Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Mountpleasant Lodge
Centre ID:	OSV-0000701
Centre address:	Clane Road, Kilcock, Kildare.
Telephone number:	01 610 3166
Email address:	mountpleasant@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	FirstCare Ireland Kilcock Limited
Provider Nominee:	John O'Donnell
Lead inspector:	Louise Renwick
Support inspector(s):	Nan Savage
Type of inspection	Announced
Number of residents on the date of inspection:	69
Number of vacancies on the date of inspection:	12

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
30 June 2015 10:30	30 June 2015 18:30
01 July 2015 07:30	01 July 2015 20:30

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

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

Summary of findings from this inspection

This monitoring inspection took place over two days, and was to inform a registration renewal decision. As part of the inspection, inspectors spoke with residents, family members, staff and members of the management team. The provider nominee had been put forward in this role as part of the application to renew registration, and was interviewed as part of this inspection. Inspectors observed practices and reviewed

documentation such as care plans, medical records, accidents and incident logs, policies, procedures and staff files.

Inspectors found that residents' health care needs were met in the designated centre. There was evidence of good access to a range of allied health care professionals. Residents were provided with varied diets and their nutritional needs were met. Residents were offered choice at mealtimes and a pleasant dining experience. This designated centre had been purpose built and offered all residents private bedroom accommodation, with ample communal spaces available around the building. The building and the grounds were safe and secure, and maintained and decorated to a very high standard throughout.

Inspectors identified a number of significant concerns during this inspection, with 10 outcomes highlighted as in need of improvement. There were particular concerns in relation to the following:

- Safeguarding of residents and the management of allegations or suspicions of abuse
- Governance arrangements for overseeing the quality and safety of care and the oversight of practice by the person in charge
- Staffing levels and the supervision of residents

The provider had failed to ensure that the person in charge was monitoring the care and support offered to residents, and that complaints and allegations of abuse were satisfactorily dealt with. As a result there were negative outcomes for residents in areas such as dementia care, social activation and the full implementation of care plans to keep residents safe. These findings are detailed within the 18 outcome headings along with 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):
No actions were required from the previous inspection.

Findings:
Inspectors found that the statement of purpose met the requirements of the Regulations. It accurately described the services and facilities that was provided in the centre and was kept under review by the person in charge and the provider. The statement of purpose was available to residents. Inspectors found that in general the services offered were in line with the content of the statement of purpose, with areas for improvements noted further in this report with regards to consistent approaches for all residents living with dementia.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found there to be a clearly defined management structure in place in the

designated centre that identified who was in charge and the lines of reporting and authority. The person in charge was supported in her role by two clinical nurse managers (CNM), with additional support from two operations managers also. Inspectors found that the management structure was known to residents, families and staff. For example, residents who spoke with inspectors were aware of who was the person in charge of the centre.

Inspectors found that the management systems were ineffective in monitoring the delivery of safe and quality care services to residents in the designated centre. While a limited system of audits was evidenced on inspection, this system did not capture the failings as identified in this report in relation to outcomes 5, 7, 8, 9, 10, 11, 13, 16 and 18, or bring about improvements for residents. Inspectors found a lack of oversight to ensure care plans were implemented, risk control measures were followed and any issues of complaints, were appropriately recorded, reported and acted upon. Inspectors were concerned that the provider had failed to ensure a suitable person in charge to manage and appropriately investigate allegations of potential abuse or harm. The provider had also failed to ensure that the person in charge had the required knowledge and understanding this area.

Inspectors found that the staffing resources in the designated centre were not promoting residents' safety and best possible health and social care. This will be discussed under outcome 18. The provider was required to attend a meeting in the Authority's office further to this inspection to provide assurances in relation to these failings.

A copy of an annual review of the quality and safety of care was not available to inspectors during inspection, but was later submitted. The annual review looked at the quality of care delivered in 2014. While this was a comprehensive document in some respects inspectors found that residents and families had not been involved in a consultative manner to inform such a review, and a copy had not been made available to the person in charge, staff or residents.

Judgment:
Non Compliant - Major

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

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

Inspectors found that there was a policy in place for the provision of information to residents available in the centre. There was a written residents guide in the centre which met the requirements of the Regulations, and was available to residents and visitors.

On review of a sample of residents files, inspectors found that written contracts were in place for residents which clearly outlined the terms and conditions of their stay, and any additional fees to be charged. In response to previous inspections of the provider's centre's amendments had been made to the content of the contracts to offer further clarity regarding an additional service charge that residents were required to pay in order to cover what the fair deal scheme did not.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge is a registered nurse with the required experience in the area of nursing older people and worked full-time in the centre.

The person in charge had maintained her continuous professional development by attending some training in relevant areas. She informed inspectors that she had undertaken a Management qualification since the previous registration of the centre. The person in charge is supported in her role by two clinical nurse managers along with a senior operations manager.

While inspectors found that the person in charge satisfied the requirements for person in charge as set out in Regulation 14, there were concerns regarding her participation in the governance and management of the centre as outlined in Outcome 2. There were also concerns regarding her oversight of the health and safety of residents. Inspectors were concerned that the person in charge failed to appropriately investigate allegations or suspicions of abuse, and did not ensure her regulatory responsibility to notify the Chief Inspector of such events. These failings will be further discussed under the relevant outcomes.

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:
This designated centre promoted a paper free environment with an online data system for residents' assessments, care plans and nursing notes and other recordings such as adverse events and complaints. On review of records and documentation, inspectors found that improvements were required in relation to this outcome.

Inspectors determined that not all records as listed in schedule 2, 3 and 4 of the Regulations were maintained in the designated centre. For example, inspectors reviewed a sample of staff files and identified gaps in relation to the documentation, such as employment history and references. There were inconsistencies in the content on individual staff files reviewed.

Inspectors found some instances of inaccurate and unclear recording in relation to residents care. Inspectors found the recording of adverse events and complaints not consistently carried out or afforded equal review. For example, details in relation to an incident between residents was not logged in the accident and incident log. Concerns or complaints raised by family members were not adequately recorded and followed up. This will be discussed under the relevant outcomes further in the report under outcome 8 and 13.

Inspectors found that the polices and procedures as outlined in Schedule 5 of the Regulations were all in place, and comprehensive in nature. Policies had been reviewed and updated as required by the Regulations, and staff had ease of access to the policies at all times. Inspectors found however, that not all policies were implemented fully in practice. For example, the risk management policies and risk register while extensive and well guiding for staff, was found to be not fully practiced over the course of the two day inspection. This will be further discussed under outcome 8 Health and Safety and Risk management. Inspectors found a link between the failings in relation to effective oversight in the centre, and the failings identified in relation to records, documentation and policies.

Inspectors reviewed all documentation as submitted as part of the application to renew the registration of the centre, and found evidence of adequate insurance cover in place.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. The provider had appropriate contingency plans in place to manage any such absence, with the clinical nurse managers identified as the persons to deputise for any absences pf the person in charge.

Judgment:
Compliant

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

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found that the provider had taken some positive measures to ensure the safeguarding of residents from harm or abuse. For example through Garda Vetting of staff and the provision of training in the policy and procedure on preventing, detection and responding to abuse. However, inspectors were concerned that allegations or

suspicions of abuse were not being managed or investigated appropriately by the person in charge to ensure residents' were safeguarded at all times.

At the start of the first day of inspection, the person in charge told inspectors that there had been no allegations or suspicions of abuse recently, or throughout the time since the centre was last registered. On review of records, inspectors were concerned to find two allegations/ suspicions of abuse that had been reported to the person in charge and logged as complaints. On discussion with the person in charge, inspectors were informed that these incidents had been investigated, however investigation documentation was not available in the centre for inspectors' review. This information was requested to be submitted post inspection. The person in charge did not demonstrate the required knowledge and understanding to investigate allegations or suspicions, and as a result there were concerns that residents could be exposed to risk.

On receipt and review of the documentation in relation to these events, inspectors were further concerned with the manner in which allegations had been recorded and investigated and were not assured that the processes in place for investigating such incidents was done in line with national guidance and the centre's own policies. There was a failure to properly investigate reported incidents. This could present a risk, and hamper the provider's ability to ensure the safety of all residents. This is further highlighted in outcome 13, were inspectors found residents, families and staff did not feel confident in bringing issues, concerns or complaints to management. The provider was required to attend a regulatory meeting in the Authority's offices to offer assurances and submit a plan in relation to this matter.

Inspectors found that the centre was managed in such a way as to promote a restraint free environment and positively support behaviours that were challenging. Inspectors reviewed the use of restraint within the centre and found that the use of bedrails for residents were well risk assessed and consistently monitored. For example, nightly checks were evidenced and clear rational for usage demonstrated. Likewise, inspectors found the use of psychotropic PRN medication as a chemical restraint was well documented and monitored with clear rational for its use outlined in the residents' files. On review of daily records, inspectors found that when they had been used, the rational was clearly documented in nursing notes, and evidence of alternatives tried prior to administration. While positive practices were evidenced in relation to the management of behaviours that were challenging and the use of restraint, some improvements were required in relation to the care planning documentation for residents with these needs, as will be discussed under outcome 11.

Inspectors reviewed the staff training records as part of the inspection and found that training in the area of prevention, detection and response of abuse had been carried out and refreshed routinely. Staff could demonstrate knowledge of the different types of abuse and their indicators and the reporting mechanisms for such incidents.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
While there was evidence of some good practice under this outcome, inspectors were not satisfied that the health and safety of residents staff and visitors was promoted at all times in relation to the management of risk, and the supervision arrangements in place for residents.

Inspectors reviewed policies and procedures and found that the documentation as required by the Regulations was in place. For example, health and safety policies, risk management policies, guidance on infection control, a fire safety policy and emergency and evacuation plans. These policies and procedures were found to be comprehensive and staff were aware of how to access them. Inspectors found that infection control measures were effective in preventing the spread of infection or disease, with low incidents of infection control issues noted.

Inspectors found that the fire detection and alarm systems, fire fighting equipment along with the emergency lighting systems were routinely checked and serviced by a relevantly qualified professional. Records in relation to these routine checks were well maintained. There was clear evidence of a number of fire drills carried out to ensure that the staff and residents knew the procedure in the event of a full or partial evacuation. Residents and staff both confirmed these procedures and had a good understanding of the procedures in place.

Inspectors raised a concern with the person in charge in relation to a fire exit with an inactive push button release in one part of the building on the first day of inspection. Should the fire system activate, inspectors were informed by staff and person in charge that the door would automatically release, however staff or residents had no way of opening the exit in the event of another type of emergency situation. The person in charge informed inspectors that the push release button had been deactivated to prevent a previous resident from leaving the building through the exit without staff supervision. Inspectors observed maintenance work being carried out on this door during day two of inspection to successfully rectify this.

Inspectors spoke with staff, and reviewed training documentation and found that staff had received training in fire safety, including what to do should a residents clothes go on fire. Staff confirmed that this training was refreshed routinely. Inspectors found appropriate risk assessments and controls in place to support residents who smoked. Inspectors observed staff sitting with residents in the courtyard while smoking, in line with the supports identified in their assessments.

Inspectors determined that while there was a comprehensive policy and processes were in places for identifying and managing individual risks for residents, there was a lack of oversight and supervision to ensure that these processes were consistently being followed by all staff. For example, inspectors observed manual handling practices that were not in line with best practice during the second day of inspection where by two staff raised a resident to their feet, and maneuvered her into a wheelchair while the resident was unresponsive, in order to bring her to the dining room for a meal. This will be further discussed and actioned under outcome 16.

Inspectors also found the risk of falling for some residents was not adequately controlled. Residents who were at risk of falls and in need of the use of mobilty aids were observed by inspectors walking around the building without their aids, and without the supervision or presence of staff in line with their care plans. This was concerning to inspectors, who were required to intervene at times and link residents who were unsteady on their feet and mobilising around the home in the absence of appropriate supervision. This will be further discussed under outcome 18, where inspectors identified issues with the number of staff and the arrangements for the supervision of residents.

Inspectors reviewed the accidents and incidents log for the designated centre, and found an online system of recording was in place for adverse events. Inspectors found that the incidents logged had all been reported to the person in charge, who had reviewed the content and followed up on the outcome. However, inspectors found some gaps in the recording of all adverse events / incidents on the accident and incident log, along with inadequate measures being put in place to prevent a re-occurrence in some instances. For example, while an issue between two residents that resulted in an injury had brought about a comprehensive wound care plan for one of the residents, there was no evidence of additional measures being put in place to prevent the same incident from happening again. Another record reviewed by inspectors highlighted that two residents were not to be seated beside each other following an incident between them, however inspectors found these residents sitting together at certain times of the day resulting in negative verbal interaction, and the possibility for escalation. Improvements were needed in relation to the process of recording and reviewing adverse events, along with improvements to the oversight measures in place in the centre to ensure all known risks are being adequately managed. As previously highlighted under governance and management these issues should have been adequately addressed by the person in charge.

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:
Inspectors found that residents were protected by safe medication practices in the designated centre, with only one minor area identifed for improvement under this outcome. Inspectors found that documentation in relation to prescriptions and administration of medication was well maintained and staff nurses could clearly outline their practices in relation to the ordering, prescribing, administration and disposal of medication, which were in line with the centre's policy. Administration was observed to be safe and in line with the nursing guidelines. Inspectors found good infection control practices during administration, and a person centred approach. There was adequate and secure storage for medication, with medication requiring refrigeration stored appropriately, and monitored daily.

Procedures around the crushing of medication required improvements to ensure in line with best practice and legislation. Not all medication was individually prescribed to be crushed by the residents' General Practitioner (GP). This was in need of address, to reduce the likelihood of potential errors or risks associated with incorrectly crushing medication.

Inspectors reviewed a recent medication audit which was carried out in June, and found that positive changes had been put in place following the findings of the audit. For example, eye drops now contained a sticker to show the date of opening, and trolley were observed to be locked at all times during the inspection when not in use.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors determined that the person in charge had failed to notify the Chief Inspector of some notifiable events that had occurred.

While there was a system in place for the recording of incidents, accidents and near misses, inspectors found gaps in appropriate review and learning from adverse events as previously mentioned under outcome 2 Governance and Management.

On the first day of inspection, the person in charge told inspectors that there had been no allegations or suspicions of abuse in the previous 3 year registration cycle. On review of the accident and incident log, inspectors were concerned that two allegations of abuse which had required preliminary screening by the person in charge, had not been notified to the Chief Inspector. Information related to these incidents was not available in the centre during the two days of inspection. The person in charge was required to submit the two notifications and supporting documentation to the Chief Inspector following inspection. These were received prior to report writing.

Judgment:
Non Compliant - Moderate

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 determined that residents' health needs were met in the designated centre through timely access to a range of allied health care professionals with evidence of referrals, appointments and follow ups to address various health care needs for residents. However, some improvements were required.

Inspectors reviewed a sample of care plans and found a system of assessing and planning for care needs was in place. For example, assessments and care plans for skin intergrity, hypertension and foot care. Of the sample of documentation viewed, the content of plans were found to be informative and offered clear guidance to staff. However, through observations inspectors found that some care plans were not informing direct practice. For example, falls prevention plans and mobility plans were not consistently implemented. This was linked to the failings as identified in relation to ineffective oversight and review in the centre, along with inadequate staffing levels to ensure appropriate supervision. Improvements were also required to address any gaps in care planning for identified needs. As mentioned under outcome 7 not all residents who presented with behaviours that were challenging or who required the use of restraint had clear and practical care plans in place to guide staff in the consistent response to these needs.

Inspectors reviewed residents social care plans, timetable of activities along with

speaking with the social care leader for the centre. Inspectors determined that there was a good array of scheduled group activities for residents to partake in. A pictorial timetable with a choice of things to do during the day was on display around the building and inspectors observed residents enjoying activities such as live music sessions and fitness class. On the files reviewed, inspectors found assessments had been carried out in relation to residents social needs and levels of participation and interests.

Inspectors were informed of the provider's plan to trial a minibus with the aim of purchasing one, to support residents to go out to the community more often. Inspectors noted in the past three weeks some residents had begun attending mass in the community which was spoken of positively by residents and families. While inspectors found positive evidence in relation to the provision of activities in the centre, further assessment and improvements were required for residents with dementia and residents with higher support needs, who could not chose to independently attend group sessions, or were not able to access the community. For example, on review of a resident living with dementia who stayed in their room a lot, they had not been supported to go for a walk around the grounds in the previous 30 days even though the care plan and assessments noted this as a preferred activity. Inspectors spoke with staff who expressed that they had limited time to spend engaging with residents who required this one to one engagement due to the other tasks of their roles, such as supporting with personal care and meal times. Inspectors determined that the issues as outlined in outcome 18 in relation to staffing in the centre, impacted on meaningful interactions and engagement with residents of higher support needs.

Inspectors found inconsistencies regarding supports offered to residents living with dementia based upon their location within the centre. For example, residents in the specific unit for dementia had some very positive things available to them to assist them with daily life. For example, detailed personal life profiles outside their bedroom doors, life story photo books, some residents had doll therapy to support them to feel secure which was promoting more positive sleep and corridors were decorated with old garments or objects to trigger memories. However, for residents on the upper floor and other parts of the building who had been diagnosed with dementia, these positive interventions had not been put in place and supports were limited in assisting them with their dementia care needs. This was not consistent with what was outlined in the statement of purpose.

Judgment:
Non Compliant - Moderate

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

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found that the location, design and layout of the designated centre was suitable for its stated purpose and met the residents' individual and collective needs in a comfortable and homely way. Overall inspectors found that the premises were decorated and maintained to a high standard and had suitable heating, lighting and ventilation. On the day of inspection the building and surrounding grounds were clean and well presented. The building was equipped with a functioning call bell system.

There was sufficient communal spaces available for residents' use throughout the building. There was accessible courtyard area which was fully accessible off the ground floor, and included numerous external seating area. Inspectors discussed with the provider nominee the absence of a secure garden space for residents in the dementia specific part of the building to independently access, as at present these residents were reliant on staff to bring them to the courtyard area to avail of outdoor space due to the restricted access in place. The provider nominee showed inspectors some plans for enhancing outdoor spaces around the centre which would be a positive change and afford more accessible space for residents.

The designated centre had a separate kitchen with sufficient cooking facilities and equipment. The designated centre had adequate laundry and sluicing facilities in place. The centre met the requirements of Schedule 6 of the regulations.

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):
No actions were required from the previous inspection.

Findings:
Improvements were required by the person in charge to ensure complaints were listened to and acted upon in the designated centre.

The person in charge was using new paper based forms for the recording of complaints

which were reviewed by inspectors, and found to be inclusive of all information required by the regulations. Inspectors noted 2 complaints had been dealt with on this new format, and this was proving effective in showing satisfaction levels, learning gained and any changes needed following a complaint that had been dealt with formally. However, overall inspectors identified that improvements were needed in the management of complaints and issues raised by residents and families.

Inspectors reviewed the complaints log, spoke with residents, relatives and staff and reviewed questionnaires and determined that the documenting of complaints was limited and as such did not ensure improvements were brought about. Inspectors found that only 10 complaints were formally recorded on the complaints log and followed up since September 2013. On discussion with the person in charge, inspectors were told that other "informal complaints" were sometimes logged as an issue raised on the residents' progress notes under family communication. Inspectors were concerned that this method did not provide for the person in charge to observing patterns of issues being raised, or ensuring learning and improvements as a result of complaints. It was also not ensuring records were being maintained as required by Schedule 4 of the regulations. Inspectors spoke with relatives, residents and staff and found that some of the complaints previously raised had not been recorded as such, and relatives had not always been given a response that was satisfactory to them. This issue was highlighted as part of previous inspection and assurances given by the provider at the time to address this.

Relatives, residents and staff who spoke with inspectors did not feel that it was always easy to raise complaints and voice concerns, and residents and relatives were not fully aware of the complaints process and their ability to appeal and seek further information should they be dissatisfied. Inspectors determined that the failings identified under this outcome were directly linked to the improvements needed in relation to the oversight and review of the service being delivered, as mentioned under outcome 2 Governance and Management.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
This outcome had been previously inspected in November 2014 as part of the thematic

program of inspections by the Authority. At the thematic inspection this outcome was found to be compliant with the Regulations.

On this inspection, inspectors determined that compliance with the Regulations and standards had been maintained. For example, residents who were at end of life had their care needs planned out for and met. There continued to be good access to appropriate health care professionals such as the hospice for palliative care. Residents who were at end of life had privacy due to single room occupancy. Inspectors discussed at feedback staffing in relation to residents who were at end of life, as rostered hours had not been increased or amended due to the needs of three residents who were at end of life. Inspectors found that impacted on staff's ability to spend meaningful time with residents who were at this stage. This will be discussed under outcome 18 Staffing.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
This outcome had been previously inspected in November 2014 as part of the thematic program of inspections by the Authority. At the thematic inspection this outcome was found to be compliant with the Regulations.

On this inspection, inspectors determined that compliance with the Regulations and standards had been maintained. Inspectors found there to be policies in place to guide staff on food and nutrition, the monitoring of intake and specific areas such as dysphagia. Assessments and care plans were in place to support residents with their nutritional needs. Inspectors met with the chef and found a four week menu was in place with evidence of choice and variety available to residents. Inspectors found the chef knowledgeable on the dietary needs and food plans for residents. Inspectors observed appropriate assistance being offered to residents in terms of sensitivity to their support needs. Inspectors were told by residents that the food was nice and well presented, and that they had choice.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents and family members spoke highly of the staff team and their attitude to their roles, and friendly nature. Inspectors observed positive interactions between residents and staff over the two days. Inspectors observed good examples of the dignity of residents being promoted throughout inspection, for example ensuring doors closed for personal care and knocking on bedroom doors before entering. Some use of language was heard or read which was not in line with the policy on privacy and dignity and this was brought to the attention of the person in charge during feeback. For example ,using the term "cot sides" instead of bed rails, or referring to residents as a "flight risk". The person in charge undertook to address this.

Inspectors reviewed minutes of two residents' meetings that had been held in the centre, along with some feedback surveys from resident and families and determined that while there was a process of consultation in place in the designated centre,

Inspectors found that due to the current staffing levels, care delivered was observed as being task focused instead of person centred due to the requirement of the staffing team to achieve their daily duties. For example, inspectors observed staff attempting to wake a resident who was asleep in an armchair in order to bring her to the dining room for dinner, when the resident failed to wake staff lifted this resident into a wheelchair and brought her to the dining room. The focus of staff was to ensure the resident was in the dining room by a certain time without regard to the wishes of the resident. Inspectors spoke with staff who outlined their cleaning, kitchen and other duties that needed to be done on each shift, which often resulted in residents not getting 1:1 time as outlined in their care plans.

As outlined in outcome 11 health and social needs improvements were required to ensure positive activation and social engagement for residents with higher needs in line with their assessments and plans and the statement of purpose.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found there to be policies and procedures in place to guide staff in the area of protection of residents' personal property. Inspectors reviewed residents' files and found there to be inventory lists of belongings and furniture. However, there was no system of recording residents clothing. This was mentioned to the person in charge at feedback.

Inspectors reviewed the new laundry system which had been put in place only recently, with all clothing going out externally to be laundered off site. As this was a new system in place, possible error were only being identified or raised to the person in charge at this time. Relatives and staff mentioned some instances were clothing went missing, this was mentioned in the questionnaires also. An adequate system to track what goes out to external laundry and its safe return was needed. The person in charge planned on bringing in a new system to address this.

Judgment:
Compliant

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

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The number of staff in the designated centre was not adequately meeting the needs of all residents, and promoting their health and safety at all times.

While the person in charge had used a tool to determine the staffing hours required based on residents' dependency levels, this tool did not encompass the individual needs of residents with dementia, residents who wandered and were looking to leave the building, or residents who were at end of life that required additional personal engagement and support. On the two days of inspection inspectos were informed that there was a full compliment of staff working in the centre, along with two additional staff who were part of the pre-registration project for staff nurses. The two clinical nurse managers were also available for the full two day of inspection.

Through discussions with families, staff and from direct observations over the two days inspectors had concerns regarding the level of staffing and direct supervision of residents in the centre. For example as mentioned across various outcomes, residents at risk of falls were observed mobilising unsupervised without their walking aids, the opportunities for staff to spend meaningful time with residents was found to be limited and residents were seeking out inspectors for assistance in the absence of a staff presence. Families spoken with during the inspection all expressed concerns regarding the amount of staff available to support their residents, and gave examples of providing personal care themselves at times of limited staffing, supporting residents to get to bed, and difficulties in finding a staff member to call on at certain times of the evening. Inspectors observed that at times of staff hand over meetings on both days of inspection there was inadequate direct supervision in place at these times with inspectors needing to call on staff to alert them that residents were in need of assistance. This was something raised by family members also. Questionnaires reviewed indicated that family members and residents felt there was not always adequate staffing on duty.

Inspectors found that the education and training made available to staff by the provider was supporting them in their roles. There was good access to mandatory training, which was refreshed routinely in line with the centre policy. Documentary evidence of training attended was in place and staff verified that training was delivered and refreshed often. Staff felt their training needs were being met by the provision of training and information from the provider.

Inspectors determined that the direct supervision of staff was in need of improvement to identify the effect of the current staffing on residents, and to ensure the effective implementation of care planning and risk management controls. Inspectors spoke with the provider nominee regarding staffing, who outlined current projects that were in place for the recruitment of staff nurses to ensure an adequate number of nursing staff in the centre. While this was a positive and proactive approach to ensuring adequate nursing cover, inspectors found that these measures would not address the issues with the overall number of staff members and supervision of residents on a consistent basis. Inspectors were also informed that the provider had taken the decision to ensure the centre did not reach full capacity in relation to resident numbers until a time when staffing had improved, on the day of inspection there was 12 vacant beds in the centre.

Staffing had previously been highlighted as an issue at past inspections, and the provider had offered assurances that this would be addressed. However, the provider had failed to implement the required improvements and there continued to be poor outcomes for residents as a result of staffing.
Judgment: Non Compliant - Major

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:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Mountpleasant Lodge
Centre ID:	OSV-0000701
Date of inspection:	30/06/2015 & 01/07/2015
Date of response:	23/09/2015

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems and oversight in place were not ensuring effective monitoring of the safety and quality of care for residents. Issues of concern to residents had not been addressed. The provider had failed to ensure the person in charge had investigated issues of concern brought to her attention.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
Mountpleasant Lodge has a clearly defined management structure under the leadership of the person in charge, and clear guidelines with regard to the delivery of quality care services to all the residents. It is clear that the report has highlighted some important concerns in regard to governance, leadership and management, and therefore we have carried out a detailed review of the current defined management structure and operations in Mountpleasant Lodge, and are currently making the appropriate changes and improvements for the benefit of all the stakeholders.

The complaints procedure and policies has been reviewed. The policy now includes a procedure in relation to concerns. The review of the policy included an examination of the audits in place, the monitoring systems and the use of the findings to improve and dictate changes to practice.

All concerns must now be logged in a similar manner to complaints, and addressed as per the Policy. All issues raised as either a complaint or a concern are reported immediately to the Operations Team and included on the weekly Report. The Operations Team are now involved in the management and resolution of all complaints/concerns in the home. The complaint log is reviewed weekly by Senior Management to ensure all complaints/concerns are managed as per the policy and to ensure satisfaction of the complainant.

Additional Training will take place for all clinical staff to include the PIC, CNMs and Nursing staff regarding the management, recording and monitoring of complaints/concerns.

The changes to Policy, are now all reflected in all appropriate documentation.

Proposed Timescale: 30/09/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of inspection, the annual review report was not available to residents, families or staff.

2. Action Required:
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
The Annual Review had been prepared prior to inspection by the Operations Team, and

was made available to the Inspectors following the inspection, and immediately afterwards to residents and families, and is currently on display in the reception area of the home. The families and residents will be approached with a view to securing their involvement, in a consultative manner, in the preparation of the Annual Report for 2015 at years' end.

Proposed Timescale: 05/07/2015

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:
Not all schedule 5 policies were fully implemented in practice. For example, the risk management policy.

3. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
Mountpleasant Lodge has a robust set of risk management policies as guides for staff. These guides and policies will be shared again with staff and further education completed by the PIC and Operations Team to ensure an understanding of everyone's roles and responsibilities in relation to the management of risks within the home and to residents. The additional staffing on a daily basis within the home, will assist in practices found lacking on the days of inspection, being implemented.

All policies and procedures on the matter set out in Schedule 5 have been reviewed.

Proposed Timescale: 31/10/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records relating to the staff files were not complete, and records regarding investigation of allegations of abuse were not available in the centre or for inspectors review.

4. 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:
An audit has been undertaken on all staff files to ensure all necessary documentation is in place. All compliance paperwork will be reviewed and updated where required. Staff, where needed will be requested to complete any outstanding documentation to ensure adherence to the regulations. If required Mountpleasant Lodge will retrieve paper copies of staff files (now in storage) to ensure compliance.

On the days of inspection it was found that items required by the Inspectors had been archived and were not readily available as they were in storage off site. An extensive audit will be completed of all documentation that should be on site to ensure that all paperwork is appropriately scanned and is available for reference should it be required at a future date prior to archiving.

Proposed Timescale: 30/11/2015

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:
The person in charge did not demonstrate understanding of the appropriate response to an allegation or suspicion of abuse.

5. 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:
Mountpleasant Lodge has longstanding and clear protocols with regard to how any allegations or suspicions of abuse are dealt with. To further assist, we have devised a more robust Policy on Notifications and a framework to assist the PIC and the management team with recognising the NF's that are required for specific events within the home.

Further training will take place with the PIC and the management team around their roles and responsibilities in relation to the detection and notification of allegations or suspicions of abuse. Training will also take place with the management team to reiterate and ensure clarity around the required response to allegations of abuse. All staff receive mandatory yearly training on how to deal with allegations or suspicions of abuse.

The new documents to assist and support the PIC and the management team are attached with this response.

Proposed Timescale: 30/09/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Preliminary screening or investigation into allegations or suspicions of abuse were not comprehensively carried out.

6. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
The allegations or suspicions of abuse indicated in the report relate to two incidents that occurred in 2014. Both of these incidents, were investigated at the time in 2014, and both allegations were determined to be unfounded.

All Standard Operating Procedures are in place in relation to investigations, and Mountpleasant Lodge has the support of our Human Resources Department in relation to any future investigations. Whilst the policies were in place in relation to the investigation of suspicions of abuse, they were not fully applied. The Operations Team continue to supervise and support the home to ensure the policies of Mountpleasant are applied where necessary. The management team has received training in this area and refresher training will be made available to the PIC. The Operations Team will continue to meet with the PIC to reiterate the importance of the role, the responsibilities, and the accountability of all involved in residents' care, in relation to safety. As a matter of urgency this further training and education will be made available to all staff participating in the management of the home.

Proposed Timescale: 31/10/2015

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:
Measures and actions in place to control all identified risks were not fully implemented or effective in practice.

7. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
Mountpleasant Lodge has a comprehensive set of risk management policies in place, to guide staff to maintain a safe environment. We have carried out a review of all risk related practices by management and staff in Mountpleasant Lodge to ensure that everyone is aware of the importance of their thorough and consistent application.

All staff are to receive further education and reminders of their roles and responsibilities in relation to the management of risks to residents. All clinical staff will have access to care plans and assessments conducted to determine risks and the measures in place to prevent those risks identified. Further training will take place with an external training company in relation to the management and actions required to control risks

Proposed Timescale: 30/11/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements for learning from incidents was not effectively preventing re-occurrences.

8. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The Operations Team has identified that an audit of the clinical audits conducted in each area of the home, needs to be developed to provide a further level of feedback to us. This audit will allow us to establish trends and learning lessons within each clinical area. This will be an extensive audit that will indicate to us where further improvements can be made. The audit should allow us to identify the changes required, implement an action plan and monitor changes going forward. It is important to note that the auditing process is cyclical and this process will be a continuous improvement tool.

The Operations Team and the PIC will continue to meet monthly to openly discuss learnings from incidents as they occur in the home, provide learning and seek clarity on events.

Proposed Timescale: 30/11/2015

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:
Practices relating to the crushing of medication was in need of review to ensure medications were individually prescribed as suitable for crushing.

9. 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:
Mountpleasant Lodge residents are protected by safe medication practices, which are regularly monitored and updated. All Residents who are to have medications crushed have had their Nursing Home Prescriptions reviewed and the issue of crushing has been addressed by the GP. Moving forward each area indicating that crushing is required will be signed by the GP.

Proposed Timescale: 07/07/2015

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two allegations of abuse had not been notified to the Chief Inspector.

10. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
Subsequent to the inspection both of these allegations relating to incidents in 2014 were notified in writing to HIQA using the appropriate NF06. There have been no allegations or suspicions of abuse in 2015, and as mentioned above, when both of these allegations were investigated in 2014, they were determined to be unfounded. A framework regarding notifications has been put in place by Mountpleasant Lodge, to ensure all staff are clear in relation to what constitutes as an allegation or suspicion of abuse and when a notification is required.

Proposed Timescale: 30/09/2015

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All residents with dementia did not receive the required level of support in accordance with their assessed needs.

11. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Mountpleasant Lodge has made considerable investment over the past few years, customising areas within the home to make it suitable for residents living with a Dementia, so that the separate stages of their journey are acknowledged, and so they can enjoy the very best quality of daily life as is possible. Linked to the latter, we have partnered with a Dementia Consultant in the UK. Together we have devised and executed a series of Dementia specific training courses, and certificate and diploma modules, for all of our staff, clinical and non-clinical, so that they have the skills and tools to equip them to care for our residents living with a Dementia.

Prior to the inspection, the Mountpleasant Lodge management team had identified to the Operations Team the rising number of residents living in the home with a dementia. After some detailed planning, a significant investment was made in incorporating the remaining ground floor in Mountpleasant Lodge, into the Aisling dementia specific homestead. We are currently reviewing the First floor of the home to see what further improvements can be made.

All residents living with a dementia in the home will continue to be individually re-assessed by a named nurse working in the home. Each resident has a care plan in place to reflect their individual needs. Each care plan puts in place an action plan with staff highlighting the needs of the resident and how best these can be met, bearing in mind the residents' level of dependency, choices, wishes, preferences and well-being.

Mountpleasant Lodge will address the issue of Regulation 5(2) with the introduction of clearly defined policies on the Management of the needs of a Resident with a dementia. (Completed 15th September 2015)

Mountpleasant Lodge have also enlisted the further assistance of an external advisor who is very well respected in the provision of dementia training, to work with the staff in the home regarding those residents with a dementia, and how best to ensure the residents needs are continually met in a dignified and person centred manner, bearing in mind their needs and required levels of care at any given time. This further training will commence alongside staff on the floor, in the first week of October 2015, and will continue to meet with staff to support them and guide them for a period of 6 months.

The development of a Dementia Garden, which was in planning at the time of the inspection, and discussed with the Inspectors, has been completed, and is in the

process of being landscaped appropriately, to meet the sensory and spiritual needs of our residents living with a dementia. (Completed 29th September 2015)

Proposed Timescale: 01/03/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care delivered in practice was not consistently in line with residents' care plans. Not all identified needs resulted in clear care plans and practices. For example behaviours of concern, or dementia needs.

12. 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:
Mountpleasant Lodge's new resident care planning system is informative and offers clear guidance to staff, and will ensure inconsistencies between the care plan and the care delivered are avoided. This computerised system allows only nursing staff access to core care plans currently. The Operations Team in consultation with the clinical staff have decided to ensure all clinical staff, including Care staff, will now have access to and be involved in the development of these care plans going forward.

Staffing increases that were in the process of being implemented at the time of the inspection, as outlined in Outcome 18, will also assist with the implementation of the needs as addressed in the care plans, and also the inconsistencies in care noted on the days of inspection.

Care plan audits are conducted monthly by the nursing home management team. Mountpleasant Lodge uses named nurses to ensure care plans are monitored and updated monthly (or sooner if indicated).

Proposed Timescale: 31/12/2015

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all complaints were sufficiently documented in the designated centre by the person

in charge.

13. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
Following the inspection the Operations Team gave all families an opportunity to meet with them in relation to any concerns they may have had. Any complaints/concerns highlighted were handled and managed as per Mountpleasant Lodge policy, and all complaints/concerns were logged and addressed. The home now has a concerns log in place and this will be replaced by an electronic log to record concerns, in a similar fashion to complaints, in the coming weeks.

Mountpleasant Lodge has implemented a new system to record concerns raised, which is inclusive of all the required information, and is proving effective in showing satisfaction levels, learnings gained, and follow-up.

All complaints and concerns are recorded on a weekly report, and monthly audit is completed to ensure that the policy is adhered to, and that all information pertaining to the complaint is logged and recorded appropriately. All learning will be logged and audited at monthly management meetings, to ensure that changes to practice that are required take place, and becomes the norm within the home.

Complaints and concerns will be recorded and summarised on the annual report. All complaints and concerns will be reviewed monthly by the senior management team to ensure compliance with Mountpleasant Lodge policy, and ensuring the appropriate management of same.

Proposed Timescale: 31/10/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all complaints brought about improvements due to the limited recording of complaints.

14. Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The Complaints Policy has been reviewed as per the response in Outcome 2 and the Senior Management Team will have more input into the management and monitoring of all complaints/concerns, including learning lessons and changes to practice.

Mountpleasant Lodge recognises the need to ensure we audit our internal audits of complaints and concerns to ensure learning is achieved and change in practice is dictated through that learning. We recognise that this process is never ending and ongoing on a continual basis. Ongoing effective monitoring will highlight the areas that require change in practice.

Families, staff and visitors need to be continually made aware of the policies in place, and the fact that complaints and concerns are tools to be used to improve practice. Improved communication is welcomed, and Mountpleasant Lodge will continue to host regular meetings with residents/families to allow issues of concern be openly voiced in a person centred manner, be addressed informally through appropriate channels, and have feedback and regular auditing, to ensure appropriate change in practice and learning is achieved.

Proposed Timescale: 30/09/2015

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:
Residents with higher dependency needs were not afforded suitable opportunities to avail of activities in accordance with their interests and capacities.

15. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
All staff in conjunction with the Activity Team/Social Care Leaders (SCL's), work hard to make the day as interesting and varied as possible for each resident. The SCL's will continue to review and audit all individual residents', 'Key to Me', and care plans, to ensure that each individual resident's interests are being cared for and met. This information once gathered and collated, is shared with all staff so that there is continuity in the activities being provided for each individual.

The SCL's will continue to review the weekly activity programme to ensure all interests and capabilities are catered for. The SCL's will address any issues, where possible, that relate to residents for whatever reason, being unable to attend specific activities of interest.

Those residents that prefer sole activities are currently being catered for in their rooms and in smaller groups. The SCL's, with the nurses, will continue to assess each individual's ability to attend and continue to attend current activities. The SCL's will liaise with families of these residents who have a cognitive impairment, to ensure all

previous interests and hobbies are known to them and catered for within the home. The SCL's ability to ensure all residents receive active and meaningful engagement has been further increased with the addition of staff as per Outcome 18.

Mountpleasant Lodge have sought the further assistance of an external advisor from the UK, to assist the SCL's with the review of the activity plans and care plans. The SCL's has attended an extensive training course, of a 12 month duration, relating to the area of activity provision. A further one day's training has taken place and the SCL's in the home during September 2015, to facilitate further learning regarding activity provision and meaningful engagement for residents living with a dementia. A new Policy relating to Activities and Activity provision has been developed by the Operations Team, and is for delivery to all staff in the home. Mountpleasant Lodge is the first nursing home in Ireland to recognise the benefits of formal training programs for Social Care Leaders through NAPA.

Proposed Timescale: 30/11/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident was not offered choice or consented to being moved while asleep.

16. 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:
Mountpleasant Lodge strives to put Person Centredness at the heart of every interaction with our residents and staff, thereby endeavouring to ensure all residents receive the appropriate care they require, as and when they require it. However, we are aware that we have to be continually vigilant and ensure that this policy is not deviated from.

As a result all staff working in the centre have been involved in a discussion around person Centred Care and what this means to Mountpleasant Lodge, and the residents in our care. Staff have been reminded that it is important to ensure that all residents are offered choice and supported to consent to actions taken by others. Where consent cannot be sought due to cognitive impairment, staff are asked to consider the resident and the fact that certain activities such as mealtimes for example, can wait until a resident wakes. Mountpleasant Lodge have sought assistance from an external advisor to complete additional training and further education for all staff in this respect.

Supervision of staff has increased informally on the floor and the management team can deal immediately with issues as and when they arise.

Proposed Timescale: 30/11/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of staff was not appropriately meeting residents' assessed needs and managing assessed risks.

17. 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:
Mountpleasant Lodge senior management are constantly evaluating the staffing needs of our residents. As advised to the Inspectors at the time of feedback, additional staffing had been approved (Heath Care Assistants), and interviews had taken place in the weeks coming up to the re-registration inspection for staff. Since the inspection these staff have been allocated to the roster. We have an additional carer on night duty between both floors to act as a floater. We also have an additional carer on both the ground floor and first floor daily from 8am-8pm. Interviews continually taking place in the home to ensure adequate staff are available to complete the roster requirements for the home.

Rosters are completed at least 2 weeks in advance with careful consideration given to:
• Skill Mix of staff
• Gender of staff
• Experience of the staff
• Staff Qualifications
• Length of tenure and knowledge of residents

A review of the handover has taken place and we are currently trialling a new practice which allows for additional staff to supervise resident's during handover times. We are giving consideration to changing the handover time from 12 noon to 2pm and have engaged with staff to seek feedback and input on the suggestions made for a more person centred safe practice to take place. (Completed July 31st 2015)

Proposed Timescale: 31/07/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate supervision of staff to ensure care plans were being followed,

control measures for identified risks were being adhered to and staff were working in line with policies and procedures.

18. 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:
We have carried out a review of the management structure in Mountpleasant Lodge to ensure that supervision of staff is always to the highest standard possible.

The management structure within the home allows for the Home Manager to supervise staff with the support of our Clinical Nurse Managers. The additional staff within the home allows for additional time with residents to ensure their needs are met as per their required needs. The restructure of break times, handovers, and staffing, allows for additional numbers of staff to maintain safety and supervision within the home.

Staff are supervised by their direct line managers and all clinical staff including the home manager are present at handovers and evident on the floors during the day.

Mountpleasant Lodge have reviewed the staffing structure within the home and have made significant changes to placement of staff, the hours worked on shifts and break times. Supervision of all staff is maintained through working with peers and managers and also through interaction daily. Supervision is also achieved through one to one meetings, appraisals and department meetings.

Proposed Timescale: 01/10/2015