Beds) occupies the first two floors of a four storey building. The building is located in a suburban area. The service provides short term convalescent and respite service with an average length of stay of one month. The main aim of the care provided is to focus on the recovery of residents' post surgery and maximise their potential in order for them to return home.

The Health Service Executive (HSE) are the provider and have been operating the centre since April 2015. The Health Information and Quality Authority (HIQA) issued letters to the provider in July and August 2015 regarding its operation without being registered under the Health Act 2007. A submission was made by the provider that this centre was not a designated centre due to its exclusive provision of short term care. A meeting was held with the provider in September of 2015 in relation to the definition of designated centre and the operation and registration of the centre under the Health Act. Following the meeting, the HSE applied to register with HIQA in December 2015. The registration inspection took place on the 21 and 22 March 2016.

The HSE have a service contract with an organisation who operates the centre on their behalf. Inspectors met the person nominated on behalf of the HSE and the director of service of the service operator during the inspection.

Inspectors also met the person in charge of the centre who was new to the role since the end of January 2016. She was responsible for the overall daily operation of the centre including the coordination and administration of the centre. There have been approximately 450 admissions since the centre opened. Overall there was a commitment to meeting the requirements in the regulations and standards. The management systems in place did not ensure that services provided are safe, appropriate to residents needs, consistent and effectively monitored.

The areas for improvement are outlined in the body of the report and the action plan at the end. The improvements included:

- health care needs
- care planning
- statement of purpose and Residents' Guide
- fire safety measures

- staff knowledge of fire safety procedures
- policies and procedures
- contract of care for each resident
- the system for reviewing the quality and safety of care
- complaints management
- aspects of the premises.

There were 16 breaches of the legislation which are the responsibility of the provider and five breaches of legislation for which the person in charge is responsible.

A meeting was scheduled with the provider on 6 April 2016.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the practice does not reflect the statement of purpose and function.

The statement of purpose outlined admissions criteria for residents requiring short stay care. However, it was not fully implemented in practice. For example, discharge plans were not fully completed or made in agreement with residents, there was no agreed discharge date with residents and there were unclear transition plans for residents after their stay. Some residents had exceeded the maximum three month stay in the centre. For example, eight residents' remained in the centre for more than three months.

The admissions criteria did not include the procedures for admitting persons for respite care or for physiotherapy/convalescence care.

The statement of purpose contained all of the information as required by the regulations. A copy was available to all residents and it was displayed in the three units of the centre.

Judgment:

Non Compliant - Moderate

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:

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found there was a clearly defined management structure in the centre. However, there was insufficient governance to ensure the effective delivery of care to residents in the centre. Furthermore, the systems in place to review the quality and safety of care provided to residents living in the centre required improvement.

The centre is operated by the HSE. A service operations contact was in place with a company who operated the centre on behalf of the HSE. However, the provider had failed to apply to register the centre in advance of it opening which is a breach of article 46 (1) of the Health Act 2007. Following a meeting with the provider in September 2015 an application was received by HIQA to register the centre.

There was a clearly defined senior management team that included a representative of the provider (the provider), representatives of the operating company and the person in charge. There were arrangements in place for all senior management to meet and clear lines of authority and accountability of their roles were in place. The provider was based in the centre one day a week. The person in charge met the provider on a weekly basis. In addition, the person in charge met a representative of the operating company on a weekly basis also. There were formal monitoring meetings of the operation of the centre on a monthly basis. These were attended by with the provider, representative of the operating company and person in charge. However, inspectors found that the governance and management arrangements did not provide an adequate level of supervision of care and practice in order for the centre to be in compliance with the regulations. This is supported in the findings of this inspection as described in Outcomes 8 (health and safety), 11 (health and social care needs) and 18 (workforce). The provider submitted an action plan after the inspection that outlined the improvements they would bring about to come into compliance (this is discussed further under these outcomes).

There were systems in place to ensure the service provided to residents was effectively monitored. However, these required improvement. There had been two clinical governance meetings since the centre opened, in May and December 2015. There were weekly key performance indicators gathered, and records of these were seen, and included clinical risks involving residents'. Inspectors were informed that clinical risks were discussed or escalated internally. A weekly audit report was presented and reviewed at the monthly meeting held between the service provider and the HSE management team. Inspectors read audits on falls, pressure ulcers, restraint, complaints, weight loss and medication audits. However, the audit process had not picked up on issues regarding weight loss and falls as identified by inspectors and outlined in the report

The provider had developed an annual report on the overall review of the safety and quality of care of residents as required by the regulations.

Judgment:
Non Compliant - Major

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors noted that a guide to the centre was available to residents and on display in the centre. However, the guide did not provide information on the complaints procedure for example, how or whom to make a complaint.

Inspectors found a copy of a contract of care on residents' files. However, it had yet to be agreed and signed by some residents or their representatives. It was not evident in some contracts that the provider had signed the document.

The document met the requirements of the regulations and included details of the services to be provided and any the fees to be charged.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors were satisfied that the centre was managed full time by a registered nurse with experience in the care of older people. Overall, this outcome is compliant however, where improvements were identified, they are actioned under the outcomes referred to below.

The centre is managed by a suitably qualified and experienced person in charge. Inspectors found there were some gaps in their knowledge of the relevant legislation and her responsibilities therein, as evidenced and reported on in the following areas: display of fire safety procedures (outcome 8) and aspects of residents' health care needs (outcome 11). These matters were discussed with the person in charge and the provider, who assured inspectors that action would be carried out to address the issues.

The person in charge was new to the role since January 2016. She was interviewed during the inspection. She informed inspectors that she was familiarising herself with the residents and their health and social care needs. She acknowledged more time was required to get to know the residents in the centre. She held monthly clinical nurse manager meetings at which clinical issues needs were discussed in detail.

The person in charge had post graduate management qualifications. She also continued her own professional development through attendance completion of courses in dementia care and leadership; various training days, seminars and talks. She had completed all mandatory training.

The residents were able to identify the person in charge to inspectors.

She was supported in her role by an assistant director of nursing (ADON), who deputised in her absence.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found most of the documents required to be maintained in the centre as outlined in Schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval. However, improvements were

required in relation to the documentation required to be maintained for residents, policies, and the documenting residents' personal property.

Some gaps were identified in the records required to be kept in the centre for each resident. For example, inspectors found some residents had no record of the treatment provided for wound care, this is discussed in Outcome 11.

All policies and procedures were in place as required by schedule 5 of the regulations. Inspectors found most policies were up-to-date. However, some policies did not fully guide practice. For example, the policy on the prevention of falls and the policy on the management residents nutrition and hydration. This is detailed under Outcome 11. The policies were not centre specific with gaps or no name stated where the centre name should appear.

There was no record of residents' property held on their behalf in the centre.

There was a hard copy directory of residents' seen which contained the information required by the regulations.

An up-to-date insurance policy was in place for the centre which included cover for residents' personal property.

Judgment:

Non Compliant - Moderate

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Inspectors were satisfied the provider had adequate arrangements in place should the person in charge take leave requiring notification to HIQA.

There were formal measures in place in the event of any such absence. An ADON deputised for the person in charge in her absence.

Judgment:

Compliant

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found there were systems in place to promote the safeguarding of residents and protect them from the risk of abuse. However, improvements were required around the use of restrictive procedures.

Inspectors found the management of restrictive practices in the centre required improvement. A policy was in place however, it was not comprehensive enough to guide staff practice. For example, it did not make reference or incorporate the principals of the National Policy 2011 "Towards a Restraint Free Environment". The implementation of the policy required improvement. Of the 58 residents' in the centre 26 were using bedrails.

Inspectors found the use of restrictive practices related primarily to the use of bedrails and monitoring residents with wandering behaviours. Inspectors reviewed some files for residents who had bedrails. There were records of bedrail assessments however, there was inconsistent evidence of the alternatives considered and if residents' had been consulted with.

The residents who required restrictions due to their wandering behaviours had no corresponding care plan developed to guide staff practice (this is further discussed in outcome 11). These matters were also discussed in detail with the provider and the person in charge. Inspectors saw staff dealing with all residents in a calm and dignified manner, where there were incidents of responsive behaviours read, these were noted in the documentation. There was evidence of psychiatry of older age specialist input when required.

The centre was guided by a policy on the protection of vulnerable adults. The policy guided practice and referenced the national HSE policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" 2014.

All staff had completed training in the protection of vulnerable adults. Records read confirmed staff had completed training. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. She was aware of the requirement to notify any such allegation to HIQA. While no allegations of abuse had been notified prior to the

inspection, the person in charge outlined the procedures that would be followed as per the policy. A number of residents told inspectors that they 'felt safe' and secure in the centre, and attributed it to the friendly staff who worked in the centre.

There are systems in place for safeguarding residents' money. The processes were reviewed by inspectors who found suitable arrangements were in place.

A visitor's book was maintained and all visitors to the centre were required to sign in and out of the centre. There was a person assigned to the main reception at the entrance over a 24 hours period.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors were not satisfied that adequate arrangements were in place to review fire safety precautions and ensure staff were fully aware of the procedures to be followed in the event of a fire.

The systems in place to respond to a fire alarm and staff knowledge of the evacuation procedures required improvement. The centre is located over two stories of a four story building. Inspectors discussed fire evacuation procedures with staff and how they would respond if the fire alarm went off on their floor. However, some staff were not fully aware of the procedures. For example, who was in charge, who was responsible for calling the fire brigade or how to safely evacuate the building. The fire evacuation procedures stated a designated person was appointed as fire marshal. However, most of the staff were not aware of this. Furthermore, the procedures were not displayed throughout the centre.

Fire drills had not taken place at suitable intervals to ensure staff were aware of the procedures in place. There had been one fire drill since the centre opened. It took place in March 2016. The records of the drill outlined the findings of the inspection and outcomes reflected some of the inspectors' findings. The person in charge told inspectors they had discussed the findings of the drill with staff who had taken part in it and would increase drills however, the findings from the drill had yet to be shared and discussed with all staff.

There was information on the back of residents' doors that indicated if a resident was ambulant or non ambulant. However, there was no other information on the level of assistance required in the event of a fire was provided. Staff were not fully aware how non ambulant residents would be assisted in the event of a fire for example, inspectors were told that they would use the bed or ski sheet to move residents, some staff told inspectors they were trained in the use of ski sheets but had been told not to use them.

All of the above matters were brought to the attention of the provider and the person in charge, and immediate action was required to be taken. Following the inspection a satisfactory action plan was submitted to HIQA. It included updated procedures, additional training and increased fire drills to be carried out. The revised procedures to follow in the event of a fire would be displayed in the building.

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. Inspectors read training records which confirmed that all staff had attended training within the last year.

A safety statement was seen by inspectors. There were risk management policies in place that met the requirements of the regulations. An electronic risk register was seen by inspectors. Risks were identified, evaluated and had controls in place for mitigation.

Inspectors observed residents being encouraged by staff to be actively mobile and were seen being escorted around the centre. A physiotherapist was based full time in the centre. The staff had completed up-to-date training in the movement and handling of residents. There was safe floor covering and handrails throughout the centre which was over one floor.

An emergency plan that guided practice was in place, which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency.

Inspectors found measures and policies were in place to control and prevent infection. Staff were observed to follow best practice. There was access to supplies of gloves and disposable aprons. Staff were observed using the alcohol hand gels which were available throughout the centre.

Judgment:
Non Compliant - Major

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found residents were protected by the designated centre's policies and procedures for medicine management. However, areas of improvement were identified.

Overall, nurses were observed to administer the prescribed medicines for each resident in line with professional guidelines. Nurses were provided with protected time during each medicine rounds and wore an apron that highlighted to other staff what that they were not to be disturbed. However, the administration of crushed medicines required improvement. Inspectors found medicines were crushed without being individually prescribed. This would be breach of the policy and professional guidelines.

There was a system in place for monitoring safe medicine practices. All nurses had completed medicine management training. They completed an online course on an annual basis.

Medicines that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked a sample of balances and found them to be correct

All medicines were securely stored in a locked room in a locked medicine trolley. A secure fridge was provided for medicines that required specific temperature control. Inspectors noted that the temperatures were within acceptable limits at the time of inspection.

There were appropriate procedures for the handling and disposal of unused and out-of-date medicines.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Overall, practice in relation to notifications of incidents was satisfactory.

The person in charge was aware of the legal requirement to notify the HIQA regarding incidents and accidents. To date and to the knowledge of the inspector, all relevant incidents had been notified to the HIQA by the person in charge.

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):
This was the centre's first inspection by the Authority.

Findings:

Inspectors found improvements were required to ensure residents healthcare needs was maintained by a high standard of nursing care, with improvements also required in relation to aspects of falls management, assessing and responding to unintended weight loss and access the care planning process. Documentation of clinical practice was deficient in respect of monitoring of weights and falls, and wound management for example.

Weight loss:

Inspectors found weight loss in the centre was not appropriately monitored and addressed. There was a policy on the management of nutrition however; it did not fully guide staff practice. For example, the policy did not include the procedures for when to refer residents at risk of malnutrition or weight loss to allied health professionals such as the dietician services. Inspectors reviewed the files of one resident who had experienced a 25% weight loss in a three month period. The resident had been weighed once on admission, but not since then or after admission following a stay in hospital. While the resident had been put on a three day food and fluid chart, they had yet to be seen by the medical officer or referred to a dietician. Inspectors requested that immediate action be taken and to provide an update to HIQA. Before the end of the inspection the resident had been reviewed by the medical officer and a referral made to the dietician. The person in charge submitted an action plan after the inspection that provided assurances on the overall management and monitoring of weight loss in the centre.

Falls prevention:

Inspectors found the management of falls required improvement. Inspectors found where residents fell, they were assessed by a physiotherapist and a falls assessment

was carried out. The majority of falls in the centre were un-witnessed. However, the completion of neurological observation required improvement. Inspectors found that records were not fully completed in line with best practice guidelines.

The residents' care plans were not consistently updated post fall and did not contain detailed information on how to prevent similar falls recurring. It was not clear how many falls a resident had as no falls diary was maintained. This was discussed with the person in charge who undertook to address the matter the day of the inspection.

Wound care:

Several of the residents had recent orthopaedic or cardiac surgery, therefore wound management was a key element of the care. Respite was also provided to residents who had reduced mobility and may have been at risk of developing a pressure sore. However, wound charts had not been fully completed for residents with wounds. See Outcome 5 (documentation).

Inspectors also noted that the wound dressing was changed frequently, while nurses said they decided the dressing required based on their judgement. The dressing changes were documented in nursing progress notes. However, there were no care plans to guide care, such as the frequency of the change of dressing or the type of dressing required.

Assessment and care planning:

An electronic system of care planning was used and a sample of residents' files was reviewed. The clinical needs of residents were assessed using recognised tools. Inspectors found care plans were in place for most residents identified healthcare needs. However, they were not consistently developed for the management of weight loss and the prevention of falls. Some care plans were not updated after a change in condition, for example, significant weight loss or after a fall. Care plans were not developed for all residents identified healthcare needs for example, the management of wandering behaviours and the use of bedrails.

There was some evidence of consultation with residents or their loved ones. However, this was inconsistent and not evident on all residents' files. There was no system of auditing or reviewing the care plan process to identify what gaps existed in the care planning process. These matters were brought to the attention of the person in charge.

There was good access to the services of medical professionals. A medical officer worked and was based full time in the centre. Inspectors met the medical officer during the inspection. A physiotherapist and occupational therapist were employed in the centre to provide valuable care to residents. There was evidence of referrals and follow up appointments with chiropody, speech and language therapy and dietician services, apart from the dietician referral above.

Inspectors found there were meaningful social activities in place on a group and individual basis. An activities coordinator was present in the centre on the inspection day. She was supported by a second activities coordinator on some days of the week. There was an activities programme and this was discussed with the activities coordinator. There was a good range of interesting things for residents to take part in if

they chose to. In addition, there was lots of one to one time with the residents who preferred not to take part in group activities.

Judgment:
Non Compliant - Major

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):
This was the centre's first inspection by the Authority.

Findings:

Overall, the physical environment in the centre was in line with the statement of purpose and the assessed needs of all residents. However, improvements were identified in terms of dining space and access to the garden.

There were two four-bedded rooms and nine three-bedded rooms, which are suitable for the short term convalescent resident. Inspectors observed that screening was appropriate in these bedrooms. Inspectors were invited by some residents to see their bedrooms. Despite the centre being for short stay care, the residents could personalise their bedroom with their personal possessions. A number of residents had been in the centre for longer than three months. Inspectors were informed residents occupying rooms for this length of time were provided with a single bedroom.

The centre is divided into three units over two floors: Maple, Cedar and Hazel units. The units are interconnected by lift and stairs that were accessible via the main entrance. There were a number of communal areas for residents to sit in, with a sitting room and dining room provided in two units. However, there was no dining room in the Hazel unit. Residents were required to have their meals by their beds in this unit. This was discussed with the provider.

There was a nicely landscaped garden area provided. However, the garden was not fully accessible to all residents. For example, there were steps into the garden and residents would have to cross a car park to access the garden.

The centre was clean, comfortable, welcoming and well maintained both internally and externally. Inspectors found that the communal spaces and bedrooms were homely in design, décor and furnishings and this was also frequently mentioned by residents and

their relatives. There were a sufficient number of bathroom and toilets for residents. In addition, there were an adequate number of assisted baths provided.

There were handrails and safe floor covering throughout the centre. Inspectors viewed the servicing and maintenance records for equipment such as hoists and found they were up-to-date.

The kitchen was found to be well equipped. Inspectors observed there was plentiful supply of fresh food was provided.

There were sluice rooms with mechanical sluicing facilities available throughout the centre to ensure that best practice in infection control could be adhered to if there was an outbreak of infectious disease.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found the management of complaints required improvement.

While there was a complaints procedure on display in the centre it did not provide sufficient detail to guide practice or reflect the complaint's policy. For example, the complaints officer and the nominated person were not named.

Relatives and residents' who spoke with inspectors were not aware of a procedure if they wished to make a complaint. Inspectors were informed during the inspection of a number of complaints, which had not been documented or investigated. These were brought to the provider's attention and an investigation requested to be carried out as per their policy. The results of the investigation were requested to be submitted to the HIQA on completion.

Complaints and feedback from residents were viewed positively by the provider and the person in charge. A complaints log was maintained and inspectors found that it contained details of the complaints and the action taken to respond to the complaint. The satisfaction with the complaint was recorded. However, verbal complaints were not documented in the centre. Therefore any issues that occurred at unit level and resolved

locally could not be trended.

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care

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.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Inspectors were satisfied that end-of-life policies and procedures were in place. There were systems in place to record residents' wishes and preferences.

An end-of-life policy reviewed provided guidance to staff. Inspectors were informed that no residents were approaching end of life on the day of inspection.

There was access to the local palliative care team who provided support and advice when required.

There were a number of private areas and meeting rooms available for relatives and friends for privacy if required. An oratory was available if families wished to use it.

Staff and residents would be discreetly informed if a resident passed away.

Judgment:
Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found each resident was provided with food and drinks at times and in quantities adequate for his/her needs.

Food was properly prepared, cooked and served, and looked wholesome and nutritious. Inspectors spent time in the dining rooms of two units during the lunch time meal. It was a calm, sociable time for residents. The rooms were maintained to a good degree of cleanliness. Where required, residents were discreetly and patiently assisted by staff. The menu was displayed on the wall and on each table.

A nurse was present to oversee the mealtime and the provision of modified consistency diets for residents. The dining experience was pleasant. Tables were nicely laid and meals were appetisingly presented. Residents told inspectors they enjoyed the meal and there was a range of choice available.

Inspectors visited the kitchen and noticed that it was well organised and had a plentiful supply of fresh and frozen food which was stored appropriately. The chef on duty discussed the special dietary requirements of individual resident's and information on residents' dietary needs and preferences. He told inspectors that he met with residents to discuss their preferences and also got information from the staff.

Where dietary recommendations had been made by specialist services in the past, these were documented and found to be followed by the staff.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The privacy of residents was maintained. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. Inspectors observed staff interacting with residents in a friendly and courteous manner.

Due to the short term nature of the service, there was no residents' committee established. This was discussed with the provider and person in charge who advised inspectors they would examine improving this for residents who resided in the centre for longer than three months.

The religious needs of residents were met. An oratory was available in the centre that residents could visit at any time.

There was a visitors policy displayed in reception which indicated restricted visiting times were in operation. The person in charge explained the rationale for restricting visiting rights to residents and it operating only at mealtimes. She assured inspectors visitors were welcome to visit loved ones at any time and a review of the policy would be carried out.

There were two activity coordinators who facilitated a range of activities in the centre. Inspectors met one activities coordinator who outlined the role she played. Inspectors observed her spending one to one time with residents and carrying out group activities. Most of the residents said there were interesting things to do during the day and were aware of what activities were available to them in the centre. Some residents stated they enjoyed attending the group activities. A hairdresser visited the centre weekly.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Residents could have their laundry attended to within the centre. As residents were in for short term care their clothes were laundered at home. A small number of residents could avail of the laundry service.

A fully fitted laundry room was available in the centre.

Residents had access to a locked space in their bedroom if they wished to store their belongings.

There was no residents' property list maintained (this is discussed in Outcome 5).

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there was a very committed staff team with low turnover. Staff told inspectors they felt well supported by the person in charge. Improvements were identified in the provision of training and the provision of qualified staff working in the centre.

Inspectors found that the nursing staff levels at certain times of the week were not sufficient to meet the assessed needs of the residents. Staff reported that on some occasions, there were inadequate levels of nursing staff on duty. On two occasions nursing staff were required to work two consecutive shifts due to staff shortages. The roster read confirmed this information and the person in charge also confirmed it had occurred. She assured inspectors action was being taken to address the deficits in the staff levels. There had been additional staff recruited to address the nursing staff shortages. The person in charge was satisfied a sufficient number of staff was now available to cover unplanned leave of staff.

Inspectors noted that there were satisfactory nursing levels and skill mix on duty on the days of the inspection.

A sample of staff files was examined and the documents required to be in place as per Schedule 2 of the regulations were maintained.

Inspectors reviewed all files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2016.

There were no volunteers in the centre. A policy was in place should volunteers apply to work in the centre.

Training records outlined the training for all staff. Records showed that mandatory training was provided to all staff. There was a system to identify those who had received any training and any deficit. All health care assistants have level 5 further education and training awards council (FETAC) qualifications.

There was evidence of other training to meet residents assessed needs such as infection control and behaviours that challenge. However, staff had not received training in wound care, falls management, nutrition or dysphagia to provide care to residents.

Judgment:

Non Compliant - Moderate

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



Provider's response to inspection report¹

Centre name:	Mount Carmel Community Hospital (Short Stay Beds)
Centre ID:	OSV-0005337
Date of inspection:	21/03/2016
Date of response:	20/04/2016

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 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

Practice in the admission of residents to the centre do not reflect the statement of purpose.

The admissions criteria does not include respite admissions.

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

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose contains the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The admission criteria have now been amended to include respite admissions.

The patient admission assessments and discharge plans now reflect the statement of purpose more accurately.

Proposed Timescale: 08/04/2016

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 provider had failed to apply to register the designated centre prior to its opening in April 2015.

2. Action Required:

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015

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

The centre was not originally intended to operate as a designated centre. Following discussions between HSE and the Authority in September 2015, an application was made to register as a designated centre under Regulation 4 of the Health Act 2007 (Registration of Centres for Older People) Regulations 2015. The registration application was submitted in December 2015.

Proposed Timescale: 20/04/2016

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.

3. Action Required:

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 comprehensive and robust systems in place for reviewing and monitoring care in order to bring about improvements or changes in the care delivered to patients.

These include:

- All patients undergo a pre-admission assessment.
- Clinical assessments are carried out on admission to determine the dependency and care needs of each individual patient and a care plan is developed on that basis.
- Care plans are reviewed and updated as care needs change and/or at a minimum of 4 monthly intervals.
- Risk assessments are undertaken where physical or environmental factors may affect care and actions are taken to reduce or eliminate such risks.
- Care standards are reviewed on a quarterly basis through a system of internal audit; action plans are developed to address non-compliances.
- A review of quality and governance is undertaken twice yearly to ensure that care and services to patients are of an optimum standard and that improvements have been identified and implemented where required. Patients are consulted and informed of all service developments in the centre.

The PIC will continue to ensure that the systems in place are monitored and reviewed regularly in order to provide safe, appropriate and consistent care to patients.

Proposed Timescale: 30/04/2016

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The guide to the centre does not include a summary of the complaints procedures.

4. Action Required:

Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

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

The Information Guide has been updated to include a summary of the complaints procedures.

Proposed Timescale: 20/04/2016

Theme:

Governance, Leadership and Management

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

Some contracts of care reviewed were not agreed and signed by residents'.

5. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

All patients admitted to the centre have been issued with a contract care and a system is in place to ensure that all contracts of care will be agreed and signed by patients.

Proposed Timescale: 30/04/2016

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:

Policies did not consistently guide staff practice e.g. the prevention of falls and management of nutrition policies.

The policies were not centre specific and contained reference to other centres.

6. 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 Schedule 5 policies are in place and they contain appropriate information to guide staff in line with best practice. The PIC and CNMs monitor staff compliance and will continue to ensure that policies consistently guide practice, including evidence-based clinical risk assessments and care plans regarding falls prevention and management and the management of patient nutrition. All policies in the centre are now site specific. The policies on falls prevention and nutrition and hydration have been re-issued to staff and they will confirm that they have read and understand the policies, which will assist them in consistently applying the principles to practice.

Proposed Timescale: 30/04/2016

Theme:

Governance, Leadership and Management

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

Records of residents personal property were not maintained.

7. 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 record of patients' personal property is now in place for all patients in the centre.

Proposed Timescale: 30/04/2016

Theme:

Governance, Leadership and Management

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

There were some gaps in the wound care records required to be kept for residents'.

8. 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:

There are appropriate wound care assessments and care plans in place for all patients for whom this is required. The PIC and ADON will ensure that the records are updated and reviewed as required and that they accurately reflect the care needs of the patients.

Proposed Timescale: 20/04/2016

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:

Practices in the management of restraint were not in line with the National Policy

There was inconsistent evidence that all forms of restrictive practices were regularly assessed, reviewed and alternatives considered.

There was lack of consultation with all residents in the use of restrictive practices.

9. 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:

The policy on restraint has been updated and is in accordance with the National Guidelines on Restraint. This policy has been re-issued to all staff to ensure that the policy consistently guides their practice in working towards a restraint-free environment.

There is a documented record that all patients have been appropriately assessed, restrictive practices have been reviewed regularly and any form of restraint in use has been considered as a measure of last resort and alternatives have been considered. The PIC and ADON will monitor staff compliance with the policy.

There is consultation with all patients and/or family representative as appropriate in relation to the use of restrictive procedures.

Proposed Timescale: 30/04/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Fire drill had not been completed at regular intervals in the centre

Staff were not fully aware of the procedures to be followed in the event of a fire.

10. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Apart from drills carried out as part of fire safety training, three fire drills have been conducted since the inspection. It is planned to do one fire drill per week throughout April, including a night fire drill; one drill per fortnight in May and one fire drill per month thereafter. The recent fire drills were unscheduled.

The Fire Safety Protocol has been comprehensively reviewed and improved and all staff have received a copy of this document and have confirmed that they understand the contents. The revised protocol is site specific and outlines the roles and responsibilities of all staff in the event of a fire, including Fire Wardens and Command & Control. Additional fire safety training has been arranged for all staff in the centre. The training is site specific and includes training for Fire Wardens and staff who may be required to act in the Command & Control role. There is a written test on fire safety which is based on the HIQA Fire Safety guidelines, issued in 2015. To ensure staff vigilance around fire safety awareness, the written test will be re-issued to staff on a quarterly basis.

Proposed Timescale: 30/04/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The fire evacuations procedures were not displayed throughout the centre.

11. Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

Procedures to be followed in the event of fire are now displayed prominently in additional key areas of the centre in accordance with Regulation 28(3).

Proposed Timescale: 20/04/2016

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Medications were crushed without being individually prescribed.

12. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

All prescription charts have been reviewed by the Resident Medical Officer and all medications that require crushing have been individually prescribed and signed by the

doctor.

Proposed Timescale: 20/04/2016

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 formally reviewed and updated on a four monthly basis or more frequently as residents needs changed.

Care plans were not reviewed in consultation with the residents or a representative where required.

13. 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:

The vast majority of patients in the centre are discharged in less than 4 months. All patients who are in the centre for 4 months or longer will have their care plans reviewed and updated. All care plans are reviewed in accordance with the changing care needs of the patients as required. All care plans will be reviewed in consultation with the patients or a representative where required.

Proposed Timescale: 30/04/2016

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Care plans did not consistently guide the care to be delivered by staff e.g. falls prevention, weight loss, prevention of pressure sores.

Care plans were not reviewed following a change in need or circumstance e.g weight loss, falls.

Care plans were not developed for all assessed needs for example, wound care and pressure sores prevention.

14. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All patients will have a care plan prepared within 48 hours of admission to the centre, based on the assessed care needs of each individual patient. The care plans are an accurate guide to the care required in practice. Care records and care delivery are supervised by the senior nursing staff to ensure compliance with care requirements. Care plans are regularly reviewed and updated according to the changing care needs of each patient.

All patients have a Stratify Falls assessment on admission and a care plan is developed if a falls risk is identified. The patients' falls risk is reassessed if the resident actually falls, an incident report is documented and the care plan is updated to reflect any change in care needs as a result of the fall, including falls prevention strategy. A post-falls review is conducted by the ADON and PIC following all falls.

All residents have a MUST nutritional assessment carried out on admission. If the resident after each is identified as being at risk of malnutrition or if their nutritional status is compromised, a specific and comprehensive individualised care plan is completed to address nutritional care needs. The ADON and PIC reviews the nutritional assessment and care plans of all patients deemed at risk of malnutrition.

Skin integrity is assessed as part of the comprehensive admission assessment. A wound assessment is conducted on all wounds and a wound care plan is implemented for patients with wounds and/or pressure sores.

All clinical risks and incidents, including pressure sores, falls and nutrition will be continually monitored and reviewed by the ADON and PIC; through the weekly MDT meetings, the monthly management meetings and at the Quality & Governance meetings.

Proposed Timescale: 30/04/2016

Theme:

Effective care and support

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

There management of nutritional needs in terms of weight loss required improvement.

The practices in the prevention and management of falls required improvement.

15. 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:

All patients have a MUST nutritional assessment carried out on admission. A specific, individualised care plan is developed for patients who are at risk of malnutrition or whose nutritional status has been compromised. Patients are routinely weighed on a monthly basis or more frequently if indicated. The PIC and ADON will ensure that if a patient loses in excess of 2kgs following admission a food intake chart is commenced over a 3 day period and the patient will be reviewed by the Resident Medical Officer and dietician. The care plan will then be updated to incorporate the medical and dietetic recommendations.

Patients at risk of malnutrition are weighed more frequently, usually weekly, until such time as their condition stabilises.

All patients have a Stratify Falls risk assessment carried out on admission. A mobility assessment is also undertaken. A care plan is developed to address the care needs and guidelines for patients who are identified as being at risk of falls. The falls prevention strategy includes mobility aids and assistance required, patient and relative education about falls prevention and awareness, moving and handling instructions and chair and/or mattress alarm if required. All patients at risk of falls are assessed by the physiotherapist and the care plan includes physiotherapy recommendations.

The PIC and ADON will monitor compliance with this falls management protocol on an ongoing basis.

Proposed Timescale: 30/04/2016

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A timely referral was not made to a dietician for a resident who had experienced significant weight loss.

16. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

All patients have a MUST nutritional assessment carried out on admission. All patients are routinely weighed on a monthly basis. The PIC and ADON will ensure that if a patient loses 2kgs or more, a referral is made to the medical officer and dietitian, and a food intake chart is maintained over a 3 day period. Such patients will be weighed on a weekly basis, unless their medical condition precludes this.

Proposed Timescale: 20/04/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The garden was not fully accessible to residents.

There was no dining room provided in one unit of the centre.

17. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

A gated garden area is available to patients. The external environment will be enhanced to ensure that it is easily accessible and safe. This will include additional signage with a marked walk way to the garden. A risk assessment of the area will be completed in this regard. Garden furniture is being ordered for the area in order to provide comfort for patients who wish to avail of this facility. Patients who are less mobile or frail will be accompanied and supervised by staff to the garden area.

An additional dining area will be provided for patients in the unit identified during the inspection.

Proposed Timescale: 31/05/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

An accessible and user friendly complaints procedures was not displayed throughout the centre.

18. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

An accessible and user friendly complaints procedure is displayed in key areas throughout the centre.

Proposed Timescale: 30/04/2016

Theme:

Person-centred care and support

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

Residents spoken to were not aware of a complaints procedure for the centre.

19. Action Required:

Under Regulation 34(1)(a) you are required to: Make each resident and his/her family aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre.

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

All patients are made aware of the complaints procedure within a short time of admission. The complaints procedure is displayed in various parts of the centre and is accessible and user friendly. The complaints procedure is now included in the Information Guide and in the Statement of Purpose, which are widely available in the centre.

All complaints, including verbal complaints are recorded, documented, investigated and addressed. Lessons learned from complaint and service improvements implemented in response to a complaint are discussed at the Quality & Governance meetings. The Director of Care Services will ensure compliance with complaints procedures, resolution of complaints and care/service improvements implemented in response to complaints.

Proposed Timescale: 30/04/2016

Theme:

Person-centred care and support

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

Some complaints have not been recorded or investigated.

Verbal complaints were not recorded.

20. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

All complaints, including verbal complaints are recorded, documented, investigated and addressed in accordance with the centre's Complaints Policy & Procedure. Lessons learned from complaints and service improvements implemented in response to complaints are discussed at the Quality & Governance meetings.

Proposed Timescale: 30/04/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff access to training to meet the assessed needs of residents required improvement.

21. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Mandatory training and education has been provided to all staff. All staff have access to appropriate education and training. The centre has a positive approach to staff education and development and records are maintained of all staff training and education.

A schedule for additional education and training has been arranged and will include wound management, falls, nutrition and dysphagia.

Proposed Timescale: 31/05/2016