### Mount Tabor Care Centre

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mount Tabor Care Centre</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000071</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Sandymount Green, Dublin 4.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 260 5772</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@dublincentralmission.ie">info@dublincentralmission.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Mount Tabor Designated Activity Company</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ann Wallace</td>
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<tr>
<td>Support inspector(s):</td>
<td>Gearoid Harrahill</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>43</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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: 31 May 2018 10:00
To: 31 May 2018 18:30

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

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<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
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<td>Substantially Compliant</td>
<td></td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliant</td>
<td></td>
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<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td></td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Compliant</td>
<td></td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection

This inspection report sets out the findings of an unannounced thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also followed up on actions required from the previous inspection and considered information received by the Health Information and Quality Authority (HIQA) in the form of notifications.

The provider had completed a self-assessment tool on dementia care and had assessed the centre as compliant in two of the six outcomes and substantially compliant in the other four outcomes under the thematic dementia assessment framework. The person in charge and the clinical governance manager had implemented an action plan to improve compliance in these four outcomes. The action plan was progressing in line with the stated timescales and inspectors found that two of the outcomes in relation to dementia care had moved into compliance at
the time of the inspection. The outcomes in relation to premises, health and social care and resident's rights, dignity and consultation were found to be substantially compliant. The outcome in relation to staffing was found to be moderately compliant as not all staff had attended fire safety training and this was an outstanding action from the previous inspection.

Overall there were sufficient numbers of staff with the knowledge and skills to provide safe and effective care and services for the residents. There was a well-established staff team many of whom had been working at the centre for more than five years. The catering team had had a significant turnover of staff since the last inspection. This had stabilized with the appointment of a new chef who was working with managers and nursing staff to ensure that residents had access to nutritious home cooked meals. Staff new the residents well and care was found to be person centred. The inspector spoke with several residents who, although unable to explain their level of satisfaction with the service, demonstrated behaviours associated with feeling safe and content. Those residents who were able to articulate their experiences expressed high levels of satisfaction with the care and services they received in the centre. This was verified by a number of relatives who were visiting residents in the centre on the day of the inspection.

Residents had good access to a range of health and social care services to meet their ongoing needs. This included physiotherapy, dietician, speech and language therapy, chiropody, optician and dental services. Residents were seen regularly by a general practitioner (GP). Specialist medical services were available when required. This included psychiatry of later life for those residents who were diagnosed with dementia and palliative care services for those residents who needed specialist input for pain management and symptom control.

The premises offers comfortable accommodation over two floors. The first floor is accessed via a passenger lift. The centre is purpose built and is designed and furnished to offer resident's comfortable accommodation. Inspectors found that bedrooms were appropriately furnished and that there was adequate wardrobe and storage space for clothing and personal possessions. Communal lounges and dining areas were bright and comfortably furnished. These areas were well used by residents and their visitors on the day of the inspection. There was a pleasant enclosed courtyard garden which could be easily accessed from each unit. The centre was very homely and was clean and well maintained. The provider had completed the actions in relation to fire safety and the staff smoking area following the previous inspection. Although the centre did have dedicated storage areas for large items of equipment the inspectors found that equipment such as linen trollies were being stored in some resident areas on each floor.

Overall, there was a good level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. There was a clear management structure in place and staff were supervised and supported in their work. The centre's quality management system monitored the quality and safety of care and services provided.
and there was clear evidence that resident's feedback was listened to and acted upon as part of the improvement processes in the centre.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: 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:
The inspectors found that residents' health and wellbeing were maintained by a good standard of evidence based nursing care and appropriate medical and specialist services. Records showed that following admission each resident had a comprehensive assessment of their needs and an individualised care plan was developed with the resident and their family. The inspectors reviewed a sample of care plans and found that there were two sets of care plan documents for some needs and that nursing staff were not consistent in how they used the documents. As a result improvements were required to ensure that care plans included clear and up to date information to guide staff providing care for residents.

Residents and their families reported a high level of satisfaction with the care they received in the centre. A number of residents told the inspectors how their health and wellbeing had improved since their admission. This was reflected in the care plans that were seen by the inspectors which recorded improvements in mobility, communications and nutritional status for a number of residents.

Care plans were reviewed every four months or more often if the resident's needs changed. There was clear evidence that residents and/or their families were involved in care plan reviews if they wished to participate. Residents and families who spoke with the inspector said that they were kept well informed about any changes in their care or wellbeing and were involved in the decisions about the care and services that were provided for them.

Residents had access to a wide range of health and social care services to meet their ongoing needs. These included physiotherapy, occupational therapy, dietician, speech and language therapy, chiropody, community mental health services and palliative care services when required. Records showed that referrals were made appropriately and where specialist interventions were prescribed these were implemented by nursing and care staff.

Dental and optical services were accessed for residents in order to maintain their
optimum health and independence. Annual flu vaccinations were available in the centre. Health promotion services such as diabetic retinopathy screening was organised where residents met the criteria for the screening programme.

Residents were seen regularly by their general practitioner (GP). The GP reviewed each resident's medication every three months or if their health changed. Out of hours medical services were in place for out of hours or emergencies. Specialist medical services were available including access to a consultant in older person's medicine and consultant psychiatry.

There were policies and procedures in place to support residents who had specific dietary and nutritional needs. Residents' weights were checked monthly or more often if significant weight loss was detected. Residents were offered nutritious snacks and a range of hot and cold drinks throughout the day. Staff monitored resident's intake of fluid and diet however one resident did not have a fluid balance chart in place as prescribed in their care plan.

The catering team prepared a choice of meal options each day. Alternatives were also available for residents who wanted something different to the menu choices. Residents chose their meals on the day and were offered a choice at each sitting. Overall residents who spoke with the inspectors said that they enjoyed their meals and that they had plenty of choice. The chef was working with one resident to ensure that the meal options included at least one of her preferences each day. Textured meals were served as separate items on the plate and portion sizes varied to meet the resident's needs and preferences. Residents could take their meals in the dining room or in their bedroom if they preferred. Some residents who required a higher level of supervision and support at meal times took their meals in the small dining area in the lounge. Staff were available to offer encouragement and support for residents who needed assistance with their meals.

There were up-to-date policies and procedures in place to guide staff who were providing end of life care for residents. The centre had implemented the Compassionate End of Life (CEOL) programme to promote best practice in end of life care. Staff in the centre had been trained in the programme. Staff and managers reported that the programme had improved their skills and knowledge and that they felt better able to ensure that residents could receive end of life care in a way that met their individual needs and wishes and respected their autonomy and dignity. There was a family suite available if the resident's family wished to stay close to them. Single bedrooms were made available for those residents who expressed a wish to have their own room at this time. There were arrangements in place for residents to access specialist palliative care services for pain and symptom management when required. The Healthcare Chaplain provide inter-denominational pastoral support for residents and families who wish to use the service.

There were comprehensive polices and procedures in place for the ordering, prescribing, storing and administering of medicines to residents. Nurses attended annual medication training and the Clinical Governance Manager oversaw medication competency assessments. Outcomes or actions arising from these assessments were reviewed by the Director of Care. The inspector observed part of the morning medication round. The
nurse knew the residents well and was familiar with the residents' individual medication requirements. Details of all medicines administered were correctly recorded in the resident's records. Nursing staff followed safe and appropriate medication practices.

Prescribed medicines were regularly reviewed by the resident's general practitioner (GP). Medication audits were conducted in the centre and a process for recording medication errors was in place.

There were clear policies and procedures in place to support the safe transfer of residents who needed assessment or treatment in another care service such as hospital or an out-patient review. Discharge information for those residents who had spent time in acute hospital and results of blood tests and other health screening details and information following clinic appointments were available in the resident's records and were well maintained and easily accessible.

**Judgment:**
Substantially Compliant

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**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:**
There were procedures in place for the prevention, detection and response to abuse. Residents told the inspector that they felt safe and knew who they could speak too if they had any concerns or complaints. This was verified by a number of relatives who told the inspectors that they were confident that their relative was being looked after and was safe. The inspectors observed that those residents who were unable to verbalise their thoughts did not exhibit behaviours associated with fear or distress.

Records showed that all staff working in the centre had attended training in safeguarding and the protection of vulnerable adults from abuse. Staff who spoke with the inspector confirmed that they had received recent training on recognising abuse and were clear about their responsibility to keep residents safe.

The inspectors observed that residents with a diagnosis of dementia or other cognitive impairment were provided with support that promoted a positive approach to living with and managing their condition. Staff knew residents well and were knowledgeable about the most appropriate interactions that were needed to engage effectively with residents. Resident and staff interactions were marked by a high level of respect and empathy towards individual residents and staff were seen to promote residents’ rights, dignity
and choice.

There was clear evidence that the centre was working towards a restraint free environment. Three residents were using bed rails at the time of the inspection which was a reduction from the previous inspection. Each resident had a risk assessment in place which showed that; with the resident’s consent, alternatives such as low-low beds and floor mats had been trialled before bed rails were installed. The use of restraints was reviewed regularly by nursing staff. The centre was in the process of reviewing the documentation in relation to restraints as part of its compliance improvement plan.

There were policies and procedures in place for working with residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff had attended training on dementia care and managing responsive behaviours. Staff had been trained in the centre’s policy and procedures relating to the management of responsive behaviours and were seen to implement these in their day-to-day work.

Residents who displayed responsive behaviours had a care plan in place to guide staff with information about the potential triggers for behaviours and the appropriate interventions to support and reassure the resident.

The centre had a clear incident reporting procedure and records showed that incidents and adverse events were investigated and any learning or improvements were communicated to the relevant staff.

The centre had procedures in place to ensure that resident's finances were safeguarded.

**Judgment:**
Compliant

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**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 found that each resident's privacy and dignity was respected and that residents were facilitated to communicate and to exercise choice and control over their day-to-day lives.

Residents who required assistance with eating or carrying out activities of daily living were supported in a dignified and discreet manner. Residents' privacy was observed,
with staff who supported residents in their bedrooms doing so with the door closed from the public areas, and knocking before entering residents' rooms.

There were a variety of activities on offer for residents both in the centre and out in the local community. Trips out to the local area included strolling down to the port to see the tall ships, or going out at night to see a recent lunar event. The provider had arrangements in place through which they could reserve suitable transport for trips further afield, such as to the zoo.

Within the centre residents had access to a range of entertainments, such as visiting musicians, magicians or ice-cream vans.

Activities were organized each day and staff made every effort to organise their time to support residents to participate in the activities on offer. Staff knew which activities residents preferred to attend and the person's ability to participate in that activity. As a result residents were supported to participate in meaningful activities at a level that was appropriate for their cognitive ability. For those residents with profound cognitive impairments specific sensory activities were provided to help retain and promote their sensory awareness and provide meaningful engagement. The activities schedule also included residents' upcoming birthdays so that these could be acknowledged and celebrated according to the resident's wishes.

Inspectors reviewed a sample of communication care plans for residents who were non-verbal or who had impaired hearing. These clearly guided staff on the most appropriate means of speaking with these residents and understanding the meaning behind various non-spoken expressions.

Both inspectors spend a period of time observing staff interactions and engagement with residents with dementia or other forms of cognitive impairments. Overall inspectors observed that staff displayed a good knowledge of the residents' names, personalities, interests and capacity. Staff demonstrated good practice around dementia care placing themselves close to residents and engaging eye contact before asking the resident a question. Light touch or use of the resident's name was used where appropriate to retain the person's attention. Staff were friendly and polite, chatting with residents to engage and reassure them. Where necessary, staff talked the resident through the process when assisting them to mobilise or switch chairs, and for residents who wanted assistance to use the bathroom, this was done in a quiet and discreet way which respected the dignity of the person.

Overall staff interactions with residents were friendly and person centred, however inspectors noted that at periods during the afternoon only one member of staff was present in the lounge on the Martello unit where twelve residents were sitting after lunch. All of the residents were high dependency and required one to one interactions. The member of staff spent short periods of time with individual residents but as the other residents were unable to join in or to socialise with one another they spent a significant period of time with no meaningful engagement or stimulation.

Residents had access to radio, television and internet facilities. Residents were registered to vote in elections or referenda and had the option of doing so in the centre or going out to the local polling station.
The Healthcare Chaplain provide inter-denominational pastoral support for residents and families who wish to use the service. Services were available on a loop system for those residents who were unable to leave their rooms. The centre had introduced a video prompt for prayers and hymns to support residents to participate in the services.

Resident committee meetings took place in the centre and the minutes of these were posted on the centre notice boards. Agenda items for these meetings were all relevant to the interests of the residents, including feedback and ideas for outings and events, notification of refurbishment of the premises, and opportunities to collectively raise complaints of aspects of living in the centre. The provider had rolled out a satisfaction survey to residents and their representatives specifically requesting feedback on food and meal service, and had identified the primary or recurring issues to be actioned.

**Judgment:**
Substantially Compliant

### Outcome 04: Complaints procedures

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

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

**Findings:**
The centre has a policy on complaints and the procedure for residents or their representatives to make complaints was displayed prominently at several locations in the centre. The procedure identified the person responsible for managing complaints. Residents and relatives who spoke with the inspectors said that they were able to raise any issues with staff and managers and that these had been dealt with promptly.

The provider maintained a log of complaints received which had not been resolved immediately. This contained information on the nature of the complaint, the immediate actions taken, the outcome of the matter, and the satisfaction status of the complainant. Records showed that any learning gained from these complaints was communicated to the relevant staff so that they were made aware of the changes that were required.

**Judgment:**
Compliant

### Outcome 05: Suitable Staffing

**Theme:**
Workforce
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found that there were sufficient staff with the appropriate knowledge and skill to provide safe and effective care and services for the residents. Staff rosters matched the staff that were on duty on the day of the inspection. There were sufficient support staff available in household and administration and maintenance staff. There had been a significant turnover of staff in the catering team. This had stabilized in recent months with the appointment of a permanent chef who was recruiting to the team and working with nurses and managers to ensure that appropriate catering services were available for residents.

Staff were organized in their work and worked well together as a team. Staff knew the residents and were able to anticipate their needs and preferences. As a result residents did not have to wait for staff to respond when they needed care and support. The centre had recently completed a review of its staffing levels to take into account the increasing dependencies of residents. The centre used a mixture of agency staff and overtime form their own staff to cover staff absences and fluctuations in resident dependencies. Where possible the centre requested the same agency staff in order to ensure continuity of care for residents from staff who knew them.

Staff who spoke with the inspector said that they were provided with opportunities to attend mandatory training updates and that they had access to further training in nutrition, infection control, end of life care, responsive behaviours and dementia. Staff were up to date in their mandatory training in safeguarding of vulnerable adults, and manual handling. However a number of staff working in the kitchen had not attended the mandatory fire safety training. This was an outstanding action from the previous inspection.

Staff were supported and supervised in their work by the person in charge and the clinical nurse manager. The centre had recently recruited a second clinical nurse manager to provide additional support and supervision.

The inspector found that staff were empathetic and respectful to residents. Staff were knowledgeable about individual residents life histories and interests and about their current needs and preferences for care and services. Residents appeared comfortable with staff and residents and relatives expressed high levels of satisfaction with the care and services that were provided to them.

The person in charge informed the inspector that all staff working in the centre had Garda vetting in place. This was verified in the sample of staff records that were reviewed by the inspectors.

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 centre comprises of a purpose built premises with accommodation and services provided over two storeys. It is located close to local shops and amenities and is accessible by public transport. Inspectors found that the location, design and layout of the centre was suitable for its stated purpose and met the residents needs in a comfortable and homely way.

The centre was in a good state of maintenance and was appropriately lit, heated and ventilated. A lift was available to travel between the two floors, and corridors were featured with handrails and safe, level flooring for residents to safely navigate independently or with the assistance of staff. The two units on the ground floor were designed around an inner courtyard area which created a circular walkway around the courtyard gardens with views of the gardens form several windows along the route. This design facilitated residents to mobilize freely around the circuit without reaching an end point or obstruction to their walk. Small seating areas were located along the route if residents needed to rest.

A number of communal areas were available for residents and these were designed in a comfortable, homelike fashion. Quiet seating areas were located away from the main lounges for those residents who preferred a quiet space or wished to meet with their visitors in private. The communal lounge/dining area located in the Martello unit featured a useful information board clearly noting the time and date and activities on offer. This was a useful aid to help residents orientate themselves.

A bright, spacious activities room was located on the ground floor away from the bedroom areas. This space allowed for scheduled activities and entertainments to take place while not disturbing those residents who did not wish to participate.

The premises included a sun room which led out to the main courtyard garden area. This garden could be accessed from multiple exits situated around the building and was open to residents and their visitors throughout the day. The garden was furnished with benches, water features and flower beds and provided adequate shade for residents in the warm weather. On the day of the inspection residents and their visitors were observed sitting out enjoying the sunshine throughout the day. The central courtyard in the dementia unit was smaller and provided bench seating for residents who required a higher level of supervision from staff. The garden was open for residents to access from the lounge/dining area.
Bedrooms were of a suitable size and layout to accommodate the number and needs of the residents, including those using hoists or other equipment. Bedrooms were personalised to include decorations, photographs and furnishings based on the residents' own preferences. There were sufficient toilet and shower facilities, and these were equipped with assistive features for residents with reduced mobility. All bedrooms, bathrooms and communal areas were equipped with call bell points.

Equipment was stored in corridors in specific designated areas however the inspectors noted that linen trollies and surplus arm chairs were being stored in two small sitting rooms which were specified as resident areas. The person in charge informed the inspector that the rooms were not suitable for residents to use due to their size and location away from the nurse's station and that the center was currently reviewing the usage of these rooms.

**Judgment:**
Compliant

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**Outcome 07: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
This outcome was not reviewed in full on this visit. however inspectors followed up on issues raised in the previous inspection.

On the last inspection, one resident's bedroom door was being propped open. A device had been added to this door which allowed it to be held open on the request of the resident, and would automatically disengage upon the fire alarm being triggered, to effectively contain smoke and flame in the event of a fire.

On the previous inspection a staff smoking shelter was observed to cause cigarette smoke to enter a resident's bedroom. This shelter had been since moved to an area which did not impact on residents.

Inspectors reviewed a fire drill report for February 2018 which was unannounced and simulated night time staffing levels. The report on the drill identified a number of instances of staff members not following correct procedure, including not responding to the alarm promptly, not ensuring that doors and shutters to contain a fire event were closed, or returning to work upon realising that it was drill and not a real fire event. The action identified in response to that was to increase the frequency of these unannounced drills to keep staff in good practice, however none were documented as
having taken place since then. The learning from the drill also identified non-clinical staff as being in urgent need of fire safety training. As reference under the Outcome 5 on Staffing, five members of staff based in the kitchen were out of date on fire safety training.

The drill also revealed that the alarm bell in a section of the ground floor did not have any power connected to it and as such the alarm was not heard there. This was discussed with the provider and they advised that while quotes had been attained for replacing the system in this area, the new alarm system had not yet been commissioned. The provider's findings gained from the drills were not reflected in the risk assessment on fire safety. These issues have been followed up with the provider since the inspection.

**Judgment:**
Non Compliant - Moderate

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**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:**

Ann Wallace  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<th>Centre name:</th>
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<td>OSV-0000071</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>31/05/2018</td>
</tr>
<tr>
<td>Date of response:</td>
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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:**

There were two sets of care plan documents for some needs and nursing staff were not consistent in how they used the documents. As a result improvements were required to ensure that care plans included clear and up to date information to guide staff providing care for residents.

1. **Action Required:**

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
A care plan workshop for staff has taken place on 14/06/2018. Another care plan workshop has been scheduled for 12/07/2018 which will focus on the requirement for consistency and clarity when managing and using care plans. Care plan formatting and templates currently used within the centre are under review.

Proposed Timescale: 30/09/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident did not have a fluid balance chart in place as prescribed in their care plan.

2. Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
All residents who require fluid balance monitoring have appropriate input and output charts in place as outlined in their care plan. Allocation charts are reviewed and updated daily to ensure consistency and reflect the number of residents requiring fluid balance monitoring.

Proposed Timescale: 11/07/2018

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some improvement was required in the allocation of staff to ensure that the standard of good person-centred individual interaction was consistent with all residents who would benefit from it, particularly during downtime in the dementia unit.

3. 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:
As part of the organisation's strategic plan a resource review is currently taking place by Clinical Management and the HR Manager. The Clinical Governance Manager is currently reviewing our activities programme in conjunction with resource planning to ensure residents are gaining maximum benefit. One staff member continues to be allocated to the Martello lounge to oversee supervision of residents at all times. A second staff member has been allocated to the Martello lounge to ensure person-centred individual interaction and stimulation is provided to residents. The activity coordinators are closely working with staff in this regard.

Proposed Timescale: 30/09/2018

Outcome 05: Suitable Staffing
Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff working in the kitchen had not attended the mandatory fire safety training. This was an outstanding action from the previous inspection.

4. 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:
All kitchen staff have completed fire safety training as of 22/06/2018

Proposed Timescale: 22/06/2018

Outcome 07: Health and Safety and Risk Management
Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Unannounced fire drills had identified to the provider that not all staff were clear on the procedure to follow in the case of fire however not all actions in relation to this issue had been completed at the time of the inspection.

5. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case
Please state the actions you have taken or are planning to take:
A fire drill took place on 03/07/2018. Follow up items arising from the February fire drill have been actioned and completed.

Proposed Timescale: 03/07/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The fire alarm did not make any sound in the area of the activities room. This had been identified by the provider during a fire drill but had not been resolved at the time of the inspection.

6. Action Required:
Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
The fire alarm sounder in the Activities Room was not faulty but is not appropriate for the space. Rectifying this requires upgrading and re-configuring the system. We have received and accepted a quotation from Chubb Fire & Security Group [QTFC000835 dated 14/6/2018], which involved a lead time for delivery of components. Chubb have now confirmed receipt of these components, and we expect work to be completed by July 18th.

Staff have been reminded to be extra-vigilant when the Activities Room is in use

Proposed Timescale: 18/07/2018