Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	Alzheimer Care Centre
Centre ID:	0113
Centre address:	Swords Road Whitehall, Dublin 9
Telephone number:	01-8374444
Email address:	info@highfieldhospital.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	J & M Eustace Partnership, T/A Highfield Healthcare
Person authorised to act on behalf of the provider:	Stephen Eustace
Person in charge:	Stephaine McMahon
Date of inspection:	28 and 29 November 2012
Time inspection took place:	**Day-1 Start:** 12:10 hrs **Completion:** 20:00 hrs **Day-2 Start:** 09:00 hrs **Completion:** 16:55 hrs
Lead inspector:	Mary McCann
Support inspector(s)	Nuala Rafferty
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	130
Number of vacancies on the date of inspection:	24

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

- to monitor compliance with Regulations and Standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This inspection report sets out the findings of a monitoring inspection, in which 14 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☒
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over two days. As part of the monitoring inspection the inspectors met with residents, relatives, and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

This centre had a site inspection in March 2012 in response to an application to vary their registration to increase capacity to 154. This variation was granted.

The last inspection report from the inspection completed in March 2011 identified non compliance in five areas and 16 regulatory matters were documented. The original completed action plan was forwarded to the Authority on 26 May 2011. The provider and the person in charge have been working to address the issues identified during that inspection and demonstrated a commitment to meeting the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

There has been significant increase in bed occupancy with a corresponding increase in accommodation provided. This has included a new build and refurbishment of the existing centre. The only unit that has not had a major refurbishment is Ryall which still has multi-occupancy bedroom areas and a lack of communal space. The completed work was finished to a high standard and provided an improved standard of comfort and accommodation to residents.

Whilst evidence of good practice was observed in many aspects of the service, improvements were required in the management of some risks, relating to fire safety and the availability of personal identification numbers for all qualified nursing staff. The provider was requested to take immediate action to address these risks and forward information to the Authority with regard to these matters by the next day. This information which detailed appropriate actions taken to address these issues was submitted as requested on 30 November 2012. This detailed that training in fire safety, elder abuse, infection control, manual handling health and safety and food hygiene was scheduled on 30 November 2012, 6 and 7 December 2012.

While care plans were in place for all residents, these required review to ensure the delivery of person-centred care. The inspectors were satisfied that the residents were well cared for. Residents had access to general practitioner (GP) services, to a range of other health services and evidence-based nursing care was provided. However, medication prescribing practices with regard to “as required” (PRN) medication and whether the medication should or could be crushed prior to administration.

Residents interviewed stated they enjoyed living in the centre and were complimentary of the staff and their surroundings. The inspectors also met with two relatives who were also complimentary of the environment the staff and the service delivered to their loved one.

The inspector found that most of the actions from the previous inspection were addressed or in the process of being addressed. Areas requiring improvement on this inspection include mandatory training in fire safety and elder abuse, care planning updating of the statement of purpose, risk management and medication prescribing practices.

The Action Plan identifies mandatory improvements in order to meet the requirements of the Regulations and the Authority's Standards.

Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The statement of purpose had been updated in June 2012 and was reviewed at the time of the variation inspection. It includes the aims, objectives and ethos of care. It describes the categories of care provided and level of needs that can be accommodated. However it requires updating to describe the current purpose and function of the designated centre, for example, to include Coghill and Daneswell as part of the designated centre and changes in staff as a result of the new build. The statement of purpose must be up to date and detail all matters listed in Schedule 1 of the Regulations.

Outcome 3

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The post of person in charge was full-time. The person in charge was appointed in September 2011. She is a registered nurse with the required experience in the area of geriatric nursing.

The person in charge had completed training in infection control, food hygiene, health and safety, fire safety, manual handling and elder abuse since her appointment.

In the past she had completed a four day course in medication management. The inspectors were of the opinion that due to the amount of residents coupled with the complex needs of residents, the person in charge should consider completing a course in management and/or a specific course in gerontology/specialist nursing of the older person. The person in charge informed the inspectors that she was discussing this with her manager.

Deputising arrangements and on call out of hours arrangements were in place. The provider was aware of his responsibilities to notify the Authority of the absence of the person in charge, although to date this had not occurred.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☒

Medical and care files reviewed. Improvements required with regard to care planning. Commented upon under Outcome 11 in the report.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

Review the admission criteria and the operational policies and procedures in relation to admissions to ensure appropriate placements of residents and that only those residents who meet the range of needs and type of service provided as outlined in the statement of purpose are admitted.

This action had been completed.

The admission policy and the statement of purpose were both reviewed in June 2012. Both these documents have been submitted to the Authority and detail the admission procedure. On files reviewed by inspectors a pre admission assessment had been completed. This was usually completed by the liaison nurse and discussed with the person in charge. The centre does not accept emergency admissions.

Operational policies and guidance documents were in place to guide and inform staff. However, some of these required review. For example, the emergency policy did not clearly state the procedure to be adapted out of hours. The policy on the prevention, detection and investigation of alleged abuse required revision to include guidance to staff as to the action to take in the event of an allegation of abuse involving senior staff of the centre. The medication policy required review with regard to informing practice re prescribing of crushed medication.

Directory of Residents

Substantial compliance ☐ Improvements required * ☒

A sample of the directory of residents was reviewed. This was found to not be up to date as one man had been admitted to the general hospital and this transfer had not been documented in the directory. A deleting substance was noted to have been used in the directory which is contrary to good practice as documented in Recording Clinical Practice Guidance to Nurses and Midwives (Nov 2002)

Staffing Records

Substantial compliance ☐ Improvements required * ☒

Seven staff files were reviewed by the inspector. These did not contain all the information required by the Regulations. Verified evidence of medical and physical fitness for the purposes of the work which the staff member were to perform at the designated centre was not available. While there was evidence of a medical assessment on some files reviewed this did not make a judgement as to whether the staff member was deemed medical and physical fitness for the purposes of the work which the staff member were to perform at the designated centre. Some files did not contain three references, evidence of Garda Síochána vetting or evidence of qualifications.

Medical Records

Substantial compliance ☐ Improvements required * ☒

The care files were multidisciplinary and contained the medical files. A sample of medication charts were reviewed by the inspector. Commented upon in the report under Outcome 8.

Records requested were generally complete, accurate and up to date. They were maintained in an organised manner and were easily retrievable and secure. The person in charge confirmed that records were accessible to the residents to whom they referred to on request.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection finding

The provider and person in charge had taken some measures to protect the safety of residents. Since the last inspection the centre had recruited many staff and had increased occupancy from 63 to 130. The centre is registered to accommodate 154 residents.

Not all staff had up-to-date training in recognition, investigation, reporting and management of elder abuse. While staff who spoke with the inspectors were clear on their responsibility to report abuse some were not clear as to what constituted abuse. The inspectors were concerned if staff were not clear as to what constituted abuse, they may fail to recognise abuse and report same.

There are no ongoing investigations with regard to allegations, disclosures or suspected abuse but where there have been concerns in the past these were appropriately dealt with by the provider and person in charge.

The inspectors did not examine fully the arrangements for the safekeeping of residents' valuables. The inspectors were informed that there was a policy relating to residents' personal property and possessions.

A record of each resident's personal property was retained in each residents file. Each resident had adequate space to store their personal belongings, including a locked unit for the storage of valuables.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Actions required from previous inspection:

1. Revise the accident and incident reporting processes to incorporate more detailed and reliable sources of information.

2. Put in place precautions to control all identified risks and ensure these are adhered to at all times

3. Establish a system which regularly audits and reviews the control mechanisms in place to manage identified risks.

Inspection findings
Actions 1 and three were completed. Action 2 required further work as the risk register was not up to date.

Accident and Incident Records
Records were maintained of all accidents and incidents. All of the records were dated and signed by a staff member and by the person in charge. Information relating to each incident was readily available and follow up actions were recorded. Any witnesses were also recorded. The person in charge reviewed the reports for each

resident to determine the root cause and preventative measures were being taken to prevent reoccurrence, such as review to physiotherapy. However, there was one area that required review, the medical staff who attended to the resident did not date or add the time they reviewed the resident, consequently it was not possible to see the timeline from the occurrence of the injury to the time the resident was medically reviewed. All incidents are reviewed on a monthly basis by the risk management committee. This process has been reviewed since the last inspection and a monthly report was available to include the number of recorded incidents per month, location, time, witnessed or not witnessed and identifies residents involved in recurrent incidents. Measures in place to prevent accidents included handrails, grab-rails and safe floor covering. The environment was uncluttered and equipment was appropriately stored to prevent tripping incidents.

There was an overarching risk management policy which detailed other risk policies such as self harm and a missing person's policy. There was a risk register available on Ryall unit which identified a range of risks, however, this was last updated in 2009 and no further risk register was made available to the inspectors. There was no smoking policy and the risks associated with residents smoking were not documented.

Fire Safety

Although the provider had taken some measures to ensure the safety of residents in the event of a fire, there were some fire safety risks identified. All means of escape were found to be unobstructed and daily checks on means of escape were documented. Smoke detectors were located in all bedrooms and general purpose areas. Up to date servicing of equipment had been carried out. Fire extinguishers were serviced in March 2012 and fire emergency lighting in February 2012. Fire drills to reinforce the theoretical training provided to staff to ensure they are confident of the procedure to be followed in the case of a fire were not carried out at regular intervals. The last recorded fire evacuation drill was carried out in October 2011. The inspectors viewed the fire training records and found that that many staff had not been provided with fire training since they were recruited. This was confirmed by staff. The inspectors noted that a high proportion of these staff were on night duty at the time of inspection. Staff interviewed were not able to tell inspectors about how they would evacuate the building if the need arose or who would decide to call the fire brigade out of hours. All were clear that they would evacuate to the next zone but were unsure what to do if further evacuation was required. This presented a risk to the prompt implementation of fire safety measures in the event of a fire. This was brought to the attention of the provider at the feedback meeting who agreed to arrange fire safety training for the evening of 29 November 2012. The day following the inspection the provider confirmed that he had carried out training and 21 staff had attended. There were no individual evacuation plans on case files reviewed to assist and guide staff as to safe and swift evacuation of residents, for example whether a resident required a wheelchair.

Manual Handling Training

From the records available it was not possible to make a judgement as to whether all staff had up-to-date manual handling training. Most staff interviewed told inspectors that they had completed manual handling training in the last three years, however, the training matrix supplied by the training officer to the inspectors detailed that 75

of the 155 staff detailed had not received manual handling training since commencement of employment at the centre. No unsafe manual handling practices were noted by inspectors during the inspection.

Emergency Plan
A comprehensive emergency plan had been developed, however, staff were unaware of the full contents of this. The emergency plan covered an outbreak of influenza. The person in charge informed the inspectors that she was keeping a record of all staff who had availed of the 'flu vaccine.

Infection Control
Policies, procedures and practice in relation to infection control have been developed. The centre was clean throughout.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspectors were not satisfied that all practice relating to medication prescribing was compliant with best practice. Medication was prescribed generically for crushing in a high percentage of medication records reviewed. On one occasion one of the inspectors noted that a nurse was crushing medication as the resident was unable to swallow the medication but there was no documented agreement by the doctor to do this.

A medication management policy was in place. One of the inspectors reviewed this and found that procedures did not provide sufficient detail to guide and inform staff in all areas of medication management, for example, crushing of medication was not detailed in the policy. The inspector also noted that the policy stated that the maximum dose of prescribed PRN medication should be detailed by the prescriber but this was not occurring in practice.

The inspector noted that prescribing practices did not comply with best practice. The prescription sheets and medication records for ten residents were inspected. The following omissions were noted with regard to medication management:

- dates and signature for discontinuation of medication were not consistently recorded
- crushing of medication was prescribed generically

- maximum doses of PRN were not recorded on all occasions
- where medication was withheld, the reason was not documented
- there was no evidence available that dissolvable or liquid preparations were available to decrease the need for crushing of medication
- photographic identification was available on the medication prescription chart for all residents to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. Surplus supplies and out of date drugs were returned to the pharmacy on a frequent basis.

The inspector observed that the clinical room was secured to restrict access in the interest of safety to residents and visitors. Surplus supplies and out of date drugs were returned to the pharmacy on a frequent basis. Medications that required special control measures were not checked on this inspection.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

All notifications should be submitted by the provider as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended)

Policies and procedures should detail the notifications required and include timescales to guide staff with legislative requirements

Inspection findings

These actions were satisfactorily completed.

One of the inspectors reviewed records of accidents and incidents that had occurred in the designated centre and was satisfied that all relevant incidents were notified to the Chief Inspector within the timescales as required by the Regulations.

All accidents and incidents were recorded in the centre and were maintained in a log. The person in charge was aware of the timescales within which notifications must be forwarded to the Authority. It was noted by inspectors that reporting timescales were documented in policies.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspectors found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The person in charge described good access to the general practitioner (GP) and documentation in the case file supported this. On reviewing case files it was evident to the inspectors that assessments were carried out on each resident. Staff utilised validated tools to risk rate residents. For example a nutritional assessment tool was used to identify risk of nutritional deficit, a falls risk assessment tool to assess risk of falling. Additionally assessments were reviewed post an incident. A post falls risk assessment was completed after each fall and preventative measure were put in place, for example, increased supervision, review of footwear, review to physiotherapist, hip protectors

to be obtained. Inspectors noted that residents were supervised at all times throughout the inspection.

Staff could clearly describe the care that was delivered but the care plans did not reflect the practice of staff and did not adequately guide care. The inspectors noted that care plans were pre printed on most occasions and not written in a person-centred manner, consequently this did not take account of individual residents' choices and preferences in all aspects of their care. Where person centred-care wishes are recorded and incorporated into care plans, this gives guidance in daily routines and management plans for staff to follow with the aim of ensuring residents are involved in their care and care is delivered in a consistent manner. For example, in care plans reviewed, one stated “provide reassurance and comfort” but there was no indication as to how this could be done and what specific measures were pertinent to this resident. Another plan stated “ensure physical needs are met” with no further information as to how this was to be done.

The inspector noted that a care plan reviews were completed on a three-monthly basis. While the review stated “care plan reviewed, no change” and there was a signature of the resident and/or their significant other on some occasions. However, there was no narrative available of a discussion between the resident and/or their significant other with regard to the care plan as to whether they agreed, disagreed or wished to make any comment with regard to the care plan. Another care plan stated on 2 April 2012 “Do a baseline frequency voiding chart assessment over a period of three days”. While this care plan had been evaluated on three occasions since it was enacted, there was no indication as to whether this assessment had been completed or not or if completed what the result was and how this was reflected in a revised care plan.

All medical records reviewed demonstrated evidence of current medical review. Nursing staff appropriately assessed residents and sought prompt medical review. Residents were also seen to have been referred to occupational therapy services for seating assessments and recommended seating had been obtained.

Staff informed the inspectors that reviews of medication were occurring at three-monthly intervals. However, a narrative note was not documented by the GP in the medical notes or on the medication charts to comment upon the review and what changes had occurred, if any. A chiropody service was available to the centre. Dental and dietetic services were available. Audiology services were arranged as required via GP referral. Eye checks were also arranged as required. Staff informed the inspectors that there was access to palliative care services.

The provider has employed four full-time activity personnel for the centre. The inspectors spoke with three of the activity coordinators. Activity provision included group and one to one sessions. Residents with a cognitive impairment were encouraged to take part in activities or where this was not possible, their attention was regularly enhanced by staff’s interaction. Activities for residents with dementia/cognitive impairment included reminiscence, hand massage, going for coffee to the coffee bar which was located on entry and social interaction to enhance communication. Mass took place weekly. Other activities included music, bingo and art, current affairs, crafts and beauty therapy. There was a social care assessment

completed for each resident. These assessments were used to assess the suitability of activities to different residents and informed the staff of the background interests of the residents. Some residents attended the local pub regularly and told inspectors how much they enjoyed these outings.

Restraint measures in place included the use of bedrails, lap belts and specialist chairs. The inspector reviewed records with regard to restraint measures in place. There was poor evidence of alternative less restrictive options being tried prior to the use of restraint.

There was a risk assessment completed prior to the use of the restraint. A rationale was provided for the requirement of the restraint measure. The inspector noted on some assessments it stated that the restraint measure was at the request of the resident and the restraint measure increased comfort and independence, for example, 'using bedrail as a positioning aid'. The inspectors noted that where a restraint measure was risk assessed as not suitable a low bed was provided.

Many residents were using specialist chairs which were enabling as they provided them with greater independence, for example, able to independently eat or support them to spend long periods out of bed or have a drink thereby enhancing resident function. However, care plans did not clearly identify the enabling function of the measures in place. There was evidence of other health professionals' and the GP involvement in the decision to use the restraint measure.

The centre used bedrails that were independently attached to some of the beds. An audit of safe positioning of these bedrails had not been completed. This is required regularly with these types of bedrails to ensure safe dimensional limit requirements to protect the safety and welfare of residents.

Inspectors found that the nursing staff monitored the nutritional status of residents. Residents' weights were recorded monthly and those deemed at risk were recorded weekly. Nutritional risk assessments were used to identify residents at risk and care plans were in place. There were three residents with pressure sores on the days of inspection. Risk of pressure sore development had been assessed by nursing staff, preventative pressure relieving equipment was in place and there was access to tissue viability services. Wound documentation that was in place demonstrated knowledge of evidence-based practice such as wound grading and supporting photographic evidence. One resident had been admitted to the centre with two wounds and one had resolved. The inspector noted that while this resident had lost weight, she was regularly seen by the GP, had been seen by the dietician, was on weekly weights, turning charts and food and fluid charts were in place and appropriate aids were in place. The inspector discussed with staff the importance of accurate recording of food intake. Staff confirmed to the inspector that a wound care policy based on best practice was in place but this was not reviewed by inspectors.

There was good practice in the management of residents with behaviours that challenge and a policy on challenging behaviour management was in place. Inspectors noted that there was good access to specialist advice from psychiatric services documented in case files reviewed.

There was a falls prevention policy in place which contained an environmental checklist for prevention of falls and a post falls assessment. All residents at risk of falls had a falls risk assessment completed and a care plan in place. Inspectors reviewed the care plans of five residents who had fallen and noted that a post falls assessment had been completed.

Nursing staff confirmed that they had had access to the required resources to monitor residents with suspected head injuries i.e. a neurological chart and pen torch. These observations were completed when a resident had an un-witnessed fall or a fall resulting in a head injury.

Manual handling assessments had been carried out for individual residents to identify their mobilising needs. These were available on the back of the wardrobe doors for accessibility for staff and to protect confidentiality.

There was a good standard of catering and residents were offered choices at mealtimes.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Actions required from previous inspection:

1. Provide suitable and sufficient equipment as required to meet the needs of residents and the requirements of the legislation specifically, safe lockable storage for chemicals.

2. Provide sufficient assisted toilets and showers/bathrooms to meet the needs of residents.

3. Provide adequate communal and private space to meet the needs of each resident specifically in relation to, communal areas, separate sitting and dining areas, size and layout of treatment rooms.

4. Ensure there are a sufficient number of assisted toilets and bathrooms having regard to the number of dependent persons in the centre.

5. A complete review of the layout of the laundry to ensure the health and safety of staff in relation to uneven ground, lack of protection from the elements, replace flooring within, provide necessary sluicing facilities and provide staff changing facilities and toilets.

Inspection findings

Action one was completed, action 5 was in the final stages of completion and actions 2, 3, 4 continued to occur with regard to Ryall unit.

Safe lockable storage space was provided for chemicals to ensure the safety and welfare of residents was protected.

Overall, arrangements for personal laundry were found to be adequate. The last inspection report detailed a requirement to make improvements to the laundry. The inspectors visited the laundry and found that it was at an advanced stage of refurbishment and were informed that this will be completed in approximately three weeks. The laundry catered for the Alzheimer's Care Centre, Elmhurst Nursing Home, the mental health services and Highfield Hospital. The laundry staff informed the inspectors that clothes were completed in batches from the different units and clothes were delivered and returned in colour coded bags according to each unit. The laundry was in operation six days per week and staff in the laundry confirmed that they could cope with the workload. They also confirmed that they had received training in infection control and described good infection control practices to the inspectors. Staff confirmed that all clothes were clearly labelled. Staff and a relative interviewed confirmed that clothing seldom went missing.

The inspectors did not visit Hampstead unit but the director of operations informed the inspectors that staff toilets and changing facilities are provided there.

A major refurbishment programme of existing units and a new build to increase numbers to 154 beds has occurred. The refurbished units and the new build have been completed to a high standard and provide a homely, clean, bright and comfortable environment for residents. Residents' choice around their daily lives has improved as a result of the enhanced environment as they now had access to a variety of comfortable communal space for activities, social time and dining. All residents have individual lockable storage facilities to ensure they can store confidential information and maintain control over their own valuables if they so wish.

Ryall unit continues to contain eight bedded multi-occupancy rooms. The layout of these areas renders it difficult to provide for residents' individual and collective needs in a comfortable and homely way on a daily basis. The residents' personal space is not designed and laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort, privacy and dignity. There are no separate dining, visitors or recreation room apart from the sitting room on this unit. As all residents on this unit are of maximum dependency and spent most of their time on the unit, consequently residents spent long periods of time in the same room. There are four residents' toilets and three shower/bathrooms. The physical environment continues to pose challenges to meet residents' needs according to the Authority's Standards.

The director of operations informed the inspectors that there is a refurbishment plan for this unit. All other units have single or twin rooms.

An internal and external smoking room was available on Gratton unit.

Staff informed the inspectors that there was appropriate assistive equipment provided to meet the needs of residents, including specialist beds, hoists and specialised appliances. One of the inspectors viewed the maintenance and servicing contracts and found that the equipment had been recently serviced. There was adequate space to store equipment safely.

Theme: Person-centred care and support

Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

A record of complaints or issues raised by residents or their representatives was maintained at the centre. The documentation supported that an investigation had occurred. However, the outcome of the complaint was not clearly documented in all records and whether there had been communication with the complainant and an indication of their satisfaction with the outcome of the complaint.

There was evidence that complaints were discussed with staff to ensure learning had occurred and to try and ensure that there was a decreased likelihood of reoccurrence.

Outcome 16
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Action required from previous inspection:

Personal care and private information of resident was publicly displayed.

Inspection findings

This action had been completed. The information regarding fluid balance sheets and moving and handling sheets was situated inside the residents' wardrobes.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors observed adequate staffing levels during the inspection and staff rotas confirmed these staffing levels to be the norm. On many occasions the staff rota included the first name only of the staff member. On reviewing the staff rota inspectors formed the view that there was an acceptable level of skill mix. Staff informed the inspector that leave was planned in advance. Where there were unplanned absences, regular relief staff had been organised to work which ensured that residents were familiar with staff and staff were knowledgeable of residents' needs. A staff handover occurred at the commencement of the morning and night shift.

A training officer was in post and a training matrix for all staff on mandatory training was in place. The training officer gave the inspectors the matrix for the Alzheimers Care Centre which detailed 155 staff. This detailed all staff nurses and care assistant staff in the centre - 75 of these were not detailed as having had mandatory training in fire safety, elder abuse or manual handling since commencement of employment at this centre.

The inspectors formed the view that improvements were required in relation to the organisation, allocation and supervision of staff to ensure the safety of residents. The inspectors discussed with staff the daily routine and were informed by staff that care assistants were not supervised in the delivery of personal care to residents in the morning as the staff nurse remained in the dining room serving breakfast. This was discussed with management at the feedback meeting who gave a commitment to review this immediately. Inspectors observed that residents were supervised at all times in the dining and sitting rooms on the days of inspection. Staff displayed good knowledge of the residents needs and were noted to communicate well with residents.

Post the inspection the director of nursing submitted a comprehensive training plan to address the staff training deficits addressed at the feedback meeting. This included four dates for mandatory training, training in challenging behaviour, care planning, communication, first aid, major incident procedures and medication management.

There was a system in place to ensure that staff were appropriately inducted. There were four clinical nurse managers grade one and two clinical nurse managers grade two employed in the centre to supervise the delivery of care to residents. These staff worked a variety of shifts and some were on duty at weekends. Personal identification numbers (PIN) which ensure that all staff are registered with the professional nursing body for Ireland were made available to inspectors for all qualified nursing staff.

On most occasions there was a staff nurse rostered for nursing care on these days to allow the nurse managers to fulfil their managerial and supervisory roles. Residents and relatives spoken with informed the inspectors that staff were always available to look after them or their loved one.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, another director of the providing company, the person in charge, the director of operations and the director of nursing to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Mary McCann

Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

5 December 2012

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Alzheimer Care Centre
Centre ID:	0113
Date of inspection:	28 and 29 November 2012
Date of response:	21 January 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Outcome 1: Statement of purpose and quality management

The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose requires updating to describe the current purpose and function of the designated centre, for example, to include Coghill and Daneswell as part of the designated centre and changes in staff as a result of the new build.
Action required: Compile a statement of purpose that describes the facilities and services which are provided for residents.
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

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

Action required: Make a copy of the statement of purpose available to the Chief Inspector.
Action required: Keep the statement of purpose under review.
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An updated Statement of purpose has been submitted to the regulating body on the 17/12/2012.	17 December 2012

Outcome 4: Records and documentation to be kept at a designated centre

The person in charge is failing to comply with a regulatory requirement in the following respect: Staff files did not contain all the information required by the Regulations. Some files did not contain three references, evidence of Garda Síochána vetting or evidence of qualifications or verified evidence of medical and physical fitness for the purposes of the work which the staff member were to perform at the designated centre was not available.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
Reference: Health Act, 2007 Regulation 24: Staffing Records Standard 22: Recruitment

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

Provider's response: New staff will no longer commence employment until all information and documentation has been obtained according to Standard 22. Current staff files will contain full and satisfactory information and documentation including 3 references, evidence of qualifications, verified medical evidence fitness to work and evidence of Garda Vetting or signed confirmation of no convictions where Garda Vetting applications are pending.	01 March 2013

Outcome 4: Records and documentation to be kept at a designated centre

3.The person in charge is failing to comply with a regulatory requirement in the following respect: The Directory of residents was found to not be up to date. A deleting substance was noted to have been used in the directory which is contrary to good practice as documented in Recording Clinical Practice Guidance to Nurses and Midwives (Nov 2002)	
Action required: Establish and maintain an up-to-date directory of residents in relation to every resident in the designated centre in an electronic or manual format and make this information available to inspectors as and when requested.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident's directory in all units is now up to date detailing transfers to and from hospital. All erasing substances have been removed from the units and it has been communicated to all staff that the use of this substance is prohibited in order to meet best practice as documented in Recording Clinical Practice Guidance to Nurses and Midwives (Nov 2002).	12 January 2013

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: Operational policies and guidance documents were in place to guide and inform staff. However, some of these required review.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policies and procedures are updated at least every 3 years and when needed. These are all due for review in 2013 by the policy and procedure committee.	17 April 2013

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had up to date training in recognition, investigation, reporting and management of elder abuse.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Mandatory Training days were held on the 7/01/13 and on the 15/01/13 which comprised of the following areas -Fire Training, Elder abuse Safe food handling, Manual Handling , Health and safety and infection control. 150 staff have attended Mandatory Training. Mandatory Training is carried out on a regular basis. Policies and procedures are available for all staff on all units and staff are obliged to read and sign that they have understood these during their super-nummery period when they commence work in Highfield.	17 March 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: There was a risk register available on Ryall unit which identified a range of risks however this was last updated in 2009 and no further risk register with regard to the centre was made available to the inspectors. There was no smoking policy and the risks associated with residents smoking were not documented. The centre used bedrails that were independently attached to some of the beds. An audit of safe positioning of these bedrails had not been completed. This is required regularly with these types of bedrails to ensure safe dimensional limit requirements to protect the safety and welfare of residents.
Action required: Put in place written operational policies and procedures relating to the health and safety.
Reference: Health Act, 2007 Regulation 30: Health and Safety Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The risk and quality management team who meet on a monthly basis are in the process of creating a risk register; this will reflect all levels of risk throughout Highfield. The policy and procedure committee have developed a new smoking policy which is now in place in all of our nursing home units a risk assessment for residents who smoke is being finalised. Residents who are smokers now have a reflective care plan and the risk assessment will be reflected in this. In an effort to reduce the risk of injury and /or harm from the use of approved bed rails, a proposed Bed rail safety check devised by nursing management was reviewed and is currently being augmented in an effort to make it more user friendly for all staff.	17 March 2013

The provider is failing to comply with a regulatory requirement in the following respect: From the records available it was not possible to make a judgement as to whether all staff had up to date manual handling training.	
Action required: Provide training for staff in the moving and handling of residents.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 150 staff designated to the Alzheimer's Care centre have attended Mandatory Training and further training is planned to facilitate those who have yet to complete it. Mandatory Training is facilitated on a frequent basis in an effort to ensure all staff can attend. The training Officer has now made comprehensive records of the staff who have attended training. This is made available to the person in charge so rosters can be created ensuring the appropriate skill mix is in place in all units.	17 March 2013

The provider is failing to comply with a regulatory requirement in the following respect:

Fire drills to reinforce the theoretical training provided to staff to ensure they are confident of the procedure to be followed in the case of a fire were not carried out at regular intervals.

The last recorded fire evacuation drill was carried out in October 2011.

The inspectors viewed the fire training records and found that that many staff had not been provided with fire training since they were recruited. This was confirmed by staff. The inspectors noted that a high proportion of these staff were on night duty at the time of inspection.

There were no individual evacuation plans on case files reviewed to assist and guide staff as to safe and swift evacuation of residents, for example whether a resident required a wheelchair.

Action required:

Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

Action required:

Provide suitable training for staff in fire prevention.

Action required:

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Reference:

Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Mandatory Training days were held on the 7/01/13 and on the 15/01/13 which included Fire Training, 150 staff designated to the Alzheimer's Care Centre have attended mandatory training. The current formal Fire training format is under review and in the forthcoming year we will focus on evacuation and drills. After the inspection on the 29/11/12 Training was provided that	17 March 2013

evening for the night staff that were rostered on duty. A fire mobility Chart for each resident will be devised and will be kept on each unit. This will be updated as needed and every 3 months. Care plans will also be in place to ensure that the needs of a resident during an emergency evacuation are reflective or their physical and cognitive function.	

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: The medication policy required review with regard to informing practice re prescribing of crushed medication. The following omissions were noted with regard to medication management : Dates and signature for discontinuation of medication were not consistently recorded. Crushing of medication was prescribed generically. Maximum doses of as required (PRN) were not recorded on all occasions. Where medication was withheld, the reason was not documented. There was no evidence available that dissolvable or liquid preparations were available to decrease the need for crushing of medication.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The medication policy is currently under review and the new policy will be drawn up supported by evidence based, best practice.	17 March 2013

All medication reviews have been carried out in conjunction with the General Practitioner, the nurse and the pharmacist. An internal medication audit is also being finalised in conjunction with the pharmacy's audit in an effort to reduce the risk of inconsistencies, omissions and medication errors.	

Theme: Effective care and support

Outcome 11: Health and social care needs

The provider is failing to comply with a regulatory requirement in the following respect:

The inspector reviewed records with regard to restraint measures in place. There was poor evidence of alternative less restrictive options being tried prior to the use of restraint.

Many residents were using specialist chairs which were enabling as they provided them with greater independence, for example able to independently eat or support them to spend long periods out of bed or have a drink thereby enhancing resident function, however care plans did not clearly identify the enabling function of the measures in place.

Action required:

Provide a high standard of evidence based nursing practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Where restraint measures are in place, greater emphasis will be placed on documenting the less restrictive measures which have been used. Care plans will be more reflective of the positive actions of the use of enablers and restraint. Care plan audits which are carried out monthly will assist management in identifying omissions or lack of clarity in respect to this. A new care plan format has been devised which will include a pre care-plan assessment which will guide nurses in creating more appropriate, specific and person centred care plans.	17 March 2013

Pre care-plan assessments will be renewed on a 3 monthly basis and/ or as needed and will be discussed with the resident where appropriate and their families. In relation to restraint and/or enablers in use for our residents whom require them , these care plans will be more reflective of the positive actions being carried out on the units in respect to restraint and/or the use of enablers	

The person in charge is failing to comply with a regulatory requirement in the following respect: The inspector noted that reviews were not used to appropriately evaluate the care plan. The inspector saw that information in care plans was not written in a person centred manner; consequently this did not take account of individual residents' choices and preferences in all aspects of their care.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances as and no less frequent than at three-monthly intervals.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As per outcome 11 (Health and social care needs) A new care plan system has been devised which will include a pre care plan assessment which will guide nurses in creating more appropriate, specific and person centred care plans. A pre Care plan assessment will highlight specific problems which will prompt the Nurse to create a specific care plan in a more holistic way. This will also create a more person centred approach to the care and reflect the actual care which is being delivered on a day to day basis.	17 April 2013

Care plans will be reviewed at least 3 monthly. Pre care-plan assessments will be renewed on a 3 monthly basis, Care plans will be renewed on a 6 monthly basis and/ or as needed and will be discussed with the resident where appropriate and their families.	

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect:

Ryall unit continues to contain eight bedded multi occupancy rooms. There are no separate dining, visitors or recreation room apart from the sitting room on this unit. There are four resident's toilets and three shower/bathrooms. The physical environment continues to pose challenges to meet residents' needs according to the Authority's Standards.

Action required:

Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Action required:

Provide adequate private and communal accommodation for residents.

Action required:

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Action required:

Provide adequate sitting, recreational and dining space separate to the residents' private accommodation.

Action required:

Provide suitable facilities for residents to meet visitors in communal accommodation and a suitable private area which is separate from the residents' own private rooms.

Action required: Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As HIQA is aware a major investment was undertaken over the past 3 years where we increase beds in the Alzheimer Care Centre from 90 to 154 all to the latest HIQA standards. This included all requirements HIQA had requested in relation to the Grattan unit and the laundry. In relation to the Ryall unit a considerable investment is required to address the issue above and we are currently in discussions with our bank.	

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: The outcome of the complaints was not clearly documented in all records and whether there had been communication with the complainant and an indication of their satisfaction with the outcome of the complaint.
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Action required: Inform complainants promptly of the outcome of their complaints and details of the appeals process.
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The new complaints form which is now available throughout Highfield Healthcare contains the addition of the following – Investigations made and outcome, a review of Learning and the conclusion of the complaint. The person in charge will follow up on initial complaints made within a two week timeframe and thereafter will again follow up after 3 months to conclude the complaint. The person who has made the complaint will be contacted directly by the person in charge on these occasions (and more often if deemed necessary) and the outcome (whether satisfactory or not) will be documented. This should ensure optimum communication between the complainant and the person in charge and improve practice. The complaints policy and procedure will be reflective of the above.	17 March 2013

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: On many occasions the staff rota included the first name only of the staff member.
Action required: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: It has been communicated to all staff by the person in charge that the full names of all regular staff and Agency staff must be included on the roster and must be reflective of the staffing on	01 February 2013

each shift. The recruitment agency provides us with a list of full names of the agency staff which is available on each unit in an effort to reduce the risk of incorrect spelling of Agency staff names. We acknowledge the importance of having the full names of all the persons whom work in Highfield to avoid any misinterpretation at any time.	

The person in charge is failing to comply with a regulatory requirement in the following respect: The inspectors formed the view that improvements were required in relation to the organisation, allocation and supervision of staff to ensure the safety of residents. The inspectors discussed with staff the daily routine and were informed by staff that care assistants were not supervised in the delivery of personal care to residents in the morning as the staff nurse remained in the dining room serving breakfast. A comprehensive emergency plan had been developed, however staff were unaware of the full contents of this.	
Action required: Supervise all staff members on an appropriate basis pertinent to their role.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff nurses have been advised to supervise the delivery of personal care to our residents. This will be reflected in the daily allocation book on each unit. The Clinical Nurse Manager 2 will oversee all practices. The emergency plan is clearly visible on each unit at the nurses' station. The up to date emergency plan is accessible to all staff in the policy and procedure manual which staff must read and sign to say they understand its contents.	17 February 2013

Any comments the provider may wish to make:

Provider's response:

There has been a couple of actions required from the previous inspection and the centre has been committed into addressing these actions.

The Alzheimer Care Centre is committed to maintaining and improving the quality service we provide to ensure the optimal care for our residents.

Provider's name: Stephen Eustace
Date: 21 January 2013