

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Cara Care Centre
<b>Centre ID:</b>	OSV-0000735
<b>Centre address:</b>	Northwood Park, Santry, Dublin 9.
<b>Telephone number:</b>	01 894 0600
<b>Email address:</b>	CCCreception@tlccentre.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	TLC Northwood Limited
<b>Provider Nominee:</b>	Noel Mulvihill
<b>Lead inspector:</b>	Leone Ewings
<b>Support inspector(s):</b>	Nuala Rafferty
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	102
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

**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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 11 March 2016 10:30 To: 11 March 2016 18:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant
Outcome 02: Safeguarding and Safety	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 04: Complaints procedures	Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliant

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. In 2015, information seminars took place for providers on evidence-based guidance and procedures were held. Guidance materials on the thematic inspection process is published on the Health Information and Quality Authority's (the Authority) website. Information was received by the Authority that highlighted concerns in relation to staffing and premises negatively impacting on the care and welfare of residents. The person in charge confirmed that there had been no complaints made in relation to staffing and premises.

Inspectors met with residents, relatives and staff members on this unannounced inspection. They reviewed the assessed care needs of all residents and tracked the journey of a sample of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a formal recording observational tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined relevant policies and the provider's self assessment questionnaire which was submitted prior to the inspection.

The person in charge had completed the provider self-assessment and compared the service with the requirements of 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 2009. A fully compliant self-assessment was submitted by the centre.

The centre provides a service for dependent persons requiring long term care and support and also dementia care. On the day of the inspection there were 102 residents in the centre, 52 residents had a formal diagnosis of dementia, with a further 12 residents suspected of having a diagnosis of dementia; a small number of people had been identified to inspectors with support plans in place for responsive behaviours and cognitive changes. There was no designated dementia care unit identified, and all residents lived together in the centre, with accommodation over four separate storeys. Most residents had single private accommodation (most of which was en-suite) and there were 21 twin rooms.

The centre provided an environment for residents to move around as they wished with wide corridors and spacious accommodation. Two passenger lifts and stair cases connected all five floors, and a parking/service area in the basement. There were sitting and dining communal rooms on the all floors. All were suitably furnished to meet the needs of up to 103 residents. The centre is located in an urban area with nearby shops and facilities. An external accessible garden was landscaped on the grounds, with an outdoor smoking area available.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or were informed of any abuse taking place. However, the practices and training for staff around managing responsive and psychological behaviours, and the safe use of any restrictive practices required improvement, as staff did not consistently implement policy and best practice in this area.

The staff were familiar with each residents health and social care needs. There was good access to the general practitioner and a wide range of allied health professionals. An activities coordinator facilitated activities in the centre and a programme including those with cognition difficulties. Residents were fully supported to give feedback which informed the running of the centre.

The one action relating to provision of improved documentation of complaints records had been fully addressed from the last inspection on 23 July 2014.

There were some improvements identified around restrictive practices and record keeping. Improvements were also required in terms of staffing and training.

The findings from this inspection are outlined in the body of the report, and the action plans at the end of the report identifies areas for improvement. Six actions are the responsibility of the provider and six are the responsibility of the person in charge.

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Residents wellbeing and welfare was maintained to a good standard, with each resident's assessed needs set out in individual care plans that identified their needs and interests. There was a policy in place that set out how resident's needs would be assessed prior to admission, on admission, and then reviewed at regular intervals. A review of the resident's records showed that this was happening in practice. All residents had a care plan that was developed on admission, and this was added to as the staff got to know the resident better. However, some improvements were required with regard to assessment tools used as outlined in Outcome 2 of this report. The care plans in place for psycho-social care, required improvement as they did not always provide adequate guidance to staff involved in care provision.

The person in charge advised inspectors that the pre-admission assessment completed would consider if the centre would be able to meet the residents' assessed needs. A written admissions policy fully guided and informed staff with regard to admission requirements. When considering admissions the person in charge or his deputy would consider if the resident's needs would be met in that environment. There were pre-admission assessments in place for all residents, and for residents admitted under Fair Deal. The common summary assessment forms (CSAR) was completed. These documents identified a detailed assessment of each resident's needs and an assessment of their cognitive abilities was completed. In addition, the person in charge completed his own assessment of residents' cognitive abilities. This involved visiting the resident at home or in the acute setting. Residents and relatives confirmed to inspectors their involvement with the pre-admission process and the care plan development and review. However, documentation of resident and relative involvement required review as in the current form it was a signature sheet and did not detail what aspects of the care plan review were discussed.

Residents could retain their own general practitioner (GP) if this was feasible, but arrangements were in place for medical practitioner services. Residents were seen on day of admission or within 72hrs, the person in charge confirmed this happened in practice. Records also confirmed that where medical treatment was needed it was provided in a timely manner. Records reviewed by inspectors showed that residents had

timely access to GP services, and referrals had been made to other services as required, for example, dietician, the speech and language therapist, optician, dentist or dietitian. The community intervention team and specialist older persons services also were available to residents at this centre on referral.

The person in charge or his deputy completed the detailed assessment for the residents, and completed the detail of how to support the residents in relation to their identified needs. For example; communication, nutrition, daily living skills, mobility and pain management. A detailed life history document was implemented by staff and involved resident, relatives and activities staff. A memory box display cabinet was also utilised outside residents rooms with items of reference for each resident. The records reviewed was reflected important personal information and events in each residents' lives.

Records also showed that where there were known risks related to a residents care they were set out in the care planning documentation on admission. Improvements were required in the documentation reviewed relating to nursing assessments completed. For example, a number of records reviewed did not have up to date risk assessments in place for the use of bed rails. Adequate behavioural support care plans were not in place to inform and guide staff prior to the use of any form of chemical restraint. Aspects of these findings are considered under Outcome 2 of this report.

Care plans were informed by this information and were seen to include health and social needs, with information about residents social, emotional and spiritual needs included. Areas such as each individuals understanding of their health care needs were covered in the documentation, and end of life care wishes (where appropriate). Where residents had religious or spiritual believes this clearly was recorded in their care plan, and it was set out how they would continue with this to support them in the centre, for example, their preference to remain in the centre, attending the services provided in the centre, or arrangements for receiving sacrament of the sick.

Evidence was seen and confirmed during the inspection that residents were closely monitored, and where there was a change in the presentation of the resident, action was taken quickly to respond to that. Where residents had been admitted to hospital, records were seen that detailed what the residents needs were, and included any medication they were prescribed.

A range of evidence based tools were seen to be in use to assess and identifying any changes in areas such as nutrition and hydration, dependency, skin integrity, oral care and risk of falls. Resident's assessed and identified needs were set out in care plans that described the care need and the support to be provided to meet the need, for example if residents needed support with mobility or pain management or communication needs. There was evidence that the care plans were being reviewed and updated every four months, or as needs changed. Documents were updated and signed by the nurses responsible for the records.

There was evidence that residents and families were involved in developing the plans, and staff incorporated these meeting dates into the care plan reviews. There were four residents in the centre with wounds or skin breakdown that required nursing intervention. There were robust evidence based care plans were developed for these

residents to prevent further difficulties and all were being appropriately monitored and managed.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and weekly when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dietitians and speech and language therapists where appropriate. Nutritional and fluid intake records, when required were appropriately maintained.

Inspectors joined residents having their lunch in one of the dining rooms, and saw that a choice of meals was offered. The system of communicating between nursing staff and catering staff for residents prescribed special dietary requirements was robust. Inspectors found that residents on weight reducing, diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. Mealtimes in the dining room were social occasions with attractive table settings and staff mostly sat with residents while providing encouragement or assistance with the meal. Some aspects of staffing at mealtimes required improvement, including the practice of staff taking breaks during mealtimes, was not conducive to ensuring that all residents received their meals in a timely manner, this aspect is considered under Outcome 6 of this report. Observation at mealtimes also was indicative of some elements of task orientated care, and a review of noise during the meal for those using the dining room was recommended to the provider and person in charge.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risks including a validated tool for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of further falls. Where residents had fallen there were post falls assessments and incident forms were completed. A review of the information about where and when falls were occurred to identify if there were any changes that could be made to reduce the risks. During the time inspectors were in the centre, they saw evidence of staff supporting residents to maintain their mobility, encouraging them to walk with staff and relatives who were visiting. There were a number of falls since the time of the last inspection, those reviewed as part of this inspection mainly related to residents undertaking activity in private in their rooms, and a review had taken place in accordance with best practice to mitigate any risks, and there was evidence of appropriate action consistently being taken.

There was evidence seen during the inspection that residents were able to make choices about the care and treatment they received. Some had recorded their wishes around end of life care during assessments and care plan reviews. Residents were seen to choose not to take part in activities, or social interactions taking place, and spent time doing something of their own choosing such as moving round the centre or resting in their room.

During the inspection there were a range of activities taking place. Some were group

activities, for example exercise classes and bingo. Others were one to one activities such as reading the paper, walking and chatting. During the week there were a range of activities including music, exercise class, art and one to one activity. A programme including a specialised communication activity which includes sensory elements was available. An activities programme was displayed on the residents notice board that outlined the activities planned for the week. Records were maintained relating to access to external outings which took place on a planned basis. However, it was noted that not all residents had been offered the opportunity to access activity external to the centre.

Inspectors did a formal observation during the day including mealtimes and other activities. They saw that staff worked to involve residents in the activities taking place, promoted independence but respected their decisions to either observe or not engage at all. This is further discussed in Outcome 3 (residents rights). Inspectors noted that aspects of communication were functional and task orientated and did not always reflect person centred care practices.

Inspectors spoke with nursing staff who were administering medication, and this was completed in line with guidance from Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland). The person in charge confirmed that the use of a p.r.n. medicines (a medicine taken only as the need arises) was monitored with regard to any behavioural management care plans, and there were regular reviews of the residents medications by the GP and the pharmacy service. However, further to a detailed review of residents care plans, they did not clearly guide staff in alternative measures to implement before considering the use of psychotropic medication on a p.r.n. basis. Some examples of this were given to the person in charge and provider on the day of the inspection.

At the time of the inspection no resident was receiving palliative care. However, there was good access to local palliative care services for support and advice where required. Relatives spoken to felt that the staff were excellent, and were respecting the dignity, choices and personal wishes of their relative.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

**Judgment:**  
Substantially Compliant

## ***Outcome 02: Safeguarding and Safety***

**Theme:**  
Safe care and support

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

**Findings:**

Inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Some elements of good practice to safeguard residents privacy and dignity and rights were observed during this inspection by inspectors. However, as outlined in Outcome 1 improvements were required with assessment, planning and implementing practice in the use of restraint in line with National policy.

There was a safeguarding policy in place which had been reviewed in March 2015, however, it did not fully reference the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (2014). Inspectors spoke with a number of staff members who were clear on what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleagues behaviour.

Records that were reviewed confirmed that staff had received training on recognising and responding to elder abuse. This took place every three years and all staff were required to attend. Since the last inspection there had been no reports or any allegation of abuse notified to the Authority. All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were 43 residents who used of bed rails in the centre. There was a written policy on "restraint use" which had been reviewed in March 2015, however, the policy was not clearly linked into the electronic record keeping system in use at the centre, that nursing staff used on admission and on a daily basis. The policy on restraint also did not include reference to the Department of Health document "Towards a Restraint Free Environment". The approach used by staff interviewed demonstrated a variance in the application of a good standard of assessment and care planning in this area. For example, the use of low low beds, crash mats and other methods were observed by inspectors to prevent the use of bed rails in some instances. However, some staff interviewed by inspectors could not evidence that they had received any formal training on implementing best practice in this area, further support to ensure that the rationale for using any form of restrictive measure was found to be necessary.

Evidence based policies in place about managing behaviour that challenges (also known as behavioural and psychological signs and symptoms of dementia) and a policy on restraint was in place. Inspectors were informed by the care assistants that they had training in how to support and communicate with residents with dementia. Training records read for the last 12 months showed that all staff had attended training on related behaviours and dementia awareness. However, as described earlier in this report the policy could not be evidenced as being fully implemented. Staff had not received specific training in the safe implementation of the risk assessments and the alternatives to consider prior to the use of any form of restraint. The audits in place to manage this aspect of care were not robust and staff were recording based on their own judgements which were not based fully on best practice or a documented evidence based care plan. For example, where behaviours of concern were observed the nursing and medication records confirmed that in some situations that p.r.n. medicines (a medicine taken only

as the need arises) chemical restraint was use as a first line approach, and triggers for challenging behaviours were not being observed and documented. At the time of the inspection, a small number of residents presented with behaviours that challenge in the centre. Where there were residents who required support, care plans were developed that set out how residents should be supported if they had behaviour that was challenging. Inspectors saw that they described the ways residents may respond in certain circumstances, and that action should be taken, including how to avoid the situation escalating. Staff spoken with were not always clear about how to consistently redirect and divert a resident with behaviours of concern. Further development was required with this aspect of care and behavioural supports plans needed further developments and to be fully implemented.

This outcome was judged to be compliant in the provider's self assessment, and inspectors judged it as a moderate non-compliance.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that residents were consulted on the organisation of the centre, and that their privacy and dignity was fully respected. The provider and person in charge were very involved with ensuring that each resident's wishes were fully respected by all staff.

There were residents meetings held in the centre every two months and these were facilitated by group advocate. The minutes were taken at each meeting and any issues were communicated to the person in charge. The person in charge or provider would take action on any issues raised (where required). The minutes were provided to all residents and also displayed on the notice board prior to the next meeting. The person in charged confirmed to inspectors that he also had an 'open door' policy and would always welcome feedback on service provision, he could evidence this with her written records of any issues raised with him. The residents' feedback was generally positive about the service.

Residents confirmed that their religious and civil rights were supported. Religious ceremonies were celebrated in the centre that included prayers and mass was in place for Catholic residents. Residents of other faiths wishes were also accommodated and respected. Each resident had a section in their care plan that set out their religious or

spiritual preferences. Residents who did not wish to engage in religious activities had their right not to fully respected.

Residents who had wished to exercise their voting rights had been fully facilitated to do so in the recent general election.

The person in charge outlined details of advocacy services that were available to the residents. The contact details were also displayed in the centre, and outlined in the complaint's policy.

Inspectors found the management style of the centre maximised residents' capacity to exercise personal autonomy and choice. Residents told inspectors they were free to plan their own day, to join in an activity or to spend quiet time in their room.

Meal times were at structured times, however, flexibility was also offered and some residents chose to eat their meals in their rooms, or get up at their own time. Where residents required assistance or medications to be administered staff were observed to quietly knock on residents doors seeking permission to enter. Residents choose what they liked to wear and inspectors saw residents looking well dressed, and moving around the centre undertaking their daily activities.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the two communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place at two different times for one hour in the main dining area of the centre, and a further half hour in the multi-purpose room.

In the first observation, inspectors found staff provided kind physical care, with lots of friendly, personable interactions, however conversation was mainly instructive and not personally meaningful. The observation took place in a dining room where a group of residents were eating lunch. The staff ensured very good physical care and checked that each resident was happy with their meal. Residents were asked did they want a drink or to sit down here but were not engaged in any more conversation. The context of the care was observed as mainly functional/task and although there were sufficient staff, more leadership and example in terms of good communication practices was required to develop and enhance the meal time experience.

Inspectors found that residents' privacy and dignity was respected and promoted. For example, staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Staff were heard explaining to residents why they were coming into their room, e.g. to give refreshments or administer their medications. The location of the nursing stations and facilities did not always allow for privacy as additional resident seating had now been placed beside the stations by resident request.

Some residents with dementia were spending time in their own rooms, and enjoyed reading and watching TV, or resting. Other residents were seen to be spending time in

the communal areas of the centre. Activities were provided in a main sitting room area by staff who facilitated these. The activities for residents with dementia were regularly assessed and needs driven. There were assessments, resident profiles, and activities of daily living records that provided detailed information on each residents assessed needs, likes and interests. Inspectors spoke to one staff who described the range and type of activities, which included one to one time, games, exercise, music, reading. There was one to one time with residents, and some joined in on activities, others were socialising with family and friends, and others were sitting quietly. Activities staff were interviewed as part of this inspection and they outlined the development of activities outside the centre where good progress had been made. However, the records indicated that a number of residents had not yet had an opportunity to partake, and further work was required to develop this to be more inclusive of those who wish to access external activity.

Residents had access to a number of of sitting rooms, and visitor's room whereby they could meet with family and friends in private, or could meet in their rooms.

There was a laundry service provided in the centre and residents' clothes were regularly laundered and ironed. A large well laid out laundry room was located in the lower ground part of the centre. The staff in this department outlined the system in place to manage residents clothes in such a large centre. Each residents clothes went into a laundry bag and was individually labelled with their room number. All clothing was labelled and well managed, returned directly to residents bedrooms after being washed. One resident told inspectors her clothes were well looked after.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. As set out in outcome 1, staff were observed to be speaking with residents in a respectful way, and using their preferred names. Where residents had a communication deficit a care plan was developed.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

**Judgment:**  
Substantially Compliant

#### ***Outcome 04: Complaints procedures***

**Theme:**  
Person-centred care and support

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

**Findings:**  
The centre maintained a complaints policy that met the requirements of the Regulations.

It was available in an appropriate format in the residents' guide. A procedure was displayed on notice boards in the communal areas. The written procedure identified the complaints officer and independent appeals process. The provider and person in charge had improved records of complaints documentation and records since the time of the last inspection, to address the non-compliance from the last inspection.

Inspectors were provided with the records of complaints and compliments received by the centre. The centre had received one written of complaint since the last inspection and the provider kept files recording all correspondence, investigations and outcomes associated with these complaints. The means by which learning was taken from events was also documented.

**Judgment:**

Compliant

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

Overall, the residents, relatives and staff agreed that there were adequate levels of staff on duty and needs were met in a timely manner during this unannounced inspection. The provider had provided an additional care assistant for the second floor from 2pm to 8pm each day at the time of the last inspection and this had been maintained, and additional staff had also been put in place on the ground floor daily from 8am to 8pm. Staffing levels had been closely reviewed by the person in charge and provider on a regular basis, and also actioned further to a concern raised by a relative with the person in charge about response to a call bell not being in a timely manner. Residents and relatives confirmed to the inspector the availability of staff throughout the day and night and were happy with the standard of care at the centre.

Staffing levels (direct care) were clearly stated in the statement of purpose and function as 1:5 during the day, and 1:10 at night. Although improvements had taken place since a previous inspection, the inspectors observations and findings relating to the newly appointed staff were that additional supports and supervision were required. In particular relating to the skill mix on some floors in terms of the use of relief staff. This aspect of staff deployment was discussed with the provider and person in charge at the feedback post inspection.

Feedback from relatives spoken to by the inspector expressed satisfaction with the existing facilities and staffing levels. The inspector found that there was a very committed and caring staff team. The person in charge and provider placed strong

emphasis on training and continuous professional development for staff. Staff told inspectors that they felt well supported by the person in charge, management team and the provider. A clinical nurse manager was individually responsible for supervising care for each of the floors. In practice one staff nurse and a team of care assistants provided direct care and each floor had a defined allocation sheet for duties and care provision.

Resident dependency was assessed using a recognised validated dependency scale and the staffing rotas were adjusted accordingly. The inspectors found that staff turnover had been an identified issue during 2015. The management team were actively recruiting staff nurses at the time of the inspection. Further improvements and monitoring of staffing was required and discussed with the provider and person in charge who undertook to keep staffing under close review.

The inspector found that there were procedures in place for supervision of residents in the communal areas, and additional staffing could be sourced internally with a clear system in place that staff were familiar with. Care staff have received training in use of the touch screen electronic record keeping system, and demonstrated competency in this area.

The inspector noted that all relevant schedule 2 documents were present including details of nursing registration numbers with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland). Vetting procedures were up to date. Administrative supports were in place to assist the provider and person in charge.

A training plan for 2016 was in place for staff. All of the care assistants employed had completed Fetac Education and Training Awards Council (FETAC) level five or above. The person in charge regularly audited the training files to ensure all relevant mandatory training was provided in order to meet the needs of the residents. Training was provided for staff in areas such as medication management, fire safety and managing challenging behaviours. Staff told the inspectors they had received a broad range of training which included falls prevention, wound management, end of life care, infection control, pain management, dysphagia, and the use of the malnutrition universal screening tool. However, further training needs were identified as outlined in Outcome 2 of this report in implementing a restraint free environment, and communication with residents with dementia were identified.

The provider and person in charge had an established appraisal system in place for all staff. Staff were formally supervised on a six monthly basis.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The premises were purpose built in 2011 and resident accommodation for 103 people and residents are accommodated over five floors. The designated centre is located in an urban setting north of Dublin city. The main building is accessed from the reception area and parking for visitors is accessed in a secure underground car park. Access to the building is controlled and all visitors are asked to sign in and undertake hand hygiene. Improvements in accessibility to the garden have taken place since the time of the last inspection.

The design and layout of the premises is suitable for the stated purpose as outlined in the Statement of Purpose. There were adequate toilet, shower and bathroom facilities for resident use. Two resident passenger lifts and three stairwells are in place. A 'dumb waiter' system operates to each floor from the kitchen to efficiently transport hot foods to the servery and dining areas of each floor.

The ground floor has a reception area, foyer, oratory, a reading area and a hairdressing salon. There is one assisted toilet and the person in charge and assistant director of nursing have an office near the front door. There are ten single en-suite bedrooms on the first floor, and day and dining space. The main kitchen is located on the ground floor which serves each of the five dining areas.

The rooms are as follows and were extensively reviewed on the initial registration inspection and were found to be substantially in compliance with the legislative requirements and met the stated purpose as outlined in the statement of purpose:

- 61 single bedrooms with full en-suite facilities
- 21 twin bedrooms with full en-suite facilities

All the centres' facilities were found to be available to each resident on all to those on all five floors. The environment has not been substantially adapted or re-designed to cater to provide care for residents with dementia or cognitive difficulties.

The inspector noted that the standard of ongoing maintenance was well managed, the premises were well maintained and there was an ongoing maintenance programme in place. There was adequate lighting, ventilation and heating in place throughout the building.

The laundry facilities were reviewed and were clean and hygienic, and were located in the basement area and well equipped with appropriate washing and drying machines and facilities to iron linens and clothing. Hot water was thermostatically controlled to wash hand basins and shower/bath facilities, and the hairdressing room.

Storage facilities were adequate and corridors were wide and had handrails in place. All residents had access to a large outdoor garden where residents were seen enjoying activity and fresh air. Seating and was in place for leisure and garden activities. An

outdoor smoking space had been designated for residents use. Each floor had private space where visitors could meet with residents. However, in practice the nursing desk on each floor was not observed to be private, but much communication took place in this area between families and staff. In recent years additional seating for residents has been placed close to this area and some review is necessary to ensure that where privacy and confidentiality is required that nursing and care staff identify and use a private space to speak to residents or relatives where appropriate to maintain the right to privacy, as outlined in action plan for Outcome 3 of this report.

The kitchen was an adequate size in relation to numbers of residents at the centre.

**Judgment:**

Compliant

### **Closing the Visit**

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

#### **Acknowledgements**

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

#### ***Report Compiled by:***

Leone Ewings  
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<sup>1</sup>

<b>Centre name:</b>	Cara Care Centre
<b>Centre ID:</b>	OSV-0000735
<b>Date of inspection:</b>	11/03/2016
<b>Date of response:</b>	29/04/2016

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

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

Nursing assessments were not consistently completed before the use of any form of restraint including physical or chemical restrictions.

#### **1. 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

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

person's admission to the designated centre.

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

(A) All potential residents are assessed before admission to Cara Care centre. This assessment covers their personal, Social and Health needs. However more emphasis will be put on the Psychosocial aspect of care.

(B) A full review of restraint assessments has been carried out and care plans have been updated to reflect the needs of residents in line with National policy and as a result we have decreased the number of restraints in use in the centre by over 50%.

(C) All staff will receive restraint training, this training will reflect the National restraint policy and the requirements to use all alternatives before restrictive practices are considered.

Proposed Timescale: Point (A) Ongoing with immediate effect

Point (B) Completed

Point (C) Will be completed by 30/06/2016

**Proposed Timescale:** 30/06/2016

**Theme:**

Safe care and support

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

Care plans for the use of as required psychotropic medication were not in place to fully inform and guide nurses and care staff in line with best practice.

**2. Action Required:**

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

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

All care plans for residents who require psychotropic medications have been updated to include all measures that should be taken prior to the administration of the psychotropic medication.

Care plans will be reflective of residents individual needs and preferences to guide staff.

Proposed Timescale: Immediate effect

**Proposed Timescale:** 29/04/2016

**Theme:**

Safe care and support

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

Aspects of communication and interactions at mealtimes were functional and task orientated and did not always reflect person centred care practices.

**3. Action Required:**

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

All residents are offered a choice of meals at mealtime.

As a group TLC are getting 16 staff trained as trainers 3 of whom are from Cara Care Centre in Person Centred Care based on the National Dementia Care Strategy. This training is planned for the 26th and 27th of May. They in turn will provide further Dementia training to all staff in the centre.

All staff will be reminded of the importance of mealtimes as a social and enjoyable experience.

Proposed Timescale: Training for all staff will begin in June and be completed by 31/07/2016

**Proposed Timescale:** 31/07/2016

**Theme:**

Safe care and support

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

Activity records evidenced that not all residents had been offered the opportunity to access activity external to the centre.

**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:**

Activity staff will complete additional documentation to reflect ongoing efforts to support all residents' rights to access external activities.

Proposed Timescale: With immediate effect

**Proposed Timescale:** 29/04/2016

**Outcome 02: Safeguarding and Safety****Theme:**

Safe care and support

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

The policy for restraint use had not been fully adopted by the provider.

**5. 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:**

Our restraint policy was developed in conjunction with the National Restraint Policy. Training for all staff around this is been rolled out starting now and is due to be complete by end of June 2016. This will ensure that the policy is fully adopted by all staff. Audit in place to ensure compliance.

Proposed Timescale: To be completed by 30/6/2016

**Proposed Timescale:** 30/06/2016

**Theme:**

Safe care and support

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

The use of chemical restraint as first line was not in line with best evidenced based practice or centres' policy.

**6. Action Required:**

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

All staff nurses have been informed that they must document all the other options tried prior to the administration of a Psychotropic medication. Care plans will be updated to reflect the needs and preferences of each individual resident. Documentation will be regularly audited to ensure practice is in line with policy.

Proposed Timescale: With immediate effect

**Proposed Timescale:** 29/04/2016

**Theme:**

Safe care and support

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

Staff did not consistently demonstrate the skills and knowledge of best practice and centres' policy when managing residents with behaviours that challenged.

**7. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

As a group TLC are getting 16 staff trained as trainers 3 of whom are from Cara Care Centre in Person Centred Care based on the National Dementia Care Strategy. This training is planned for the 26th and 27th of May. They in turn will provide further Dementia training to all staff in the centre. Part of this training will cover how to manage behaviours that challenge. All care plans will be reviewed to ensure they are person centred and that they guide practice.

Proposed Timescale: All staff will receive training by 31/7/2016

**Proposed Timescale:** 31/07/2016

**Theme:**

Safe care and support

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

The assessment, use of alternatives and implementation of restraint policy was not fully in line with National Policy.

**8. 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) Restraint policy has been reviewed and does reflect the national policy.

(B) All staff will receive restraint training, this training will reflect the National restraint policy and the requirements to use all alternatives before restrictive practices are considered.

(C) Monthly audit in place to ensure compliance.

Proposed Timescale: Point (A) immediate effect

(B) To be completed by 30/6/2016

(C) Immediate effect

**Proposed Timescale:** 30/06/2016

**Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The location of the nursing stations did not ensure the right to privacy at all times.

**9. Action Required:**

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

Alternative locations have been identified for staff discussions.

Residents offered alternative locations to sit and relax.

Cordless phones on floors offer opportunities to discuss resident issues elsewhere.

Proposed Timescale: With immediate effect

**Proposed Timescale:** 29/04/2016

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

The staffing and skill mix requires review to ensure that residents can received assessed and appropriate care on a consistent basis.

**10. 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:**

We at Cara Care always strive to have a proper skill mix on all floors and as noted in your report Residents, Relatives and Staff all agreed that we were adequately staffed and that all needs were met in a timely manner. However on the day of inspection we found ourselves in the unprecedented situation where we had 3 members of our regular staff out sick from the same floor and so we had to have 3 members of our relief staff in to cover. All our relief staff have a minimum of Fetac 5 and on the day 2 of the relief staff were ex-senior carers who have been with the company more than 4 years and have experience on all floors. The other relief staff member on the day is a graduated nurse who is currently working a a care assistant.

Proposed Timescale: Ongoing

**Proposed Timescale:**

**Theme:**

Workforce

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

Training in communication with residents with dementia and the use of any form of restraint was required

**11. 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) As a group TLC are getting 16 staff trained as trainers 3 of whom are from Cara Care Centre in Person Centred Care based on the National Dementia Care Strategy. This training is planned for the 26th and 27th of May. They in turn will provide further Dementia training to all staff in the centre.

(B) All staff will receive restraint training, this training will reflect the National restraint policy.

Proposed Timescale: Point (A) will be complete by 30/6/2016

Point (B) will be complete by 31/7/2016

**Proposed Timescale:** 31/07/2016

**Theme:**

Workforce

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

Schedule 3 residents' records were not found to be fully or consistently maintained by nursing staff

**12. 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:**

All staff nurses have been informed to follow up and get written reports for residents who have had appointments at outside facilities and not to update care plans until written recommendations have been received.

Proposed Timescale: With immediate effect

**Proposed Timescale:** 29/04/2016