

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Mount Tabor Care Centre
Centre ID:	OSV-0000071
Centre address:	Newgrove Avenue, Sandymount Green, Sandymount, Dublin 4.
Telephone number:	01 260 5772
Email address:	info@dcmis.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mount Tabor Limited
Provider Nominee:	David Reynolds
Lead inspector:	Valerie McLoughlin
Support inspector(s):	Linda Moore;
Type of inspection	Unannounced
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 09 March 2015 10:30 To: 09 March 2015 20:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was unannounced and took place over one day. The purpose of this inspection was to monitor compliance with the Regulations and to follow up on the action plan of the previous inspection from January 2014.

As part of the monitoring 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.

Inspectors found that there were 43 residents in the centre and one in hospital on the day of the inspection and one new resident being admitted in the afternoon. There were no vacancies.

Sixty-four percent of residents had a history of dementia. Care was provided in three different areas of the centre, and all residents could join in group activities together if they choose. Routines were flexible and the premises were maintained to a very high standard.

The provider nominee and the person in charge met all of the required actions from the previous inspection but there were areas for improvement required.

Inspectors were concerned that residents' healthcare needs were not being consistently met to a high standard of evidenced based care. The statement of purpose was not implemented in practice in relation to the provision of evidenced based healthcare and incident management. Issues identified include:

Lack of appropriate documentation and evidenced based practice on clinical issues such as:

- prevention and management of falls including a high level of recurrent falls
- management of behaviour that challenges
- chemical and physical restraint (restrictive practice)
- dysphagia (difficulty swallowing),
- nutrition and hydration,
- supervision of residents in dining room and day rooms
- bowel care and urinary catheter care management
- poor care planning in end of life care management including symptom management

While the person in charge had attended various seminars and clinical education relating to her role, inspectors were not satisfied that the person in charge had effectively disseminated and implemented learning to ensure a consistent high standard of nursing practice.

Inspectors found that the management of risk was in its infancy as the concept of risk identification, investigating and learning from serious or untoward incidents involving residents was not effectively implemented or monitored.

Improvements are also required in risk management, manual handling practices and medication management which are discussed in the body of the report and detailed in the Action Plan at the end of the report.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Inspectors read the statement of purpose which met the requirements of the Regulations in a number of areas and found that it accurately outlined the arrangements for residents to engage in social activities, religious services and detailed the ways in which residents are consulted about the running of the centre.

Inspectors found that the statement of purpose adequately described the names and positions of all persons participating in the management of the centre, the admissions criteria and the number and sizes of all bedrooms and communal areas within the centre. This had been an action from the previous inspection, and it had now been addressed.

Inspectors observed practices during the inspection and found that the delivery of care was not consistently in line with the aims set out in the statement of purpose. For example, there was a lack of a comprehensive reassessment of residents following a change in health status and inadequate care plans in place to provide evidenced based nursing care. This is discussed in more detail under Outcome 11, (Health and Social Care).

The statement of purpose did not provide enough details about the healthcare services required from other allied health professionals to ensure residents health care needs were being consistently met to a high standard.

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:

Inspectors found there was a clearly defined management structure that identified the lines of authority and accountability and this was reflective of the statement of purpose. The provider nominee had put management systems in place to provide and monitor residents care to ensure residents were well cared for. However, inspectors found that the management systems in place were not consistently effective.

The person in charge was a registered general nurse, had the relevant necessary experience as required by the regulations and worked full-time in the centre. The person in charge had attended a number of courses relating to resident care issues, such as medication management, care of residents with dementia, challenging behaviour, food and nutrition and end-of-life care.

Staff and residents told inspectors that the person in charge was approachable, supportive and actively involved in the centre.

The person in charge was supported in her role by two clinical nurse managers (CNMs) who deputised in her absence.

However, inspectors were not satisfied that learning was effectively disseminated and implemented learning to ensure a high standard of evidenced based nursing practice. There was limited evidence that learning had occurred from incident reviews. This will be discussed in more detail under Outcome 8 Health and Safety and Risk Management.

A residents' committee continued to meet, this was provided for residents to give them the opportunity to express any concerns they may have and for it to be discussed with the person in charge if they wished. The meeting was chaired by volunteers and two nurses who worked in the centre. The minutes of the meetings were available to residents.

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that there was a centre-specific policy available on protection of older adults which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse.

The previous inspection found that a substantial number of staff required refresher training in protection of vulnerable adults in order to be in line with the centres policy. Inspectors reviewed the training records and found that staff had received training and additional training was scheduled throughout the year. Therefore this action had been addressed.

A review of incidents since the previous inspection showed that there were no allegations of abuse in the centre. The person in charge also confirmed this to be the case. Inspectors found that staff spoken to were knowledgeable about what constituted elder abuse and what they would do if they suspected that a resident was at risk of abuse. Residents reported that they felt safe in the centre because staff were available, approachable and kind.

Inspectors observed good practice in the reduction in the use of physical restraint such as bed rails.

However, where chemical restraint and a lap belt were being used, the practices were not in line with the Department of Health's national policy.

Appropriate documentation was not in place for the use of restraint as there was no recorded evidence that alternative interventions were tried, and there was no recorded evidence stating the duration of restraint. In one instance there was no rational recorded for the use of a lap belt, although a risk assessment was in place.

Consent forms were inappropriate as request for consent was obtained from next of kin. There were no care plans in place for some residents when restraint was in use, and there was no system in place to check residents while restraint was in use.

While behaviour monitoring charts were in use to gather information on the triggers to behaviours, this was not consistently recorded. The care plans in place did not guide effective care.

While residents were seen by Psychiatry of Old Age and commenced on regular medication, inspectors observed the use of this medication was also being used routinely on a PRN basis to control behaviour without specific criteria being recorded for its use. There was no recorded evidence that alternatives had been tried prior to using the medication as required by evidenced based practice guidelines.

One resident who was receiving medications on a regular basis appeared unrousable during the inspection. It was recorded in the progress notes that this residents' condition had deteriorated over an eight week period; being described as sleepy with a reduced appetite. While the side effect of the medication is drowsiness and dizziness the residents response to this medication was not being consistently being monitored by the nursing staff. The care plans in place were not reflective of the current health status, and would not guide evidenced based care. Inspectors notified the senior nurse who acted immediately to assess the resident.

Resident's finances were not checked on this inspection as the procedure had been looked at on the previous inspection and found to be satisfactory.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

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

Findings:

There was a risk management policy in place. While it had been revised to include the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents, it did not include all of the items set out in regulation 26(1), for example, the measures and actions in place to control abuse.

Inspectors found that the risk management policy had not been implemented fully as there was no recorded evidence that poor outcomes to residents had been investigated, or that any learning had occurred to reduce the risk of similar incidents recurring.

While there were systems in place to review clinical risk and incidents and accidents, the application of this process and its oversight was ineffective because incidents such as recurrent falls continued to happen. (This is discussed in more detail in Outcome 11, Health and Social Care).

This was not in line with the statement of purpose, which stated that, 'a system of harm prevention and harm response would be implemented, to check that all follow up actions were completed, identify what can be done to prevent a similar incident occurring and make recommendations about how future incidents that cannot be

prevented could be managed more effectively’.

Inspectors noted there was a risk register in place to record risks. The risks recorded for 2014 were reviewed regularly by staff at the Health and Safety Committee. Inspectors read the minutes of the meetings and found that these committees were not yet effective in managing risks. Inspectors found there was limited learning from these meetings in relation to incident management. This was not in line with the provider nominees’ written response to the action plan of the previous inspection in January 2014 which stated, ‘we will continue to examine and learn from incidents at our quarterly Health and Safety / Clinical Governance meetings’.

The previous inspection found that a number of staff did not have up-to-date training in fire safety prevention and response. A review of the training records indicated that fire training had been provided. Therefore this action was addressed.

Overall fire safety was well managed. Inspectors viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire. Recorded reviewed indicated that fire drills were carried out by staff at suitable intervals, and staff confirmed this to be the case.

Inspectors viewed the fire records which showed that fire equipment had been regularly serviced. The fire alarm had been serviced quarterly. Staff told inspectors that fire prevention checks were carried out regularly. Inspectors found that all internal fire exits were clear and unobstructed during the inspection.

Inspectors reviewed the emergency plan, which was revised since the previous inspection and found that it provided sufficient guidance to staff on the procedures to follow in the event of an emergency. Therefore this action was met.

The premises were maintained to a high standard with safe and appropriate floor coverings and hand rails on both sides of wide corridors. Many residents had assistive devices to enable independence.

Inspectors found that there were measures in place to control and prevent infection. Staff were knowledgeable in infection control. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre.

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):

Findings:

Overall, inspectors found the system and process in place for medication management was good although improvements were required.

There was a medication management policy for prescribing, transcribing, administering, recording and storing of medicines which included pro re nata (PRN), crushed medications and self-medication.

The previous inspection found that the arrangements for transcribing medications and the procedures for General Practitioner (GP) pro re nata (PRN), medications required review. This was reviewed on inspection and inspectors found that this action had been addressed.

There were some improvements required in medication management as follows; Inspectors observed nursing staff administering medication in the dining room, and observed that the nurse did not sign the administration sheet after administering the medication. This was not in line with professional nursing guidelines. Inspectors noted that residents and staff called on the nurse for assistance while she was administering the medications. Inspectors were concerned that such distractions could result in a medication error and poor outcomes for residents.

The process of prescribing high alert medication such as Warfrain required improvement to ensure its consistent safe administration. For example, the dosage needed to be recorded to ensure that there were no room for error occurring when nurses transcribed the medication following receipt of the blood results. For example, the drug was written as '2 and 3', the dosage being omitted which could be interpreted as 2 and 3 tablets as opposed to 2mg and 3 mg. The nurse explained that two nurses always checked high alert medications prior to administration. The nurse was very clear about what the correct dosage was and the correct medications had been administered.

There was no system in place to record medication telephone orders following review of therapeutic blood results. This could result in poor outcomes for residents. The nurse explained that they needed to develop a form to record GP's prescribing by telephone.

Inspectors reviewed the medication audit completed for two resident's medication charts in February 2015. There were no discrepancies found during the audit.

Medications were stored appropriately. Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines and the centre's policy. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the time of administration and change of each shift. Inspectors checked the recorded balances and found them to be correct.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

Inspectors found that resident's health care needs were not being consistently met to a high standard. Health care management was not consistently evidenced based. Inspectors found that the nursing process was not implemented effectively in all cases. For example, assessment, planning, implementation and evaluation of healthcare needs.

While residents had an assessment of living completed on admission, not all assessments were fully completed. For example, some aspects of the assessments were left blank such as the usual bowel and bladder pattern. This was not in line with the centres policy on continence management which stated, 'on admission assess the resident to establish usual elimination patterns'.

A reassessment was not consistently completed every four months as required by the Regulations or when there was a change in the residents' condition. This was also not in line with the centres own policy which stated, 'review at four monthly intervals or there is a significant change in the resident's care and / or condition.

Clinical risk assessments were not consistently updated. This meant that healthcare needs were not always being identified and as a result there were instances where residents did not have a plan of care in place to guide staff in providing a consistent high level of evidenced based care. For example, in the management of falls, behaviour that challenges, wound care, end of life care, nutrition, , malnutrition and hydration (fluid intake and output), dysphagia (difficulty swallowing), blood glucose monitoring, elimination, including the management of constipation and urinary catheter management.

Falls Prevention and Management.

Inspectors were concerned that some residents continued to have a high incidence of recurrent falls and some residents had poor outcomes from falls. While there was evidence that some falls prevention strategies had been put in place such as posey

alarms these were not consistently effective and additional preventative measures were not put in place following recurrent falls.

Inspectors found evidence of failure to act efficiently and effectively when deterioration in a resident's condition was noted by staff. This led to poor outcomes of care for one resident.

There was not a multidisciplinary approach to falls prevention management. Inspectors reviewed an audit of falls. It was not comprehensive and would not guide quality improvement.

Inspectors noted that care plans had not been reviewed and updated to direct evidenced based care for resident's having recurrent falls. Residents did not consistently have a falls reassessment or falls risk assessment completed following a fall or when there was a change in the residents' condition. This information would be helpful in the development of a care plan to reduce the risk of recurrent falls and protect the residents from harm.

Evidenced based guidelines were not consistently implemented. For example, neurological observations were not carried out frequently to rule out the possibility of a head injury. This is contrary to the centres policy which stated that neurological observations would be recorded and monitored over a twenty-four period. This could place residents at risk.

Recorded measures in a care plan for one resident having recurrent falls was 'constant supervision'. However, the care plan did not specify who would provide the supervision, how it would be provided or its duration. It was recorded that the resident continued to have recurrent falls and sustained an injury.

While an out of hours doctor was available at night time, staff told inspectors that the doctor had not been contacted to review residents following unwitnessed falls at night time and the GP was not informed until 2 to 4 days following a fall. Inspectors were concerned that this could result in poor outcomes for residents.

Wound Care Management.

There was a low incidence of wounds in the centre. Staff had access to tissue viability personnel (wound care) and there was recorded evidence that residents were reviewed on referral. However, inspectors found that wound assessment charts were not consistently completed fully; therefore it was not possible to determine the status of wound healing.

Bowel Care Management

Bowel care management and the use of laxatives required improvement. Inspectors spoke with staff and checked bowel monitoring records. Inspectors noted occasions recorded when dependent residents did not have a bowel motion in 4 to 9 days. The care plans in place would not guide effective care.

Diabetes Care Management

There was no recorded evidence that raised blood glucose levels were acted on and followed up. Inspectors reviewed documentation and found that there was no record

that the blood glucose had been rechecked and monitored. There was no record to indicate that the GP had been asked to review the resident.

Nutrition

Where residents were identified as at risk of malnutrition and had lost weight, they were not routinely referred to the dietician for assessment. This was not in line with the centres policy on Nutrition. The Malnutrition Universal Screening Tool (MUST) was not consistently used correctly, so residents at risk of malnutrition were not being identified promptly.

Resident's weight was not consistently monitored. Inspectors found that there was a lack of a comprehensive plan in place to address weight loss as part of the overall care for residents. For example, while one resident had been referred to their GP, there was no evidence that other referrals or advice had been sought for other residents at risk.

The overall management of nutrition required improvement. During the course of this inspection, inspectors were concerned that residents were not receiving appropriate meals in the consistency required and residents were not receiving appropriate assistance with their meals..

Inspectors observed residents who had a medical condition and swallowing difficulties eating food of an inappropriate consistency and some residents were not sitting in an appropriate, safe position when eating their meals. While residents' diet sheets were being kept in the dining room, these were not referred to when serving the meals to residents.

Staff who assisted residents with their meals were not aware of these residents' special dietary requirements; as a result some residents were provided with regular meals instead of altered consistency. In addition where residents had been assessed by a speech and language therapist (SALT) and the dietician, their care plans had not been consistently updated to reflect this and the recommendations were not being followed. This could result in poor outcomes for residents.

Inspectors found that there was a lack of availability of modified consistency snacks for residents at mid morning break. The only option available was biscuits. These arrangements were not based on the needs or preferences of individual residents and were not suitable for a resident who had a poor appetite and required small portions offered regularly during the day.

Hydration Management.

Inspectors were not satisfied with the provision of fluids to residents. While residents were provided with a drink mid morning and at the set meal time, there was no water or alternative drinks available in the sitting room where residents sat. This was not in line with the centres Nutrition and Hydration Policy.

The monitoring of residents intake and output required improvement. Where fluid intake and output charts were in place for residents with poor oral intake and or urinary catheter, these charts were not consistently keep up to date. As a result it was not possible to determine if residents were taking enough fluid to maintain hydration. One

resident with a reduced appetite appeared dehydrated. Staff could not tell inspectors when the resident last had something to drink. There was no system in place to review fluid balance charts on a daily basis to ensure they were accurate and up to date.

There was inadequate assistance provided to residents at meal times. Inspectors observed in both dining rooms that one staff member was assisting two residents with a meal at the same time, this did not promote the residents dignity or ensure a meaningful dining experience for residents. Inspectors observed that lunch for one resident who required support to eat was left on top of the food trolley for twenty-five minutes, going cold.

Activities.

Two activity coordinators were employed, they both work on a Wednesday together and were not working at the weekends. Inspectors spoke with one of the activity coordinators who demonstrated passion for the role. Many of the residents had opportunities to participate in activities that were meaningful and purposeful and in accordance with their interests. These included the 'cuppa day' once per month where residents invited their families to the centre.

On the day of inspection residents were seen to be enjoying an extend (exercise) class in the morning and watching a movie together in the afternoon.

A programme of activities was widely displayed. It included pastoral care, residents group choir, relaxation and music group, reminiscence, baking, dog therapy twice per week and numerous planned outings,. Residents told inspectors, 'there is no shortage of things to do here', and residents commented that they loved going out on planned events.

The staff had commenced developing life stories for residents and had plans to include all residents who wished to participate. Some staff were also scheduled to for additional training in the provision of additional meaningful activities for residents with dementia related conditions.

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):

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

Findings:

The previous inspection found there were inadequate storage facilities for equipment. While storage space continued to be a challenge, the provider nominee had had put a storage plan in place. Maps and signs were seen posted in small annex areas indicating storage of wheelchairs. Inspectors observed that the wheelchairs were stored safely and there was no equipment blocking corridor, doorways or fire exits on the day of inspection.

Judgment:

Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

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

Findings:

Complaints appeared to be well managed. The complaint's policy was in place and inspectors noted that it met the requirements of the Regulations. This had been revised since the previous inspection. The complaints procedure was on display at in the centre. Relatives and residents who spoke with inspectors knew the procedure if they wished to make a complaint.

Complaints and feedback from residents were viewed positively by the provider and the person in charge. There were some verbal complaints since the previous inspection and there was evidence that these had been managed appropriately.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

End of life care planning required improvement to reflect the residents' preference for end of life care arrangements ,for example, a preference to return home or for a private room so that such preference shall be facilitated in so far as is reasonably practicable.

Staff spoke respectfully about care of the dying and care of the deceased. They respected residents' religious preferences and celebrated their life with respect by forming a guard of honour and having remembrance services. There was access to palliative care service.

End of life care planning reflected the residents' religious preferences and a Do Not Resuscitate Status (DNR).The care plans in place did not reflect the residents daily changing healthcare status and would not guide end of life care healthcare issues such as symptom management and management of constipation. This was not in line with the centres policy which stated that, 'the resident's condition will be monitored and the care plan updated in accordance with changing care and condition'.

Judgment:

Non Compliant - Moderate

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):**Findings:**

Inspectors found that there was a very committed and caring staff team. Residents spoke highly of the staff, and said staff were always very friendly, helpful and respectful, and "they couldn't do enough for you".

All staff told inspectors that they felt well supported by person in charge and provider and described the workforce as like part of a family. The person in charge was described as having hands on approach to care.

Inspectors found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents. However supervision of residents at meal times and in the day rooms required improvement.

There was a recruitment policy in place and inspectors were satisfied that staff recruitment was in line with the Regulations. A sample of staff files were examined and the inspector noted that all relevant documents were present. The provider had ensured that volunteers were vetted appropriate to their role.

Staff told inspectors they had received a broad range of training which included fire training, manual handling, protection and behaviour that was challenging and that a training session in first aid was planned for the week of the inspection.

However, not all staff were suitably trained to meet the needs of residents. For example training had not been provided on falls prevention and management, wound management, infection control or the use of the malnutrition universal screening tool.

Supervision of staff and residents in the dining room was inadequate as the nurse was unable to supervise due to being busy administering medications.

Inspectors observed poor manual handling practices and were concerned that this could result in poor outcomes for residents.

Staff told inspectors there was informal and formal communication within the centre to discuss issues and residents needs as they arose. However, trends had not been identified; as a result there was insufficient evidence that any learning or sustainable improvements in care provision from these discussions had taken place.

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:

Valerie McLoughlin

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Mount Tabor Care Centre
Centre ID:	OSV-0000071
Date of inspection:	09/03/2015
Date of response:	08/06/2015

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:

The delivery of care was not consistently in line with the aims set out in the statement of purpose

Action Required:

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

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

Proposed actions to ensure that the delivery of care is in accordance with the aims and objectives of the statement of purpose and function are outlined under Outcome 11.

Proposed Timescale: 08/05/2015

Theme:

Governance, Leadership and Management

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

The statement of purpose did not provide enough details about the healthcare services required from other allied health professionals to ensure residents health care needs were being consistently met to a high standard.

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 will be amended to include the range of allied healthcare services that are available to residents in Mount Tabor. It is available for inspection

Proposed Timescale: 08/05/2015

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:

Management systems in place did not ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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:

We plan to improve and seek assistance with clinical governance and risk management to ensure that:

- Our current audit plan is further developed and improved to ensure that care and

services are continually improved based on audit findings.

- Our system of risk management is under review so that clear improvement is occurring from identification, recording and investigation of incidents or adverse events involving residents.

We will be expanding and improving our Clinical Governance to include audit tool review and audit reviews to ensure that governance changes are identified and acted upon where necessary.

Proposed Timescale: 03/07/2015

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:

There was no recorded evidence that alternative measures were tried prior to implementing restrictive practices.

Where physical and chemical restraint were being used, the practices were not in line with the Department of Health's national policy.

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:

A) An assessment exists for the resident who used a lap belt. We will review the documentation of all residents, whose care includes the use of bedrails. We will ensure that assessments, care plans and consent forms are completed in accordance with the national policy.

B) The resident charted for a PRN psychotropic medication at the time of inspection who was receiving the medication on a regular basis, has been reviewed and the medication has been charted as a regular medication and has been prescribed to treat agitation which causes this resident significant distress on a daily basis and seriously affects her quality of life. This resident's care plan has been updated to reflect the above.

C) Training has been booked for early May on the Legal Aspects of Restraints.

Proposed Timescale: 08/06/2015

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:

The risk management policy did not include all of the items set out in regulation 26(1), for example, the measures and actions in place to control abuse.

Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

The risk management policy will be updated to include the measures in place to prevent abuse and respond to allegations of abuse and an independent policy on elder abuse is and was in place.

Proposed Timescale: 08/05/2015

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:

Staff were interrupted while administering medications.
Some medication management processes required improvement.

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:

We have arranged for medication administration to be a protected activity by stopping the practice of administering medications throughout mealtimes except where a resident specifically requests to have their medicine with their meals, so as to reduce distractions. The findings of the inspection regarding medication administration, specifically, that apart from emergency situations, the nurse administering medicines must not be interrupted and that nurses must sign the medication administration chart when they have administered each resident's medication. This was addressed at a meeting on 28th April.

A form has been developed for nurses to record telephone orders.

The warfarin form has been amended to ensure that the dosage is recorded correctly.

Proposed Timescale: 08/06/2015

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:

Residents did not have a comprehensive assessment in place.

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:

We will complete a full review of our Care Plan Audit tool and process. This will include further professional training on assessment and care planning and training on updating assessment and care plans with changing needs. We will continue to ensure appropriate referrals to allied health care professional will be sought and review care plans on a four monthly basis.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

Care plans in place would not consistently guide practice.

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:

We will complete a full review of our Care Plan Audit tool and process. This will include further professional training on assessment and care planning and training on updating assessment and care plans with changing needs. We will continue to review care plans on a four monthly basis.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

Residents were not consistently assessed / reassessed by allied health care professionals as outlined in the centres policies.

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:

We will continue to ensure appropriate referrals to allied health care professionals are sought and will document referrals and recommendations in appropriate care plans.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

Resident's health care needs were not being consistently met to a high standard. Evidenced based guidelines were not consistently implemented as described under Outcome 11.

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:

Assessment and care planning training as outlined earlier.

a) Falls

We will continue to conduct falls analysis for 2015 and implement, where necessary, any interventions required for residents and update the care plans accordingly. Staff will continue to have professional development training in Falls Prevention and Management to ensure changes in practice reflected. We have escalated this training to a higher priority.

We will also reinstate our 2013 'Focus on Falls Prevention' month in August and commit to having the focus month annually. This focus on falls month will also include reviewing all relevant documentation.

b) Risk Management

We will be expanding and improving our Clinical Governance to include audit tool review and audit reviews to ensure that governance changes are identified and acted upon where necessary.

c) Nutrition

We will continue to review and monitor our documentation for assessments and care planning for residents with dysphagia and those with weight loss to ensure that their assessments and care plans reflect their individual needs and referred where necessary to allied professionals. Training for staff on dysphagia management has been booked for May.

Since April a dietician comes regularly to oversee the dietary needs of all residents and is also available for referrals when required.

We have reviewed and improved the mealtime arrangements to ensure that each resident has the appropriate assistance to meet their needs. Improvements have been communicated to staff at a meeting held in April. We will ensure that staff use the existing information to identify resident specific mealtime needs.

We have added to the choice of snacks available to residents so as to ensure that those who require modified diets have access to snacks to meet these needs.

We now have fluids accessible for residents in communal areas.

Each resident who requires monitoring of fluid intake and output is assigned to a named member of staff who ensures the resident's fluids are recorded.

Staff Nurses check fluid intake and output charts at schedule intervals during shifts to ensure they are completed correctly.

Proposed Timescale: a) 31st August, b) 3rd July, c) 31st May

Proposed Timescale: 31/08/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

End of life care planning required improvement to reflect the residents' preference for end of life care arrangements.

Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

We will revise and amend our documentation to ensure that residents' preferences for end of life care arrangements are recorded as part of their assessment and end of life care plan.

Proposed Timescale: 12/06/2015

Theme:

Person-centred care and support

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

The care plans in place did not reflect the residents daily changing healthcare status and would not guide end of life care healthcare issues.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

We will continue regular daily monitoring of residents on end of life care will document updated information to reflect their changing needs in care plans.

Proposed Timescale: 30/06/2015

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

Some staff were observed to demonstrate poor manual handling practices.

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 plan is in place for 2015. As part of this plan, wound management training

has been scheduled for September and October 2015. MUST training has also been included in the 2015 training plan. Mandatory manual handling training is also to include problems experienced by staff in manual handling practices.

Falls prevention training will be provided as outlined in Outcome 11.

Proposed Timescale: 31/12/2015

Theme:

Workforce

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

Staff were not appropriately supervised.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Nurse will no longer carry out medication administration rounds throughout mealtimes and will be available to supervise staff during mealtimes.

Proposed Timescale: 01/05/2015