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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mount Alvernia Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000723</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Newberry, Mallow, Cork.</td>
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<tr>
<td>Telephone number:</td>
<td>022 214 05</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:MHSCorkKerry@hse.ie">MHSCorkKerry@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
</tr>
<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 2 day(s).

The inspection took place over the following dates and times
From: 13 November 2019 10:00
To: 13 November 2019 17:30
14 November 2019 09:30
14 November 2019 16:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td></td>
<td>Non Compliant - Moderate</td>
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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 the centre. Overall, the inspector found that staff provided care to residents in a caring and respectful manner. Improvements, however, were required predominantly in relation to the provision of activities, medication management and care planning.

As part of the thematic inspection process, providers were invited to attend information seminars facilitated by the Chief Inspector of Social Services. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge 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) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The person in charge assessed the centre as compliant in five of six outcomes and substantially compliant in the remaining outcome. These judgments and the judgments of the inspector are outlined in the table above.

The journey of a sample of residents with dementia within the service was tracked. The inspector reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies, including those submitted by the centre prior to this inspection, as part of their self-assessment process. Residents' health needs were met to a good standard through access to nursing, medical and allied health care. There was variation in the quality of care plans reviewed, with some of the more recent admissions having person-centred care plans while others were generic in nature. Additionally, some care plans contained lots of narrative notes that made it difficult to identify information that was relevant to day-to-day care.

Medication administration practices were reviewed and were observed to be largely in compliance with recommended guidance. Medications were stored securely, including medications requiring special control measures and medications requiring refrigeration. Medication administration practices, however, were not always in compliance with legislation and some prescriptions used by nurses were not valid as they were not signed by a medical practitioner or registered prescriber.

The inspector observed care practices and interactions between staff and residents who had dementia, using a validated tool. Interactions and care practices by staff with residents, as observed by the inspector, were predominantly person-centred, therapeutic, respectful and kind. Staff were familiar with residents and addressed them by name.

Residents were supported to engage in activities outside the centre, including local day services. Residents were also supported to go out visiting with friends and relatives, and to attend family celebrations. There was a need, however, to review the social care element of the lives of residents living in the centre in the context of the provision of a programme of meaningful activities. Residents were frequently left in sitting rooms with music DVDs playing in the background. Only limited organised activities were provided and residents' days lacked stimulation. This was particularly relevant for residents on the third floor who did not have free access to the external grounds, but was also for residents on the other floors, as their main form of occupation during the day was to have a walk on the grounds.

The premises was old and was not purpose built with the aim of accommodating residents for long-term care, however, some of the limitations had been overcome through incremental renovations. The standard of décor varied in each of the three floors. The standard of décor and furnishings in Camillus was of a good standard, however, this was less so in the upper floors, where residents had a higher level of dependency. Parts of the premises required painting and there was a need to review the furnishings and décor with the aim of creating a more homely environment for
residents and to personalise their bedrooms.

Residents' rights were supported through the processes of communication and consultation. The inspector was informed that an advocate regularly attended the centre and also consulted with residents on an individual basis. Residents were not facilitated to vote in the centre and the inspector was informed that only a small number of residents voted at the local polling station. The provider was requested to put in place systems to ensure that those residents that wished to vote were included in the register of electors and were facilitated to vote. Regular resident meetings took place in each unit, however, the records of these meetings did not identify whether issues raised had been addressed to the satisfaction of the resident.

The Action Plan at the end of this report identifies the areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.
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:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. The inspector focused on the experience of residents with dementia and tracked the journey of a number of these residents.

Of the 39 residents in the centre on the days of the inspection, six had a formal diagnosis of dementia. All of these residents were over 65 years of age and four were over 80 years. The inspector was informed that there were no other residents in the centre with significant cognitive impairment that would lead to a suspicion of having dementia.

Admissions to the centre are under the auspices of mental health services. On admission, all residents have a formal assessment of dependency needs, which includes an assessment of cognitive ability. Following these assessments, care plans are developed to guide staff in their day to day interactions with residents. There was significant disparity in the quality of the care plans in relation to individualisation and guidance contained in the plans. Some care plans, predominantly those of residents that were more recently admitted to the centre, contained adequate guidance, while others were generic in nature and contained little person-centred information. Additionally, some care plans contained pages of narrative notes of daily care or of advice from specialist and allied health services but it was difficult to pick out the detail of what was currently relevant guidance. Nursing notes were completed on a daily basis.

Most staff had worked in the centre for a number of years and were fully aware of the areas where residents had difficulties and needed support. The inspector observed residents being prompted to eat and drink at mealtimes and being orientated to the time of day. Residents at risk of developing pressure ulcers had pressure relieving mattresses and cushions to prevent ulcers developing. The inspector was told that staff had access to support from a tissue viability nurse if required. There were no residents with wounds on the days of the inspection.

The inspector saw that residents had access to appropriate medical and primary care
services. Residents could retain the services of their own general practitioner (GP). Residents’ medical records indicated that reviews of health conditions were completed regularly and also that medicine regimes were reviewed and altered to meet residents’ changing needs. Residents had access to allied health professionals, including physiotherapy, dietetics and speech and language services. Residents were assessed on admission for risk factors such as poor nutrition and the risk of falling. Where residents required modified diets or supplements these were outlined in professional assessments and relayed to care and catering staff who were observed to follow the recommendations outlined.

The inspector observed that residents appeared to be well cared for, which was further reflected in residents’ comments that their daily personal care needs were met. Residents, where possible, were encouraged to be as independent as possible and the inspector observed residents moving freely around the corridors and communal areas.

The centre had policies on medicine management and these described the ordering, receipt, administration, storage and disposal of medicines. Medicines were stored securely. There was a system for reconciling medications delivered to ensure that they correlated with residents’ prescriptions. There was a system for reviewing medication management practices; however, some improvements were required as administration practices were not always in compliance with professional guidance. For example, based on a sample of prescriptions reviewed, all were not signed by a registered medical practitioner.

There were adequate systems in place for the management of medicines that required special control measures. These medicines were stored securely and were counted at the end of each shift and following administration. Medications requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded.

The inspector found that there were suitable arrangements in place to meet residents’ end-of-life needs, including the needs of residents with dementia. There were no residents considered to be end of life on the days of the inspection. There was a need, however, to ensure care plans contained adequate detail around discussions of end-of-life preferences to ensure that discussions and preferences were adequately detailed in the plans. Families were facilitated to be with residents at end of life and facilities were provided for their comfort. Overall the inspector found that care practices and facilities in place were designed to ensure residents received end-of-life care in a way that met their individual needs and wishes.

There were systems in place to ensure residents’ nutritional needs were met, and that the residents received adequate nutrition and hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis. Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to were complimentary about the food provided. Mealtimes in the dining rooms was observed by the inspector to be a social occasion. Nursing staff told the inspector that if there was a change in a resident’s weight, they would reassess the resident, inform the GP and referrals would be made to the dietitian and speech and language therapy service (SALT). Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed.
All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

**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:
The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to residents. The inspector saw that safeguarding training was ongoing and training records confirmed that staff had received this mandatory training. This training was supported by a policy document on safeguarding which defined the various types of abuse and outlined the process for the investigation of abuse incidents or concerns should they arise. The inspector observed that staff were sensitive and appropriate in their approaches to residents. All interactions were noted to be respectful, courteous and helpful. Residents told the inspector they felt safe, secure and well cared for by staff.

Residents with responsive behaviours were being effectively supported by staff during the inspection. Relevant training to support residents with dementia and behavioural and psychological signs and symptoms of dementia (BPSD) had been provided and completed by some, but not all staff. There was a policy in place covering the management of responsive behaviour and there were good links with local hospitals and psychiatric services.

There was an up-to-date policy on restraint. The inspector saw that there was a comprehensive assessment in place for the use of bedrails. Alternatives to bedrails were explored in an effort to reduce the number of bedrails; however, 11 of the 39 residents in the centre on the days of the inspection had bedrails in place. Where bedrails were required the inspector saw evidence that there were regular checks completed and their use was discussed with residents and families.

The provider was a pension agent for a number of the current residents and adequate banking arrangements were in place for the management of this money. Small sums of money were also held on behalf of residents. There were two signatures associated with each transaction, but the system of record keeping could be enhanced through more detailed records of each transaction.
Judgment:
Substantially Compliant

**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:**
The inspector found that residents, including residents with dementia, were consulted about how the centre was run and were enabled to make choices about their day-to-day life in the centre. There were regular residents' meetings and residents were also consulted on a one-to-one basis. Records of meetings, however, did not clearly identify that issues raised were addressed to the satisfaction of the residents.

The inspector observed that staff interacted with residents throughout the day, while also respecting their privacy. Residents were able to exercise choice in relation to the time they got up and went to bed and told the inspector they were able to have breakfast at a time that suited them.

The inspector spent three periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents in the communal sitting areas and dining rooms. While staff were present with residents in the sitting rooms there was predominantly meaningful interactions with residents. The inspector observed that staff knew residents well and engaged with them in a personal, meaningful way.

Social care opportunities were somewhat limited. While there were frequent outings to local amenities, restaurants and cafes, there were limited organised activities within the confines of the centre for when there were no outings. Organised activities included Yoga on Tuesdays, Arts and Crafts on Wednesdays, and Bingo on Sundays. Each of these activities, however, were brief and usually lasted for less than an hour. There was also Mass one day a week and a prayer group visited once a week also. Outside of these organised activities, residents spent a significant period of time with little stimulation other than watching music DVDs.

During main mealtimes, staff were observed to offer assistance in a respectful and appropriate manner. All staff sat beside the resident they were assisting and were noted to encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace, with minimal assistance to improve and maintain their functional capacity. Adequate time was allocated to
mealtimes and residents were observed to take as much time as they wished over their meals.

The inspector was informed that the arrangements were not in place for the returning officer to visit the centre and only a small number of residents voted in local, national and European elections or in the referendum. The provider was requested to review arrangements so that residents who wished to vote could do so in any forthcoming elections.

The inspector was informed that an advocate regularly attended the centre and consulted with residents on an individual basis.

**Judgment:**
Non Compliant - Moderate

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<th><strong>Outcome 04: Complaints procedures</strong></th>
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<tr>
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<tr>
<td>Person-centred care and support</td>
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<tr>
<td><strong>Findings:</strong></td>
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<tr>
<td>There was a policy detailing the procedure for making complaints. The policy included an appeals process. The procedure was on display in the centre detailing for residents and visitors how to go about making a complaint. A review of the complaints log indicated that no complaints had been recorded since the last inspection.</td>
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<tr>
<td>Workforce</td>
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<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
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<tr>
<td>No actions were required from the previous inspection.</td>
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<tr>
<td><strong>Findings:</strong></td>
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<tr>
<td>The staff rota maintained in the centre outlined the numbers of staff deployed to varied roles. The person in charge was on duty Monday to Friday. The inspector found the</td>
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Number and skill-mix of staff was appropriate to meet the needs of the current residents in the centre. There was a minimum of two nurses on duty in each of the three units during the day and one nurse at night. Nursing staff were supported by a team of healthcare assistants.

There were good communication arrangements in place to ensure staff were familiar with residents’ needs and changing health conditions. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector saw records of regular staff meetings at which operational and staffing issues were discussed. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents’ needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have a very good knowledge of residents' needs as well as their likes and dislikes.

Records viewed by the inspector confirmed that there was a varied training programme available to staff. Mandatory training was organised and while all staff were up to date with training in safeguarding vulnerable persons a number of staff were overdue training in other mandatory areas, such as in fire safety, safe moving and handling and responsive behaviour.

The inspector reviewed a sample of staff files and found that all files contained evidence of each person's identity, a full employment history and appropriate employment references. Vetting disclosures were not available in the centre for all staff and an urgent compliance plan was issued to ensure that adequate safeguarding arrangements were in place until Garda vetting disclosures had been secured. These vetting disclosures were made available to the inspector on the day following the inspection and an assurance was provided that vetting disclosures were in place for all staff and would, in the future, be available on site.

**Judgment:**
Non Compliant - Major

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Mount Alvernia Hospital is situated on large grounds in a rural location approximately six kilometres from the town of Mallow. It is a four storey premises and all resident accommodation is on the first, second and third floors. The ground floor contains offices, a chapel, a visitor’s room, the laundry and the main kitchen.

The building was constructed in the 1950s as a general hospital and its appearance is consistent with the style of that era. It was not designed as a centre to accommodate residents long-term, resulting in some limitations to the design and layout of the centre. Some of these limitations were addressed incrementally over the years with the reduction in multi-occupancy bedrooms and the creation of communal space. However, some limitations remained such as limited dining facilities, particularly on the third floor and also lack of access to secure outdoor space, also for residents on the third floor. Residents on the other floors were free to come and go and therefore had ready access to the outdoors but most residents on the third floor only had access to the outdoors when accompanied by staff.

The first floor, St. Camillus, accommodates 14 residents in five twin bedrooms and four single rooms. The second floor, Clyda accommodates 14 residents in one triple bedroom, four twin bedrooms, and three single rooms. The third floor, Avondhu, accommodates 14 residents in five twin bedrooms and four single rooms. None of the bedrooms have en-suite facilities.

The centre was generally bright and clean throughout. The standard of décor varied considerably on each of the floors with the first floor having a higher standard of décor than the second floor and the second floor having a higher standard of décor than the third floor. The residents on the first floor were more independent and many of the bedrooms on this floor were furnished to a good standard and had a degree of personalisation. The bedrooms on the other floors were less personalised, and much like the standard of décor, the degree of personalisation decreased from floor to floor as you ascend the building.

Areas of the centre required redecoration with scuff marks on walls, skirting boards and door frames. Some of the old style radiators also had damaged paintwork and required review. There was a leak in the in the pipework with visible dampness in one of the bedrooms and in the staff locker room and repair work was underway on the day of the inspection.

Sanitary facilities comprised three assisted bathrooms with toilets on the first floor and two assisted bathrooms on each of the other two floors, also with toilets. There were also two toilet cubicles on each of the three floors. Based on the dependency and mobility status of the residents living in the centre on the days of the inspection, sanitary facilities were adequate to meet the needs of residents.

A separate kitchen area on the ground floor was appropriately equipped for the size and occupancy of the centre. A laundry area was located in the basement area that was both well equipped and staffed, with sufficient space and facilities to manage all laundering processes.
Residents had access to assistive equipment as required. Equipment such as wheelchairs and beds were maintained in good working order and supporting documentation was available in relation to the maintenance of this equipment.

**Judgment:**
Substantially 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):**
No actions were required from the previous inspection.

**Findings:**
Some areas of risk were identified during the inspection, including:
- there was a damaged smoke seal on one of the fire doors
- a fire door was seen to be obstructed by a chair on both days of the inspection and would not automatically close in the event of the activation of the fire alarm
- even though some residents were risk assessed as being suitable to retain control over cigarettes and lighters, there was an inadequate system in place for the supervision of residents. This was predominantly due to the location of the smoking shelter, which was a distance from the premises, leading residents to smoke in non-designated smoking areas
- the risk assessment for some residents that smoked specified that they wear smoking aprons but this did not happen in practice.

**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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000723</td>
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<tr>
<td>Date of inspection:</td>
<td>13/11/2019</td>
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<tr>
<td>Date of response:</td>
<td>07/01/2020</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:

Some improvements were required in relation to care planning, for example:
• some care plans, predominantly those of residents that were more recently admitted to the centre, contained adequate guidance, while others were generic in nature and contained little person-centred information. Additionally, some care plans contained pages of narrative notes of daily care or of advice from specialist and allied health services but it was difficult to pick out the detail of what was currently relevant guidance.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
• there was a need to ensure care plans contained adequate detail around discussions of end of life preferences to ensure that discussions and preferences were adequately detailed in the plans.

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

Please state the actions you have taken or are planning to take:
All Care Plans are currently being reviewed and rewritten. Further care plan training will be arranged in 2020. Care plans will be person centered and user friendly.

Proposed Timescale: 01/02/2020

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all prescriptions were signed by a registered medical practitioner.

2. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Medication Management Audit has been completed. Prescriptions have been rewritten and are now compliant.

Proposed Timescale: 19/12/2019

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Small sums of money were also held on behalf of residents. There were two signatures associated with each transaction, the system of record keeping could be enhanced through more detailed records of each transaction.

3. 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:
Resident Log books are to be maintained on each floor clearly documenting input and output logs.

**Proposed Timescale:** 19/12/2019

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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:
Records of residents' meetings did not clearly identify that issues raised were addressed to the satisfaction of the residents.

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

Please state the actions you have taken or are planning to take:
I have met with the CNM2s on each floor and discussed this issue with them. Residents and staff will go through the outcomes of the meetings with residents and follow up on requests will be discussed at the beginning of the next meeting to ensure that they are happy with the outcomes.

**Proposed Timescale:** 19/12/2019

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

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While there was a programme of activities, organized activities were only available for brief periods each day and residents spent a significant period of time with little stimulation other than watching music DVDs.

5. **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:
An activity co-ordinator will be in place in January 2020. She will work two days a week and she will ensure that there is adequate activity arranged for the days she is not...
here. A meeting will be held in January with the residents of Mt Alvernia to discuss meaningful person centred activity sessions for all the residents.

**Proposed Timescale:** 05/01/2020  
**Theme:**  
Person-centred care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
Arrangements were not in place for the returning officer to visit the centre and only a small number of residents voted in local, national and European elections or in the referendum.

6. **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:**  
I will make arrangements to accommodate the Residents in Mt Alvernia to vote.

**Proposed Timescale:** 01/05/2020

**Outcome 05: Suitable Staffing**  
**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Training records indicated that not all staff had attended up-to-date training in responsive behavior, manual and people handling and fire safety.

7. **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:**  
Fire Evacuation training records are now up to date. Fire Extinguisher Training has been arranged for January. 2 Days of responsive behaviour training has been arranged for Feb 20. I will arrange Manual Handling training in 2020 to bring all staff up to date.

**Proposed Timescale:** 01/07/2020  
**Theme:**  
Workforce
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Vetting disclosures were not available in the centre for all staff and an urgent compliance plan was issued to ensure that adequate safeguarding arrangements were in place until Garda vetting disclosures had been secured.

8. 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 Vetting disclosures are now on site in Mt Alvernia Hospital.

Proposed Timescale: 15/11/2019

Outcome 06: Safe and Suitable Premises
Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements required in relation to the premises included:
• areas of the centre required redecoration with scuff marks on walls, skirting boards and door frames
• some of the old style radiators had damaged paintwork and required review
• there was a leak in the in the pipework with visible dampness in one of the bedrooms and in the staff locker room
• the standard of décor varied considerably on each of the floors with the first floor having a higher standard of décor than the second floor and the second floor having a higher standard of décor than the third floor
• the bedrooms on the some floors were less personalized, and much like the standard of décor, the degree of personalization decreased from floor to floor as you ascend the building
• residents on the third floor did not have ready access to secure outdoor space.

9. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
There is a maintenance plan in place for Avondhu ward. Funding has been approved for new flooring and painting of some rooms and the main corridor. We will personalise the bedrooms and make the floor more homely. The leak in the staff locker room has been repaired and the room redecorated. The leak in the bedroom on the First Floor has
been repaired and the room has been redecorated. The residents on Avondhu ward do not have access to a secure outdoor space. Currently I cannot do anything about this as the residents are on the Third floor of the building however when the weather is the Staff do take the residents out into the grounds.

**Proposed Timescale:** 01/06/2020

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**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:**

Some areas of risk were identified during the inspection, including:

- there was a damaged smoke seal on one of the fire doors
- a fire door was seen to be obstructed by a chair on both days of the inspection and would not automatically close in the event of the activation of the fire alarm
- even though some residents were risk assessed as being suitable to retain control over cigarettes and lighters, there was an inadequate system in place for the supervision of residents. This was predominantly due to the location of the smoking shelter, which was a distance from the premises, leading residents to smoke in non-designated smoking areas
- the risk assessment for some residents that smoked specified that they wear smoking aprons but this did not happen in practice.

10. **Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
All the Fire doors in Mt Alvernia have been assessed and seals replaced where required. The chair has been removed from in front of the door in the dayroom in Avondhu ward. The location of the smoking shelter has been discussed with the safety officer and a better location will be discussed in 2020 .In the meantime Risk Assessments have been reviewed .New Smoking Aprons have been ordered .Residents will be encouraged to use them .St Camillus ward will monitor the CCTV of the smoking shelter every 30 minutes and will keep a registrar of same .We will encourage residents to only smoke in the designated area .In 2020 we will recommence a smoking cessation programme to try and further reduce the number of smokers in Mt Alvernia in line with HSE policy .

**Proposed Timescale:** 01/06/2020