Centres name: Mount Hybla Private  
Centre ID: OSV-0000744  
Centre address: Farmleigh Woods, Castleknock, Dublin 15.  
Telephone number: 01 869 9722  
Email address: tanyag@mounthyblaprivate.ie  
Type of centre: A Nursing Home as per Health (Nursing Homes) Act 1990  
Registered provider: Mount Hybla Nursing Home Limited  
Provider Nominee: Ciaran Larmer  
Lead inspector: Leone Ewings  
Support inspector(s): Ann Wallace  
Type of inspection: Unannounced Dementia Care Thematic Inspections  
Number of residents on the date of inspection: 65  
Number of vacancies on the date of inspection: 1
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).
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 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: 03 March 2017 09:30
To: 03 March 2017 18:00

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

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Summary of findings from this inspection

The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection focused on six outcomes and also followed up the actions from the last monitoring inspection on 6 and 7 January 2016. A detailed review of the statement of purpose to inform this inspection also took place. Improvements had taken place with the in terms of the audit and oversight of psychotropic medicines management since the last inspection. Nonetheless, further improvements were required with the records and audit of the use of these medicines.

Prior to this inspection the provider had been requested to complete a self-assessment document and review relevant polices. The judgments in the self
assessment stated four outcomes were in compliance, and two outcomes staffing, and premises were in substantial compliance. Twenty-four residents in the centre had a diagnosis of cognitive impairment, Alzheimer's disease or dementia.

The statement of purpose outlined that the centre supported residents with dementia. However, it did not reflect the use of Lavender unit as a dementia specific unit. The provider self assessment document had been returned and stated that there was a dementia specific unit.

Overall, the inspectors found that the centre met the individual care needs of residents with dementia. The inspectors found the provider was in compliance with three of the seven outcomes reviewed, and four outcomes required improvement. One outcome - Premises was a moderate non-compliance.

Information was available for residents and relatives about dementia and residents' health care needs were well met. Responsive behaviours and could be managed by staff with good communication techniques, and meaningful activities or diversion. However, the finding of this inspection were that some improvements were required to consistently implement care plans and records where psychotropic medicines were used, in line with best practice. Residents with dementia had their choices in relation to aspects of their daily lives respected by staff. However, some aspects of service provision were not found to always individualized or person-centred and required review to promote independence and autonomy of the people living at the centre.

The staffing in place including numbers and skill-mix were found to meet the needs of residents. Staff had received appropriate training which equipped them to care for residents who had dementia. Feedback from residents and relatives was generally positive with the majority complimenting the kindness of staff and how quickly they responded to resident's needs. Relatives were also happy with how staff kept them informed of any changes in their loved ones health condition. Feedback was also received that staff and the environment was welcoming, warm and friendly.

The six action plans at the end of this report identify areas where improvements by the provider and person in charge are required in order to fully comply with the regulations. These include premises, medicines management, statement of purpose and residents' rights dignity and consultation.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome was judged to be compliant in the self-assessment, the inspectors judged it as substantial compliance.

Overall the care and welfare of residents with a diagnosis of dementia, Alzheimer's and those with cognitive impairments was being well met. The nursing, medical and social care needs of these residents were met to a good standard. Residents' confirmed their wellbeing to the inspector during the inspection. Since the last inspection the provider and person in charge had made improvements in terms of reviewing and auditing psychotropic medicine use in line with best practice. However, further improvements were required to fully implement policy in place. Residents with dementia had their choices in relation to aspects of their daily lives respected by staff. However, some aspects of service provision were not found to always individualized or person-centred and required review to promote independence and autonomy of the people living at the centre.

There were admissions, transfers and discharge policy in place. However, aspects of the admissions policy did not include details of good practices observed by inspectors. For example, including and reviewing cognitive abilities prior to admission, and records of multi-disciplinary assessment which was reflected in practice. However, suitability for accommodation and the environment in Lavender unit was not referenced in the admissions policy in terms of its' use as a dementia specific area. Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital on file together with nursing and medical transfer letters from the acute hospital back to the centre.

Residents had access to medical and allied health care professionals. Evidence was seen that a general practitioner visited the centre to see residents regularly. Access to out of hour’s medical care was also fully facilitated. Where required, some residents had access to a consultant psychiatrist and other acute hospital consultant referrals. Referrals for residents for assessment to any of the allied health care team members were timely, and well documented. A small number of residents living at the centre were living with
an acquired brain injury, with complex health and social care needs.

The inspector saw evidence of referrals made, assessments completed and recommendations made in residents' files. The provider facilitated all residents to have routine assessments of eyesight and dental hygiene/needs. There was clear evidence that all residents had their medical needs including their medications reviewed by the pharmacist, general practitioner and person in charge. The pharmacist delivered medicines to the centre as required and provided support and training as required. The person in charge had addressed the non-compliance further to the last inspection and had conducted detailed audits of medicines management practice. Nonetheless inspectors noted further to a review of medicines administration records and nursing notes, that the records to support the use of prn (as required) psychotropic medicines was not consistently in place in line with best practice. For example, a record reviewed did not record an indication for use or the effect of the medicine to inform and guide staff. Records of medicine administration was incomplete in a sample of medication administration records viewed by inspectors.

Risk assessments and care plans were reviewed on a four monthly basis and those reviewed reflected the residents' changing needs. Each need had a corresponding care plan in place reflecting the care required by the resident in order to meet that need. Assessments and care plans were updated on a four monthly basis. A sample of care plans reviews read by the inspector were up-to-date.

Staff provided end-of-life care for residents with the support of the general practitioner and the palliative care team if required. Each resident had their end-of-life preferences recorded and a detailed end-of-life care plan in place. These care plans addressed the resident's physical, emotional, social and spiritual needs. They reflected each resident's wishes and preferred pathway at end-of-life. They were detailed and included input from the resident and their next of kin.

Overall the nutritional needs of residents were met to a good standard and they were supported to enjoy the social aspects of dining. The menu provided a varied choice of meals to residents.

As outlined in outcome 6 of this report some improvements were required in lavender in terms of access to dining space. Residents who required support at mealtimes were provided with timely assistance from staff. The inspector saw this was provided in a quiet, calm and professional manner. Some residents were given a choice at each meal time and those residents diagnosed with dementia were also seen to eat their meals with other residents.

Residents had a malnutrition risk screening tool (MUST) completed on admission and this was reviewed three monthly. Residents' weights were recorded and had their body mass index calculated on a monthly basis. Those with any identified nutritional care needs had a nutritional care plan in place. Nursing assessments for any resident identified as at risk of malnutrition triggered a referral to a dietician. The inspector saw that residents' individual likes, dislikes and special diets were all recorded and were known to both care and catering staff.
Where appropriate wound assessments and care plans were in place to guide staff in evidence-based practice. The records were also fully reflective of care provided. Pressure ulcer prevention and management practice was found to be adequate and all staff were knowledgeable and well informed about skin care and prevention with policy implemented.

**Judgment:**
Substantially Compliant

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
This outcome was judged to be compliant in the provider's self assessment, and the inspectors judged it as compliant.

The inspector found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. The approach used by all staff demonstrated a good standard of consent led service provision. Elements of good practice to safeguard residents' privacy and dignity and rights were observed during this inspection.

There was an up-to-date safeguarding policy in place. The inspector 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 resident safety or wellbeing.

Records that were reviewed confirmed that staff had received training on recognising and responding to elder abuse. All staff were required to attend this mandatory training. Since the last inspection there had been two reports made as required by legislation to the Chief Inspector. Both reports had been responded to in line with policy and an investigation took place the outcome of which was reviewed at the time of the inspection. Residents were appropriately safeguarded throughout the process in both reports.

All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. They also spoke highly of the care provided by the staff and their caring attitude.

At the time of the inspection, a small number of residents presented with some identified responsive behaviours in the centre. Residents who required support had an
assessment completed and care plans were developed that set out how residents should be supported if they had responsive behaviours. The inspector 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. For example, using a low arousal or a sensory approach with music. Staff spoken with were clear about how to manage and re-direct each resident. Staff also considered how residents were responding to their environment and were supporting people to feel calm.

Evidence based policies in place about responsive behaviours (also known as behaviourial and psychological signs and symptoms of dementia) and a policy on restraint was in place. As outlined in outcome 1 of this report some aspects of medicines management and records required improvement in this area. The inspector was informed by the staff that they had training in how to support and communicate with residents with dementia. Training records read confirmed that staff had attended training on responsive behaviours and dementia awareness. A number of staff were undertaking specialist post-graduate training at the time of the inspection.

There were a small number of residents who were assessed as requiring the use of bed rails in the centre. There was a clear policy on any restrictive practices. The policy, practice and assessment forms reviewed reflected practice that was in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011).

The provider did not act as a pension agent for any resident or was not involved with support for finances.

Judgment:
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:
Overall residents' rights were promoted and dignity was respected. Residents in the centre were consulted with about how the centre is run and staff were courteous and friendly towards residents, relatives and visitors.

Inspectors observed staff and resident interactions throughout the day. Staff were observed to be calm and spoke to residents in a kind and friendly manner. Staff and residents were observed to be chatting throughout the period of the inspection. Inspectors observed staff knocking on doors before entering resident's bedrooms. The findings of this inspection would confirm that overall a move towards person-centred
care was taking place. However, some areas required review in terms of policy and practice. Staff addressed residents in their preferred title throughout the inspection.

Residents were observed to be moving throughout the centre, both independently and assisted. Staff informed the inspectors that there was an open visitor policy. The reception area near the front door was where visitors reported and this area was staffed throughout the inspection. Visitors signed in and residents received visitors throughout the day. Residents could receive visitors in private either in their bedrooms or in the visitor’s room located on the ground floor. Staff were aware of residents preferred wishes in terms of visiting and any restrictions which may be in place. Staff informed inspectors that not all residents had the code for exiting the centre independently and this was not routinely offered to residents. The inspectors asked if this could be individually assessed in terms of implementing a restriction which may be unnecessary for all residents living at the centre. The policy was not being clearly implemented in a person-centred way, and the risks (if any) of residents exiting and entering the building independently were not quantified by records in all cases.

There was a detailed activities plan in place for the centre. During the inspection, the activities for the first and second floor were held in the activities room on the ground floor, and sitting rooms. In lavender there was a quieter parlour room where imagination gym session took place.

Residents had access to individual and group advocacy for older people, contact details were listed under the complaints procedure and in the resident's guide. The advocacy organization facilitated the holding of resident's meetings. Any issues raised by residents during these meetings were submitted to the management of the centre in an anonymous manner, so they could be addressed and put into practice if possible.

Residents' religious and spiritual needs were observed to be met in the centre. Mass was regularly held in the centre to which residents could attend if they wished in the spacious oratory. Residents had access to land-line telephones and each room was wired for this, some residents had their own mobile phones. Newspapers were delivered to residents on a daily basis. There was access to television, radio and internet in the centre.

Residents' civil rights were respected in the centre. Residents were supported to visit the local polling station. Less mobile residents were also facilitated administratively to exercise their voting rights in the centre.

One area for improvement centres was around personal grooming activity which was observed by inspectors to take place in a communal seating area where staff used the same equipment for four residents. This did not respect resident's privacy and dignity in terms of this practice.

**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:**  
A clear complaint's procedure and a complaint's policy was in place that guided practice. The person in charge was the person nominated to deal with all complaints and ensure that they are fully investigated. There was an appeals process outlined within the policy.

The complaint's procedure was displayed prominently and was in line with the information within the complaint's policy. The policy listed the various contacts relating to making a complaint, the process for appealing the outcome of a complaint and clearly differentiated between which contact was involved in the initial complaint and which contact should be contacted to appeal the outcome of a complaint.

The process confirmed by the inspectors was that in the first instance the nurse on duty would try to resolve the issue, and the person in charge as complaints manager would then follow the policy, which was overseen by the provider. An appeals process was in the policy and outlined also in the resident's guide. The right for a complainant to access the ombudsman was also clearly outlined.

There had been a number of verbal complaints recorded in the files reviewed by the inspectors since the last inspection. Some were found to be in process and others complaints were completed and documented in a separate file.

**Judgment:**  
Compliant

**Outcome 05: Suitable Staffing**

**Theme:**  
Workforce

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

**Findings:**  
The centre had appropriate staff numbers and skill mix to meet the assessed needs of the residents. Throughout the inspection, the inspectors found that staff numbers in the centre were sufficient to meet the needs of the residents. The atmosphere throughout the inspection was calm. Staff did not seem rushed. The provider had identified 'natural turnover of staff' as an area where training was important. Some staff members had completed post-graduate (or were working towards) training in dementia care.
Provision of care was satisfactory and overall care was undertaken in a person-centred manner. Staff were observed to reassure and communicate clearly with residents, offering choice before continuing to assist them. Some improvements were required in terms of some minor practices observed during the observations as part of this inspection, including the routine use of disposable clothes protectors left on the table in the main dining room.

Inspectors reviewed the planned and actual rota in the centre. The actual rota was found to be representative of the staff that were on duty during the inspection. Agency staff were used for unanticipated leave on occasions and inspectors were informed that the centre aims to use regular agency staff and they had worked in the centre on a number of occasions. Inspectors found that supervision was appropriate for staff. During the day there was always at least one nurse on duty on the first and second floor. There was also a Clinical Nurse Manager on duty between both floors, and the assistant director of nursing. At night two staff nurses worked with one assuming overall charge.

A small number of residents had assessed needs or preferences for additional staff inputs and this had been supported by the provider in line with staffing and supervision in place.

Five staff files were reviewed and it was found that all contained the requirements listed in schedule 2. Inspectors were informed by management that Garda Vetting disclosures were in place for all staff. Inspectors confirmed that this was in place for the three most recently recruited staff members. The provider confirmed that he had the full staffing complement in place. Staff training records were reviewed and all staff had received up-to-date mandatory training. Relevant training confirmed on inspection included one activity co-ordinator has completed imagination gym training course and was observed by an inspector in a session which took place on the day of the inspection. Staff had completed positive communication training, rights, privacy and dignity training and understanding dementia care.

No volunteers were working at the centre at the time of the inspection, however, the provider was aware of the requirements of regulations if there were future plans to do so. Some feedback received related to the staff turnover as identified by the provider in the self-assessment document. However, staff turnover was now settling down and staff induction procedures were found to be detailed and supportive of people working in their new roles.

**Judgment:**
Compliant

**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:
This outcome was judged to be substantially compliant in the provider's self assessment, and the inspectors judged it as a moderate non-compliance. Overall, the premises were found to be in compliance with the regulations at the time of the last inspection in 2016. The centre was kept clean and maintained to a good standard of repair. Each of the four areas, Orchid, Magnolia, Rose and Lavender had a single bedroom with en-suite facilities to undertake activity in private. The Hybla Café was located near the reception area and had developed into an area where residents, visitors and staff could enjoy refreshments and family visits.

The centre was purpose built and laid out over two floors which were accessed by two passenger lifts and staircases. The ground floor housed the reception area, kitchen, nurses' station, dining room, offices, oratory, visitors room, staff facilities, the Hybla Café. Adequate private accommodation was provided, and the area of communal space as a whole in the centre was sufficient.

The provider had developed and changed the purpose and function of one unit - Lavender. In terms of a dementia care focus an environmental design project was described as improving the sensory environment and way-finding in the centre. This project had commenced in the Lavender unit and due for completion by the end of May 2017. This news had been communicated to residents and relatives in a colourful newsletter. A dementia care mapping exercise had taken place in November 2015, and this had not been repeated since this time to evaluate practices.

Inspectors visited the Lavender unit which was now used to accommodate 16 people with dementia. They were informed by staff on arrival that this area operated as a 'secure' unit, in terms of use of a key pad entry and exit system. Some positive environmental improvements were noted, and interesting murals had been applied to the corridors in lavender, and some sensory items were evident. The observations made by inspectors were that some improvements in lavender were required with communal spatial requirements. The amount of communal space to facilitate dining requirements and social activity was in place for the centre as a whole. However, in Lavender unit there was a one small room used as a parlour and the open walk-through 'coffee-dock' area which had a range of comfortable lounge seating in place. This area was used in the main for sitting; staff preparing snacks and the serving meals and drinks. Residents were offered a choice of where to eat on the day of the inspection and one resident visited the nearby main dining room for his meal. Two residents had their meal while seated at chairs and a table in the nearby corridor overlooking the courtyard. This allowed for supervision by staff nearby. However, access for all residents in lavender to suitable and sufficient dining space was not found to in place to facilitate free movement and choice of where to eat. The inspectors formed a view that all residents could not be seated comfortably for meals and leisure-time. There was insufficient space for residents, assistive equipment staff and any visitors in this area. Additional seating with a sofa was found on one part of the corridor, and level access to the courtyard which also had outdoor suitable seating which could be used by residents and visitors weather permitting. Inspectors also noted that the flooring was similarly coloured to some of the
armchairs in use and may be indistinguishable to those residents with visual sensory
difficulties.

The residents’ bedrooms were located on the ground and first floor. All bedrooms were
single occupancy. Each bedroom was provided with a large wardrobe and a locker for
personal items. All bedrooms were en-suite, with a shower, hand wash basin and toilet.
There was also sufficient number of large assisted communal bathrooms and showers to
meet the needs of all residents. On the first floor there was an additional dining area,
hairdressers and communal space near to the resident accommodation.

An additional accessible and secure, landscaped sensory garden was accessible to
residents. The inspector found the premises was designed and laid out in the communal
areas, to ensure discrete supervision could be maintained from a distance by staff, with
due regard for the residents' right to privacy.

All beds had an emergency call facility and each resident was assessed for their use.

There was provision of assistive equipment such as hoists and lifts. Suitable storage was
provided for assistive equipment.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Statement of Purpose**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The purpose and function of the services provided were not clearly outlined in the
statement of purpose, other than general guidance that the centre could accommodate
people with dementia. One of the four units was identified to inspectors and relatives as
being dementia specific in the pre-inspection self-assessment by the provider and
person in charge.

Inspectors found that the centre did accommodate 16 residents living with living with
dementia. Nonetheless the statement of purpose did not clearly outline the range of
needs the centre was designed to meet. Since opening the centre the provider had
developed Lavender unit. However, the admissions, transfer and discharge policy had
not been reviewed to reflect any specific requirements.

**Judgment:**
Substantially 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
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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
Signature omissions in medication administration records were found by inspectors in some residents' charts.

1. 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
Please state the actions you have taken or are planning to take:
One of the signature omissions was corrected during the inspection and the relevant agency nurse was contacted and corrected second signature omission. The ADON and CNM’s who conduct medication management audits are including medication administration signature audit. Audit complete with action plans on 07/03/2017. This audit will be ongoing.

Proposed Timescale: 07/03/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As required psychotropic medicines prescribed and outlined in care plans to support residents were not consistently used in line with best practice prior to the use of alternatives.

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:
We have contacted our care monitor programmer to create an action plan link to our prn psychotropic event button. This means that Nurses will be prompted to complete a record of all actions prior to administration of a prn psychotropic medication and the effects of the administration. This is currently being designed and will be completed by the end of April. In the meantime The DON has held a training meeting with all nurses and CNM’s to highlight this problem. An audit was conducted on the 7/3/2017 and actions plans created which the CNM’s are following up on. Within the monthly audits the CNM’s are highlighting this issue. When the action plan trigger is designed it will be implemented and monitored within our audit system.

Proposed Timescale: 30/06/2017

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:
Personal grooming activity was undertaken in a communal space using one piece of
equipment for four residents.

3. **Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
The DON has met the team about this issue within our quality circle and we focused our understanding person centred care using this as an example. Both the undertaking of the intervention in a communal space and the use of one piece of equipment for a number of residents was discussed within the circle. A renewed understanding of such an issue was obvious to staff. This practice was stopped immediately. Families have been reminded to provide sufficient personal items for the needs of their loved ones. Where this is not possible Mount Hybla will provide such equipment to ensure this does not happen again.

**Proposed Timescale:** 30/04/2017

<table>
<thead>
<tr>
<th>Outcome 06: Safe and Suitable Premises</th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Effective care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>Review colour schemes in use in the lavender unit to ensure that chairs are easily distinguishable from flooring visually.</td>
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<tr>
<td><strong>4. Action Required:</strong></td>
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<tr>
<td>Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>Three chairs are to be replaced with chairs of a different colour in order to create contrast with the floor. These chairs have been ordered and we await their delivery. The planned delivery date will be in the first week of week in May.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 05/05/2017</td>
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<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Effective care and support</td>
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There was inadequate recreational and dining space in lavender for 16 residents.

5. **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:
Mount Hybla has been undertaking an innovative project on Dementia Care within our lavender Suite. This has involved both, creating and enhancing the environment and articulating our model of care for our residents. Currently we have one parlour and one living area and have created two themed dining areas. Currently some of our residents attend the main dining room for meals and most of our residents attend the activity centre and main sitting room for activities during the day as per their care plan and particular interests. We will monitor this on an ongoing basis to ensure the Unit meets the resident’s needs.
In relation to the environment we are conscious of the fact that the living and dining space have presented challenges.
We met with our architects in relation to extending the day space in the Lavender suite out into the secure courtyard. They are drawing up a plan for the extension. This has then has to be brought to the quantity surveyor. At this point it will be presented to the Board of Directors for approval. Form then planning permission needs to be sought. Upon approval works can begin.

**Proposed Timescale:** 30/04/2017

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**Outcome 09: Statement of Purpose**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The information on the statement of purpose requires updating to reflect any developments around the purpose and function of the designated centre.

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

Please state the actions you have taken or are planning to take:
The Statement of Purpose has been updated to include the fact that we have a Dementia Specific Unit. Our Statement of Purpose, Resident Guide, Admissions Policy and our Dementia Care Policy have all been updated in line with this information.

Proposed Timescale: completed

**Proposed Timescale:** 13/04/2017