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**Mount Cara, OSV-0000747, 26 September 2017**

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Mount Cara
<b>Centre ID:</b>	OSV-0000747
<b>Centre address:</b>	Redemption Road, Blackpool, Cork.
<b>Telephone number:</b>	021 439 5737
<b>Email address:</b>	administration@mountcara.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Mount Cara Limited
<b>Provider Nominee:</b>	Margaret Kiely
<b>Lead inspector:</b>	John Greaney
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	20
<b>Number of vacancies on the date of inspection:</b>	5

## **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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**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 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 1 day(s).

**The inspection took place over the following dates and times**

From: 26 September 2017 08:15 To: 26 September 2017 17:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

Mount Cara is a purpose built facility comprising 25 single bedrooms and is located in the north side of Cork city. It is built on an elevated site with panoramic views of the city. The centre provides respite, convalescent and continuing care for persons assessed as being at low and medium dependency.

This inspection was unannounced and took place in response information received by HIQA, and also in response to recent governance and management changes. HIQA had been notified that the person in charge was resigning and there were inadequate assurances provided in the notification of the management arrangements in place during the absence of the person in charge. In the weeks leading up the inspection a new chairperson of the board was appointed and a new person in charge was appointed in the week prior to the inspection. The inspector met with the new chairperson and the person in charge on the day of the inspection and both demonstrated a commitment to provide a quality and safe service to residents.

The centre was registered to provide care to 25 residents who were assessed as being of low and medium dependency levels. When residents became more

dependent, and the centre could no longer meet their needs, they were transferred to a more appropriate setting, such as a nursing home. This was clearly outlined in the statement of purpose, in the contract of care and on an information leaflet given to prospective residents.

There are full time nursing staff in the centre. Care staff are a mix of qualified healthcare assistants and staff undergoing Quality and Qualifications Ireland (QQI) training in healthcare. The inspector observed staff interacting with residents in a caring and respectful manner. Residents spoken with by the inspector were very happy living in the centre and were complimentary of the care provided by staff. While there appeared to be adequate numbers of staff on duty during the day to meet the needs of residents, some practices in the centre were institutional in nature and appeared to be based on staffing levels. For example, residents were provided with their breakfast at 07:00hrs each day in their bedrooms and the inspector was informed that this was due to there being insufficient staff in the morning time. While residents expressed satisfaction with the timing of breakfast and stated they "were used to it", many went back to sleep again after breakfast.

Improvements were required in relation to governance and management. There were recent changes in the governance and management structure. Due to this recent change, reporting arrangements were not yet clarified and a structured reporting system had not been established. There was not an adequate system in place to ensure the service provided was safe and effectively monitored, for example, through a programme of audits. Significant improvements were required in relation to medication management, and while this had been recognised by staff, the process of improving medication management practices had only just commenced.

Other required improvements included:

- the statement of purpose did not contain all of the information specified in the regulations
- there was no annual review of the quality and safety of care
- the use of bedrails did not comply with national policy
- staff training records
- inadequate records on consultation with residents in advance of proposed changes in relation to fees.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

**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 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):**

No actions were required from the previous inspection.

**Findings:**

There was a written statement of purpose that was most recently reviewed in June 2017. Further review, however, was required in order for the statement of purpose to comply with Schedule 1 of the Regulations. For example, the statement of purpose did not include:

- the information set out in the Certificate of Registration
- a description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function
- the total staffing complement, in whole time equivalents, with management and nursing complements as required in Regulations 14 and 15
- the organisational structure of the designated centre
- arrangements for the management of the centre when the person in charge is absent
- the arrangements for residents to engage in social activities, hobbies and leisure interests
- the arrangements made for consultation with residents
- the arrangements for residents to attend religious services
- the arrangement's for dealing with complaints.

**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:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There were adequate resources to support the effective delivery of care. The management structure was not yet clearly defined due to significant changes in management personnel. The person in charge had only commenced in the role on the week prior to this inspection. Due to difficulties experienced by the centre in recruiting a person in charge, the new person in charge had been seconded to the role by the Health Service Executive. The chairperson of the board of management had recently resigned and a new chairperson had taken up the role in the weeks prior to this inspection. While the person in charge stated that she was in regular contact with the chairperson by phone and email, a structured reporting system had not yet been established. The person in charge would also be reporting to the Health Service Executive, but this relationship was also not yet clearly defined.

The inspector was informed that the previous person in charge reported to the board on a regular basis on issues such as occupancy, staffing, accidents and incidents, and on premises maintenance. These reports were both verbal and written, however, records were not available on the day of inspection. The inspector was informed that they would be submitted following the inspection but this did not occur.

Records were not available of any audits that were conducted since the last inspection and it was not known what audits had been completed, if any. There was no record of an annual review of the quality and safety of care available and it was not known if one was completed.

**Judgment:**

Non Compliant - Major

***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):**

No actions were required from the previous inspection.

**Findings:**

There was a person in charge of the centre that had commenced in the role on the

week prior to this inspection. The person in charge is a registered nurse and works full time in the centre. Based on a review of documentation, interview, and observations of the inspectors, the centre was managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

The person in charge demonstrated sound clinical knowledge and a good knowledge of the legislation and her statutory responsibilities. She was engaged in the governance, operational management and administration of the centre.

**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):**

No actions were required from the previous inspection.

**Findings:**

The person in charge was requested to undertake a review of staff files as, based on the sample reviewed, there was not always photographic identification, a full employment history or two written references, available for all staff.

**Judgment:**

Substantially 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):**

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

**Findings:**

There were policies and procedures in place in relation to safeguarding residents. The inspector reviewed a number of staff personnel files that indicated training was provided in elder abuse, however, there was no overall training matrix to confirm if all staff had attended this training. Additionally, it was not clear if the training provided was up-to-date with latest guidance in relation to safeguarding practices.

Residents spoken with by the inspector stated that they felt safe in the centre and were happy living there. Staff were observed interacting with residents in a kind and caring manner. Staff were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse.

Notifications had been submitted to HIQA in relation to theft of residents' personal possessions, including money, most recently in April 2017. An Garda Síochána had been notified and conducted an investigation. Residents were advised not to have large sums of money in their possession and each resident has access to lockable storage. There were systems in place for the management of residents' finances. In instances where the centre held sums of money for safekeeping on behalf of residents, there were signatures of either two staff or of the resident and a staff member verifying any transactions. Some improvements, however, were required as some of these signatures were on envelopes and staff were informed that a more permanent record was advisable.

The only form of restraint in use were bedrails. Even though there were records of consent by residents for the use of bedrails, there was no record of a risk assessment conducted prior to the use of bedrails. Even though the inspector was informed that residents were checked regularly throughout the night, there were no records of safety checks while the bedrails were in place and there was no record of an assessment to determine the frequency safety checks should be undertaken. The person in charge was also advised to carry out an assessment of the bedrails to ensure they complied with guidance on the dimensions of the rails in relation to the bed and the risk of entrapment.

There were no residents in the centre that presented with significant responsive behaviour. Training records indicated that some, but not all, staff had attended training in responsive behaviour.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

There were policies and procedures in place in relation to medication management. Significant improvements were required in relation to medication management. A review of prescriptions identified that some medication was being administered from a faxed copy of a prescription and not the original. This was usually for short term medications, such as antibiotics; however, the inspector did find that for one resident their entire prescription was a faxed copy. There was not a general practitioner (GP) signature associated with each individual medication as sometimes a number of medications were grouped together with only one signature. The maximum dosage of PRN (as required) medication was not written on most prescriptions.

Frequent errors were encountered by staff in medications delivered to the centre from the pharmacy. Medications were delivered in unit dose dispenser packs with the medication to be administered to each resident at relevant times each day in individual units. When these packs were delivered to the centre, the nurses checked the medications in each pack to ensure it complied with the medications prescribed for each resident. Medication error records indicated that these packs frequently contained medication that was not prescribed on a regular basis, did not contain the medication prescribed or contained the incorrect dose. The inspector reviewed a sample of unit dose packs and found that one contained paracetamol that was only prescribed on a PRN basis and should not have been included in the pack. A meeting had been held with the pharmacy to outline concerns of the centre in relation to the supply of medications.

There were adequate procedures in relation to the management of drugs that required special control measures. These were stored appropriately and counted at the end of each shift. Medication requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded. The person in charge was requested to review the recommended temperature range written on the fridge temperature record sheet to ensure in complied with the guidance for medications stored in the fridge.

**Judgment:**

Non Compliant - Major

***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.***

<p><b>Theme:</b> Effective care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Residents' health care needs were met through timely access to medical treatment. Residents had a choice of medical practitioner and records indicated they were seen when required. The centre was registered to provide care to 25 residents who were assessed as being of low and medium dependency levels. When residents became more dependent, and the centre could no longer meet their needs, they were transferred to a more appropriate setting, such as a nursing home. This was clearly outlined in the statement of purpose, in the contract of care and on an information leaflet given to prospective residents. Improvements were required in relation to the assessment of dependency levels. For example, a validated tool was used to assess the dependency level of residents and each resident was given a dependency score. However, there was no rating chart to identify what level of dependency the dependency score equated to, such as low, medium, high or maximum.</p> <p>Residents were assessed prior to admission and were invited to visit the centre to ensure that it met their needs. Residents were assessed regularly and care plans were developed based on these assessments. Validated tools were used to assess the risk of falling, mental status, and dependency levels. Many of these care plans were personalised and provided adequate guidance in relation to the needs and preferences of each resident. Some care plans, however, required improvement as they did not provide adequate detail of the care to be delivered.</p>
<p><b>Judgment:</b> Substantially Compliant</p>

<p><b><i>Outcome 16: Residents' Rights, Dignity and Consultation</i></b> <b><i>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.</i></b></p>
<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b></p>

Staff were observed interacting with residents in an appropriate and respectful manner. Staff addressed residents by their preferred names and spoke in a clear, respectful and courteous manner. The privacy and dignity of residents was respected during care provision. Residents were supported to live as independently as possible. Residents chose what they liked to wear and all were neatly dressed on the day of inspection. Residents were very complimentary of the staff and of life in general in the centre.

Residents' religious preferences were ascertained and facilitated. Residents had access to radio, television and newspapers.

The inspector was not satisfied that the timing of breakfast each morning supported the independence and freedom of choice for residents and did not reflect a homely environment. All residents had their breakfasts at 07:00hrs each morning in their bedrooms. While residents stated that they were happy with this routine and "were used to it", a number said they returned to sleep after breakfast. The inspector was informed that a trial of providing breakfast at a later time was undertaken but there were insufficient numbers of staff on duty to provide personal care and also to provide breakfast at this time. The person in charge was asked to review meal times to ensure that residents' independence was promoted and supported.

Fees had recently been increased for residents in the centre. The inspector was informed that residents were informed of this proposed fee increase and residents were consulted in relation to their ability to pay. There was, however, no documented evidence of the consultation process or the satisfaction or otherwise of residents with the fee increase.

**Judgment:**

Non Compliant - Major

***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):**

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

**Findings:**

There was a nurse on duty at all times. Prior to the change in management, the nurse on duty at night time was present in the premises from 20:00hrs to 08:00hrs, but on call from 12 midnight to 07:00hrs. There were also two healthcare assistants (HCA) on night duty. Recent changes in governance and management of the centre resulted in a change from there being a nurse on call from 12 midnight to 07:00hrs, to there being a nurse on duty at all times.

Care staff were a mix of qualified HCAs and staff at various stages in their Quality Qualifications Ireland (QQI) in healthcare training programme. For example, on the morning of the inspection, there were four care staff on duty, two of whom were HCAs and two were undergoing the QQI training programme.

Other staff on duty included the person in charge, catering staff, an administrative staff member, an activities coordinator, and a maintenance staff member, who was also undertaking a QQI training programme.

While there appeared to be adequate staff on duty to meet the needs of residents during the day, the person in charge was requested to review staffing levels to support the provision of breakfast to residents at a time of their choosing.

There was no training matrix, so it was not possible to determine with certainty what staff had completed training. However, from a review of a sample of staff files, all those reviewed had undergone elder abuse training, manual handling training, and fire safety training. The person in charge was requested to undertake a review of staff files as, based on the sample reviewed, there was not always photographic identification, a full employment history or two written references, available for all staff. This action is addressed under Outcome 5. There was a record of Garda Síochána (police) vetting in the files reviewed and the inspector was assured that all staff had vetting in place.

**Judgment:**

Substantially 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:***

John Greaney  
Inspector of Social Services  
Regulation Directorate

**Health Information and Quality Authority  
Regulation Directorate**

**Action Plan**



**Provider's response to inspection report<sup>1</sup>**

<b>Centre name:</b>	Mount Cara
<b>Centre ID:</b>	OSV-0000747
<b>Date of inspection:</b>	26/09/2017
<b>Date of response:</b>	21/11/2017

**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:**

There was a written statement of purpose that was most recently reviewed in June 2017. Further review, however, was required in order for the statement of purpose to comply with Schedule 1 of the Regulations. For example, the statement of purpose did not include:

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

- the information set out in the Certificate of Registration
- a description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function
- the total staffing complement, in whole time equivalents, with management and nursing complements as required in Regulations 14 and 15
- the organisational structure of the designated centre
- arrangements for the management of the centre when the person in charge is absent
- the arrangements for residents to engage in social activities, hobbies and leisure interests
- the arrangements made for consultation with residents
- the arrangements for residents to attend religious services
- the arrangement's for dealing with complaints.

**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 is under review to ensure it 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.

A strategic plan is under consultation at present to identify our vision, mission and our core values

**Proposed Timescale:** 17/11/2017

**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:**

Records were not available of any audits that were conducted since the last inspection and it was not known what audits had been completed, if any.

**2. 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:**

A process of auditing has commenced. Psychotropic medication audits have started on the 20/10/17

An audit on anti-microbial usage started on the 20/10/17, both of these audits will be re done every two weeks.

Bedrail risk assessments and assessment for use of a bed rail has been almost

completed for all residents. This will be completed on the 30/10/17.  
Care planning audit has also been completed.  
Environmental auditing will commence on the 20/11/17.  
Medication management audits have also been commenced on the 17/10/17.  
A falls incident review from January 2017 to the end of September 2017 has also been completed.

Timescale: On-Going

**Proposed Timescale:** 30/11/2017

**Theme:**

Governance, Leadership and Management

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

There was no record of an annual review of the quality and safety of care available and it was not known if one was completed.

**3. Action Required:**

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

An annual review will be submitted by the end of December 2017 for a 3 monthly period (October, November, December) using the HIQA annual review template. Going forward from that a full annual report will be submitted from January 2018 to December 2018.

A performance review template for staff will be implemented and completed by November 30/11/17.

**Proposed Timescale:** 31/12/2018

**Theme:**

Governance, Leadership and Management

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

While the person in charge stated that she was in regular contact with the chairperson by phone and email, a structured reporting system had not yet been established. The person in charge would also be reporting to the Health Service Executive, but this relationship was also not yet clearly defined.

**4. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The Person in Charge reports to the Chairperson of the Board. Meetings occur every 2 weeks and are minuted.

The Person in Charge meets with the full Board of Directors once a month and these meetings are also minuted.

Role Description and Person Specification for Directors/Trustees of Mount Cara CLG is in place.

Nursing staff and support staff report to the Person in Charge. Job descriptions for support staff of Mount Cara are currently being reviewed and will be up dated.

The job description for the Person in Charge is also currently being reviewed.

**Proposed Timescale:** 02/11/2017

**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 person in charge was requested to undertake a review of staff files as, based on the sample reviewed, there was not always photographic identification, a full employment history or two written references, available for all staff.

**5. 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 staff personnel files has been conducted. A letter has been issued to each staff member outlining the required information i.e. photographic identification, a full employment history or 2 written references.

A copy of the community employment workers files have also been requested from the community worker supervisor.

**Proposed Timescale:** 03/11/2017

**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:**

Improvements were required in relation to the management of restraint. For example:

- even though there were records of consent by residents for the use of bedrails, there was no record of a risk assessment conducted prior to the use of bedrails
- even though the inspector was informed that residents were checked regularly throughout the night, there were no records of safety checks while the bedrails were in place
- there was no record of an assessment to determine the frequency safety checks should be undertaken
- the person in charge was also advised to carry out an assessment of the bedrails to ensure they complied with guidance on the dimensions of the rails in relation to the bed and the risk of entrapment.

**6. 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:**

Risk assessments have been completed for the residents that are using bedrails at night and risk assessments are almost completed for all other residents should the need arise for bedrail usage.30/10/17

A residential restraint register has been introduced and a bedrail and evaluation careplan, a restraint release and review chart to frequent safety checks are carried out.

A medical equipment company has also assessed bedrails to ensure that they are safe and in line with national restraint policy. 03/11/17. Report from the company to be issued.

The national policy on restraint is also in place.

Proposed Timescale: all risk assessments 30/10/17. Report from company 03/11/17

**Proposed Timescale:** 03/11/2017

**Theme:**

Safe care and support

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

The inspector reviewed a number of staff personnel files that indicated training was provided in elder abuse, however, there was no overall training matrix to confirm if all staff had attended this training. Additionally, it was not clear if the training provided was up-to-date with latest guidance in relation to safeguarding practices.

**7. Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection

and prevention of and responses to abuse.

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

Safeguarding the vulnerable older adult training has been organised for all staff on the 27/11/17.

A training matrix for staff training records and needs is being reviewed and will be completed by the 03/11/17

Proposed Timescale: 21/11/17, 03/11/17

**Proposed Timescale:** 27/11/2017

**Theme:**

Safe care and support

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

There were systems in place for the management of residents' finances. In instances where the centre held sums of money for safekeeping on behalf of residents, there were signatures of either two staff or of the resident and a staff member verifying any transactions. Some improvements, however, were required as some of these signatures were on envelopes and staff were informed that a more permanent record was advisable.

**8. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

A Standard Operating Procedure plan for resident relating financial transactions in Mount Cara which includes record keeping for all transactions and includes a process for receiving monies outside of office hours. A receipt must be issued for all monies received. This is currently under consultation at present.

**Proposed Timescale:** 03/11/2017

**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:**

The person in charge was requested to review the recommended temperature range written on the fridge temperature record sheet to ensure in complied with the guidance for medications stored in the fridge.

**9. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Fridge has been serviced to ensure correct measurement of temperature between 2-8 degrees celcius.

**Proposed Timescale:** 26/10/2017**Theme:**

Safe care and support

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

Frequent errors were encountered by staff in medications delivered to the centre from the pharmacy. Medication error records indicated that these unit dose dispensing packs frequently contained medication that was not prescribed on a regular basis, did not contain the medication prescribed or contained the incorrect dose. The inspector reviewed a sample of unit dose packs and found that one contained paracetamol that was only prescribed on a PRN basis and should not have been included in the pack.

**10. 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:**

A root cause analysis is currently underway to determine the source of the errors.

PRN medications will no longer be provided in the blister packs and a small stock of these PRN medications will be kept at the centre.

The pharmacist will conduct 3 monthly reviews on all drug charts and medications.

A grid system has been put in place identifying the dates for renewal of the blister packs. These will be done a week in advance to the previous blister packs being completed. There is now a delivery service available from the pharmacy to the centre and designated days for this.

Medication management training has been sourced for the nursing staff. No date confirmed as yet.

Medication management policy and An Bord Altrainais guide for medication management has been made available to the nursing staff.

Proposed Timescale: 20/10/17, medication management training 17/11/17

**Proposed Timescale:** 17/11/2017**Theme:**

Safe care and support

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

Improvements were required in relation to prescription records. For example:

- some medication was being administered from a faxed copy of a prescription and not the original. This was usually for short term medications, such as antibiotics, however, the inspector did find that for one resident their entire prescription was a faxed copy
- there was not a general practitioner (GP) signature associated with each individual medication as sometimes a number of medications were grouped together with only one signature
- the maximum amount of PRN (as required) medication was not written on most prescriptions.

**11. 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:**

New drug administration charts have now been introduced which eliminate the use of faxed prescriptions( unless in an emergency situation)

There are specified times on these drug charts for medications to be administered and a signature is required for each prescribed medication. The maximum amount of PRN dose is being addressed with each GP.

**Proposed Timescale:** 03/11/2017

**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:**

Some care plans required improvement as they did not provide adequate detail of the care to be delivered.

**12. 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 care plans are currently being reviewed and audited. A flow chart has been introduced to ensure activities of daily living are being assessed and documented. A primary nurse has been given responsibility for 4 careplans to be updated and

reviewed.

**Proposed Timescale:** 27/10/2017

**Theme:**

Effective care and support

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

A validated tool was used to assess the dependency level of residents and each resident was given a dependency score. However, there was no rating chart to identify what level of dependency the dependency score equated to, such as low, medium, high or maximum.

**13. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

A rating chart is in place in each care plan so that it can be clearly identified as to how the measuring and assessment of dependency level is determined 16-20 low dependency, 10-15 medium dependency, 5-9 high dependency, 1-4 maximum dependency. The measuring tool is currently being adjusted to reflect the above scoring.

**Proposed Timescale:** 31/10/2017

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The inspector was not satisfied that the timing of breakfast each morning supported the independence and freedom of choice for residents and did not reflect a homely environment. All residents had their breakfasts at 07:00hrs each morning in their bedrooms. While residents stated that they were happy with this routine and "were used to it", a number said they returned to sleep after breakfast. The inspector was informed that a trial of providing breakfast at a later time was undertaken but there were insufficient numbers of staff on duty to provide personal care and also to provide breakfast at this time. The person in charge was asked to review meal times to ensure that residents' independence was promoted and supported.

**14. Action Required:**

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

Education for all staff will take place on the 27/11/17 with regard to person centred care.

All residents are given a choice as to what time they would like breakfast, have a shower/bath etc

**Proposed Timescale:** 04/10/2017

**Theme:**

Person-centred care and support

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

Fees had recently been increased for residents in the centre. The inspector was informed that residents were informed of this proposed fee increase and residents were consulted in relation to their ability to pay. There was, however, no documented evidence of the consultation process or the satisfaction or otherwise of residents with the fee increase.

**15. Action Required:**

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

SAGE have met with the residents to inform them of their rights and to ensure that residents are aware that there is an independent body that they can address any issues or concerns that they may have.

A residents forum will be set up and regular meetings will be held for the residents. A record of these meetings will be kept going forward

Proposed Timescale: On-going

**Proposed Timescale:**

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

While there appeared to be adequate staff on duty to meet the needs of residents during the day, the person in charge was requested to review staffing levels to support the provision of breakfast to residents at a time of their choosing.

**16. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Staff are now required to commence work at 8 am except for the community workers who start at 9 am. This is to facilitate a change in work practices and to facilitate a handover for all staff.

**Proposed Timescale:** 04/10/2017

**Theme:**

Workforce

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

There was no training matrix, so it was not possible to determine with certainty what staff had completed training.

**17. 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:**

A training matrix is currently under review to identify training that staff have attended and also to identify training needs and refresher/updating or up skilling. The names of all staff and the training relevant to their role as well as all mandatory training will be made available.

**Proposed Timescale:** 03/11/2017