Health Information and Quality Authority
Regulation Directorate

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

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:	Dulce Tagacanao
Date of inspection:	6 and 7 August 2013
Time inspection took place:	**Day-1 Start:** 11:30 hrs **Completion:** 18:45 hrs **Day-2 Start:** 08:55 hrs **Completion:** 15:55 hrs
Lead inspector:	Mary McCann
Support inspector(s):	Sonia McCague, Sheila McKevitt
Type of inspection	☒ **announced** ☐ **unannounced**
Number of residents on the date of inspection:	147
Number of vacancies on the date of inspection:	7

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 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*.

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	Inspected
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 carried out as part of the Health Information and Quality Authority's (the Authority's) regulatory monitoring function to review progress made on the actions identified in the action plan which was issued to the provider following the monitoring inspection on 28 and 29 November 2012. The purpose of this inspection is also to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2009 (as amended), and to carry out an interview with the new Person in Charge. It was announced. This was the sixth inspection of this centre. The reports of all previous inspections of this centre can be accessed at www.hiqa.ie.

The inspectors reviewed the 15 actions from November 2012 inspection and found that six actions were complete, six were partially complete but required some further work and three were not completed. The non-complete actions related to the premises and use of restraint measures and review of policies and procedures to ensure they were sufficient to guide and inform staff.

The inspectors met with residents relatives and staff members during the inspection. The inspectors observed practices and reviewed documentation such as care plans, medical records, audit file, staff training records, policies and procedures and staff files. Residents spoken with by the inspector were complimentary of the service provided and stated "food was good "and "staff look after us well".

It was found that although progress was made by the provider, person in charge and the entire staff team in implementing the required improvements identified in previous inspections recurrent issues identified on previous inspections continue for example care planning, restraint, ensuring a high standard of evidence-based nursing practice is delivered to residents and risk management procedures.

Inspectors found that there was poor communication between staff and there were deficits with regard to clinical governance in the centre.

At the feedback meeting the inspectors requested that documentation with regard to wound care be reviewed and any modifiable wounds be notified to the Authority as per Regulation 36, that confirmation of review by a dietician of a resident is submitted and confirmation with regard to the emergency lighting be forwarded to the Authority. At the time of writing this report notifications with regard to two pressure wounds have been submitted.

Areas where review is required post this inspection include:

- Training for staff in evidenced-based practice in all areas of clinical care with regard to the management of older persons for example, nutritional management, wound care, restraint management is required.
- While auditing practices had been commenced and data had been collected a review of the quality of care and the quality of life of residents had not occurred, a report had not been prepared as per Regulation 35. There was also no evidence of discussion with residents and relatives.
- Development of quality improvement plans.
- Competency assessments and supervision of staff to ensure competent to provide safe quality care with regard to provision of care and knowledge re responding to allegations of elder abuse and to ensure practice complies with contemporary evidence-based practice.
- The physical environment of one unit does not comply with the Authority's Standards.
- Policies require review to ensure they guide and inform staff in the procedures to be adapted for example the risk management nutritional care policy, elder abuse policy.
- Ensure access to allied health care services to include occupational therapy, physiotherapy, speech and language therapy and dietetic services are available to all residents in a timely fashion to ensure their assessed needs are met.
- Submission of all notifiable incidents to ensure compliance with Regulation 36.

- Ensure unintentional weight loss is managed in line with contemporary evidence-based practice.
- Ensure all emergency lighting is functioning.

The Action Plan at the end of the report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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: Leadership, Governance 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:

Compile a statement of purpose that describes the facilities and services which are provided for residents.

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

Make a copy of the statement of purpose available to the Chief Inspector.

Keep the statement of purpose under review.

Inspection findings

The actions required from the previous inspection were partially completed.

The statement of purpose had been updated to include all units operational in the centre. An updated Statement of purpose was submitted to the Authority on 17 December 2012. The most recent statement of purpose dated July 2013 was made available to the inspectors on inspection. On review of this a number of issues was

identified that required review to ensure that the statement of Purpose consists of all matters listed in Schedule 1 of the Regulations.

For example, the following areas require review (this is only a sample):
- details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision
- the fire precautions and associated emergency procedures and evacuation procedures
- the arrangements made for dealing with complaints required updating and clarification
- day care services are not provided, this should be documented.

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

Action required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The centre appointed the director of nursing as the person in charge on 18 May 2013. She works full-time and is the director of nursing for this centre and the company's sister centre. She informed the inspectors that she generally worked from 9am to 5pm, Monday to Friday and spent approximately one hour per day in the sister centre. She also deputises for the person in charge in her absence in the sister unit as this unit does not have a clinical nurse manager post in place.

She qualified as a registered general nurse in 1995 and was admitted to An Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland) in 2002. She has worked in elderly care on a continuous basis since 2006.
She completed a graduate diploma in first line management in 2009 and certificate in Gerontology in 2010. She confirmed that the provider was supportive and that she met frequently with the director of operations.

Deputising arrangements for the person in charge were in place. A clinical nurse manager deputised in her absence. She confirmed that her mandatory training and her registration with An Bord Altranais agus Cnáimhseachais Na hÉireann was up to date.

The inspectors informed the management team at the feedback meeting that there were poor clinical governance systems in place in the centre. Furthermore, communication between staff required improvement to ensure that all staff in charge of units and the person in charge had an up-to-date clinical picture of the residents to ensure that suitable and sufficient care, to maintain the resident's welfare and

wellbeing, is protected and a high standard of evidenced-based practice is provided for residents.

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 * ☒

Inspectors found that improvements were required in this area. These are detailed throughout the report including amendments to care plans and assessments.

General Records (Schedule 4)

Substantial compliance ☐ Improvements required * ☒

Only partially inspected and required improvements are detailed throughout the report.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

All policies listed in Schedule 5 of the Regulations were available but many required review to ensure they provided clear guidance to staff of the procedures to follow to ensure the delivery of safe quality care to residents. The risk management policy was in draft format and required review in order to comply with the Regulations. This is discussed under Outcome 7. The complaints policy required review to ensure it complied with Regulation 39.

Adult Protection Policy
The adult protection policy required review to ensure it provided sufficient information to guide and inform staff should a resident make an allegation of abuse. The procedure on how to manage an allegation of abuse against a senior member of the management team was not detailed and the policy failed to contain the contact details of the Health Service Executive (HSE) Adult Protection Officer.

Nutritional Care Policy
Monitoring and documentation of nutritional intake was not detailed sufficiently to ensure adequate arrangements were in place to provide a high standard of evidence-based practice.

Behaviour Management
This policy required review to guide staff in the assessment and management of behaviour that challenges. For example, it did not include the requirement to develop reactive strategies to ensure consistent management of behaviour that challenges.

Medical Records

Substantial compliance ☒ Improvements required * ☐

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

At the time of the last inspection the Directory of Residents was found not be up to date and 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* (November 2002).

A Directory of residents was available for each unit. This was found to be 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 these substances are prohibited.

Staffing Records

Substantial compliance ☐ Improvements required * ☒

Staff files did not contain all the documents specified in Schedule 2 of the Regulations. While files reviewed contained three references, evidence was not available that references were verified even when there were three references on plain paper. 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 also not available. Documentary evidence of attendance and certification of courses attended by staff were not available.

The inspectors requested to review two files of agency staff that were scheduled to work on the roster reviewed. The clinical nurse manager had informed the inspector that these staff had worked on the unit on many occasions. There was no documentation available for these staff but the person in charge contacted the Human Resources department who obtained documentation by way of fax for the inspector to review.

The documentation available did not include any evidence that any induction had been given to these staff, no evidence was available with regard to mental and physical fitness, no references were available on one of the files, one file had no evidence of elder abuse training and neither file had any evidence with regard to fire training. The inspector was concerned with regard to this information as these two carers were on the roster on one unit to work with a staff nurse on night duty. The person in charge stated that they have a contract with the agency that covers all information with regard to compliance with the regulations but information is not verified prior to agency staff commencing employment at the centre.

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

Action required from previous inspection:

Put in place all reasonable measures to protect each resident from all forms of abuse.

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.

Inspection findings

The action required from the previous inspection was satisfactorily implemented.

At the time of the last inspection, not all staff had up-to-date training in recognition, investigation, reporting and management of elder abuse. As training was open to all staff of the provider group the documents available contained lots of names of staff from other units. There was no specific documentary evidence of attendance and certification of courses attended by staff of this centre therefore it was difficult to obtain sufficient evidence that all staff had received training. However, the person in charge confirmed that all staff had up-to-date training in recognising and responding to elder abuse.

The policy for protection of vulnerable adults was available. However, it was not sufficiently detailed to guide and inform staff should a resident make an allegation of abuse, this is detailed under Outcome 4. Not all staff spoken with displayed sufficient knowledge of the different forms of elder abuse and while most stated they would report an allegation of elder abuse, inspectors were concerned with regard to the competency of staff in this area. The current training in adult protection is included in a one day training course where six courses are delivered to include fire safety, moving and handling, adult protection, health and safety, infection control and food hygiene on the same date. The person in charge confirmed that competency assessments were not carried out on staff in any of these areas post training. Inspectors were not satisfied that this practice was in accordance with best practice requirements and was sufficient to protect residents.

There was a receptionist on duty at all times and visitors' log in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents.

Systems in place for safeguarding residents' money were not inspected on this occasion.

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

Action(s) required from previous inspection:

1. Put in place written operational policies and procedures relating to the health and safety.

2. Provide training for staff in the moving and handling of residents.

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

4. Provide suitable training for staff in fire prevention.

5. 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.

Inspection findings

The actions required from the previous inspection were reviewed by the inspectors. Actions 1, 2, and 4 were completed. Actions 3 and 5 were partially completed.

There were some systems in place to promote health and safety practices. Accident and incident forms were well completed and neurological observations were completed post falls. Window restrictors were in place. A quality and risk management meeting was held monthly.

There was a risk register available which identified a range of risks. However, the inspector noted that some of the risks identified as control measures. For example, 'hip protectors', 'specialist mattress' were only available where the resident and/or their representative purchased these on the advice of the centre staff.

A smoking policy had been developed and risk assessments were in place for residents who smoked. On one unit the inspector noted that the risk assessment documented that residents should be observed closely. However, this was difficult without staying in the smoking room as there was no other way of observing residents. Residents who smoke also have a safety care plan in place with regard to smoking.

The centre used bedrails that were independently attached to some of the beds. An audit of safe positioning of these bedrails to ensure safe dimensional limit requirements to protect the safety and welfare of residents had not been completed. This was requested as an action post the last inspection. This had not been completed.

The health and safety statement was dated March 2012 and was comprehensive. This requires review yearly. The risk management policy which was currently under review. This was reviewed by one of the inspectors who informed the person in charge that it must comply with Regulation 31.

Manual Handling

There was no specific documentary evidence of attendance and certification of courses attended by staff of this centre therefore it was difficult to obtain sufficient evidence that all staff had received training. However, the Director of Mental Health Services who was the previous training officer met with one of the inspectors and informed her that all staff had up-to-date mandatory training, which included moving and handling training.

Fire Safety
Staff informed the inspectors that 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 carried out at regular intervals, but there was poor documentation available of this.

The person in charge and staff spoken with confirmed that they had never completed a mock evacuation from the centre, to reinforce the theoretical training provided to ensure they were confident of the procedure, to be followed in the case of a fire, including how all residents would be evacuated from the building if necessary. The director of operations said they planned to do this. Each resident had been risk assessed to indicate the equipment required to evacuate them in the event of fire or other emergency situation. Staff were aware of the fire assembly point.

Twice daily checks of fire exits were completed and a record kept. The person in charge confirmed that fire safety and evacuation training for all staff was up to date. This was one of the courses included in the day training course for staff.

A review of fire records showed that all fire safety equipment, including the fire alarm had been serviced at appropriate intervals. Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building however one of the inspectors noted that there were deficits with this. The maintenance person informed one of the inspectors that a meeting had occurred on day two of the inspection and these issues would be resolved as a matter of priority and he assured the inspector that he would forward confirmation of this to the authority. This has not been received to date.

An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors and noted these were serviced quarterly. Fire extinguishers were serviced annually.

Emergency Plan
An inspector reviewed the emergency plan with the person in charge. This requires review to ensure it covers all potential emergencies that may occur in the centre and to ensure that a place of safety is identified should the centre have to evacuate all residents. The person in charge informed the inspectors that a copy of the emergency plan is available on each unit and staff must read and sign that they have read the plan. However, inspectors found some staff were not aware of the contents of the emergency plan and did not know if a place of safety was identified and if it was where it was located - some staff described different locations.

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

Action required from previous inspection:

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.

Inspection findings

The action required from the previous inspection was partially implemented.

A comprehensive medication management policy with procedures for prescribing, administering, recording and storing of medication was available. The maximum amount for PRN (as required) medication to be administered within a 24 hr period was specified on the prescription sheets. Dates and signature for discontinuation of medication were not consistently recorded.

Maximum doses of as required (PRN) were recorded on all occasions. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error.

A dedicated fridge was used to maintain a cold chain and ensure those medications which required cold storage was stored appropriately, the temperature of the fridge was monitored daily.

Inspectors observed part of medication rounds on different units and found that medication was not administered in accordance with an Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland) guidelines.

In the sample of resident prescriptions reviewed inspectors found the following required review:

- The dose prescribed was different to the dose to be administered which may increase the risk of errors. The dose documented was the dose of the table dispensed. For example, 10 mgs was recorded on the medication administration chart but a quarter of a tablet 2.5 mgs was administered to the resident. Where medication was withheld, the reason was not documented.

- An inspector noted on one unit that where medication was administered on an as required basis in addition to the regular medication for behaviour that challenges, the time of administration was not recorded.

- Crushing of medication was prescribed generically. There was no evidence available that dissolvable or liquid preparations were available to decrease the need for crushing of medication.This was found to be the case at the last inspection.In one instance medication was being crushed which the pharmacist had deemed was not suitable for crushing on the 20 June 2013. This was documented in the medication audit but had not been enacted.

- A medication management audit has been undertaken but this had not identified some of the omissions noted above.

There was good evidence in the medication records to support that medication was being reviewed at three monthly intervals.

Medication was stored safely and controlled drugs stock levels were recorded at the end of each shift and recorded in a register in keeping with legislative requirements.

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 required from previous inspection:

No action was required from the previous inspection.

Inspection findings

Practice in relation to notifications of incidents required review. Inspectors reviewed a record of all incidents/accidents that had occurred in the centre since the previous inspection and cross referenced these with the notifications received by the Authority The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. The inspectors noted that there was two grade two pressure wounds reported on the tissue viability audit. However, neither of these had been reported to the Authority. These have since been reported.
The centre has reported a substantial amount of notifications with regard to allegations of abuse between residents. Most of these allegations are as a result of behaviour that challanges.The inspectors spoke with the person in charge with regard to these and she agreed that she will discuss this practice with the management team to ensure that it reflects a true and accurate picture of the situations.

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 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

A system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre had been established. While data was collected there was no further analysis of this information to ensure a continuous quality improvement system was in place.

It was not clear to the inspector how the information collected was been used to improve the service for residents. Further work is required to review the statistical data collected and use it to identify possible trends and areas for improvement and ensure that the review results in improvements in the quality and safety of the service for residents.

Although forums were established for residents/relatives the inspector did not see any evidence that information collected as a result of audits or reviews was conveyed to residents.
A report on reviews conducted for the purpose of Regulation 35 was not available.

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:

1. Provide a high standard of evidence-based nursing practice.

2. Set out each resident's needs in an individual care plan developed and agreed with the resident.

3. 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.

Inspection findings

The actions required from the previous inspection were partially implemented. Action two was completed and action three was completed in some instances. Action two was not completed.

Assessment and Care Planning
Inspectors reviewed 18 care files in detail and aspects of other care files were reviewed. While all residents had care plans, improvements were required. Assessments were carried out on each resident. For example, a falls risk assessment to risk rate propensity to falling was in place. There was poor evidence that where care plans were commenced or reviewed that the resident and/or their relative/s had been consulted. Some care plans were written in narrative format and it was difficult to elicit the specific care that was required to meet the identified need of each resident.

Inspectors noted that the assessments did not consistently inform the care plans and where a reassessment was undertaken the care plan was not reviewed. Care plans were not linked together to give a global view of the residents care.

While care plan audits had been carried out these did not identify deficits with regard to the care planning process. The inspectors noted that reviews were not used to appropriately evaluate the care plan. Where reviews were completed and these detailed changes that had occurred the care plan was not updated to reflect these changes. The inspectors spoke with nursing staff regarding care plans and formed the view that training in care planning for nurses was required.

Pain Assessment and Monitoring
Assessment of the requirement for pain relief was taking place and there was a process in place for monitoring of the effectiveness of the analgesia administered.

Wound Management
Wound prevention and management required improvement. At the commencement of the inspection the inspectors were informed that there were no new wounds in the centre. The centre had notified a grade three pressure wound some time ago and this had remained a grade three. Later on during the inspection the inspectors noted

from the tissue viability audit that there were two residents with what was described as grade two pressure ulcers. Some staff seemed not to be aware of contemporary evidence-based practice with regard to wound care and did not display an adequate knowledge of wound grading according to best practice guidelines. The wound care policy was not comprehensive and failed to guide and inform staff re best practice in wound care. The person in charge confirmed that no unit staff had completed a substantial wound care course. Neither of these residents had been seen by a tissue viability specialist. Photographic evidence or any system of monitoring to ensure that there was a base line obtained for comparative purposes to monitor whether the wound was progressing or regressing was not available. A care plan was not in place with regard to the wound. While specialist pressure relieving mattress was available staff informed the inspectors that these attributed an additional cost and were not included in the contract fee.

Access to Other Health Professionals
There was good evidence of access to general practitioner (GP) services. Residents had access to the services of a physiotherapist. Dietician services were available and there was documentary evidence of reviews by the dietician. There was access to the local palliative care team. Most allied health professional services were available on a private basis.

Restraint
A policy was available on restraint. Some staff informed the inspector that they had not received training on restraint. Care plans in relation to restraint were not reflective of best practice. For example, one resident had been assessed as a low risk of falls but had a restraint measure in place to protect her from falling out of bed. Care plans were not in place to explain whether the measure in place was an enabler or a restraint and if so why. There was poor evidence of alternatives or less restrictive options being tried prior to the use of restraint. This was also a finding at the last inspection. The centre was using monitoring bracelets but there was no evidence available of consent from the resident with regard to their use. There was also no information available as to whether these were deemed a restraint measure or an enabler.

Behaviours that Challenge
There was a policy on the management of behaviours that challenge. However, this required review as detailed in Outcome 4. Many staff told inspectors that had not received training in challenging behaviour. Inspectors were informed that there were no residents with challenging behaviour at the time of inspection. However, the centre had submitted a high level of notifications with regard to behaviour that challenges to date. The person in charge confirmed that they had good input from psychiatric specialist services.

Social Care
There was good availability of activity therapists. An activity programme was in place on each unit. However, these were not linked to individual social care assessments as a social care assessment was not completed for each resident.

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:

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.

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.

Provide adequate private and communal accommodation for residents.

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

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

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.

Inspection findings

The actions required from the previous inspection were not completed. However, the provider informed the inspectors that he had a plan which he was ready to submit to the Authority with regard to refurbishment of this unit to ensure compliance with the Authority's Standards.

Ryall unit contains 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.

There was no call bell in the smoking room in Addison unit.

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

Action(s) required from previous inspection:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented. The outcome of the complaints was documented in records reviewed. A new template for recording complaints has been developed.This details investigations made and outcome, a review of learning and the conclusion of the complaint.
The procedure now includes that the person in charge will follow up on initial complaints made within a two week timeframe and again at three months to conclude the complaint. The complainant will be contacted directly by the person in charge on these occasions and the outcome documented. The complaints policy requires review to reflect this and the development of the new template form. This is included under Outcome 4.

Outcome 15
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors found that nutritional care was better managed on some units than others. However, the nutritional care policy as documented under Outcome 4 requires review. The nutritional monitoring and management of residents requires review to ensure that all residents assessed nutritional needs are met.

Staff confirmed that they were not concerned with the loss of weight of any resident. Inspectors found that all residents were weighed monthly. However, there was not a robust system in place to ensure that if a resident was losing weight unintentionally that this would be actioned appropriately.

Inspectors found that a resident whose weight monitoring clearly showed substantial loss of weight but the staff failed to review the care of the resident and ensure appropriate procedures were put in place. For example review by a dietician, accurate food and fluid recording thereby minimising the risk of continued unintentional weight loss. Staff informed the inspector that this resident was referred to the dietician on the second day of inspection. Inspectors requested at the feedback meeting that the centre confirm to the Authority when this residents is seen by the dietician.

Nutritional care plans were not updated in response to the changing needs of residents. There was feeding guidelines available to guide and inform the staff with regard to safe feeding of residents. Where fluid balance charts were in place these were totalled over a 24 hour period.

All residents spoken with expressed satisfaction with their meals. Residents who required assistance were sensitively aided by staff. The inspector saw residents being offered a variety of drinks throughout the day. The inspectors observed part of the tea time meal and found that the occasion was pleasant and that residents had a choice of meals.

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:

Supervise all staff members on an appropriate basis pertinent to their role.

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented. The person in charge informed the inspectors that all staff nurses have been advised to supervise the delivery of personal care to residents. A daily allocation book was available on each unit and it is the responsibility of the clinical nurse manager grade II is to oversee all practices and any deficits to be discussed at staff meetings. Inspectors noted that care staff were supervised by the nursing staff.

Inspectors noted on viewing the rosters that they contained the full names of all regular staff and agency staff.

The inspectors formed the view that improvements were required in relation to communication between unit staff and management staff to ensure that the clinical nurse managers and the nursing staff had a complete clinical picture of the residents changing needs. On discussing clinical issues with staff there was contradictory evidence available with regard to the clinical issues relating to residents. As discussed throughout the report some staff did not appear confident with regard to the procedure they would adapt should a resident make an allegation of elder abuse, what arrangements for in place with regard to evacuation to a place of safety and staff informed the inspectors that their manual handling training did not involve a practical aspect. Additionally, documentation on residents' files was not reflective of contemporary evidenced-based practice.

The total staffing complement, in whole time equivalents had reduced, the post of Director of Nursing and person in charge were two full-time posts at the time of the last inspection. There were four clinical nurse manager's grade one at the time of the last inspection – this has decreased to 3.5 on this inspection.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, Director of Operations and the two clinical nurse managers 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

15 August 2013

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's Care Centre
Centre ID:	113
Date of inspection:	6 and 7 August 2013
Date of response:	04/09/2013 and 08/10/2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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 most recent statement of purpose dated July 2013 was made available to the inspectors on inspection. On review of this a number of issues was identified that required review to ensure that the statement of Purpose consists of all matters listed in Schedule 1 of the Regulations.
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.
Action required: Make a copy of the statement of purpose available to the Chief Inspector.

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

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: A reviewed copy of the Statement of Purpose and Resident's guide has been sent to the Chief Inspector ensuring all matters in Schedule 1 of the Regulation is listed.	02/09/2013

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: All staff working in the centre did not have information available as required by the Regulations.	
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: Staff whose medicals do not specify that they are mentally and physically fit to work will be written to requesting this information from their Doctor.	31/03/2013

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. However these require review to ensure that they provided guidance to staff.	
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: A copy of the following updated policies has been sent to the Chief Inspector. Protection of Vulnerable Adults, Nutritional Care Policy,Behaviour Management, Abuse of Older People, Risk Management and Responding to Complaints. All these policies have been reviewed to provide clear guidance to staff of the procedures to follow to ensure the delivery of safe quality care to residents.	04/09/2013

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 spoken with displayed sufficient knowledge of the different forms of elder abuse and while most stated they would report an allegations of elder abuse, inspectors were concerned with regard to the competency of staff in this area. The person in charge confirmed that competency assessments were not carried out on staff in this area.
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: Training had been given to all staff on elder abuse however emphasis will be put on removing the vulnerable adult from the person. Further training will be held on Elder Abuse and is due on September 03 to highlight the different scenarios and give opportunity to the staff to impart learning through feedback discussion after the training. A flow chart which has been distributed to all the units has been developed to guide staff in the detection and reporting of Abuse and will be covered in the training on the 3rd of September which includes the name and details of the adult protection officer in the area.	03/09/2013

Outcome 7: Health and safety and risk management

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

The health and safety statement was out of date.

The risk management policy which was in draft was currently under review.

While inspectors were informed that all staff had up-to-date moving and handling training staff confirmed that there was no practical aspect to this training.

Action required:

Put in place written operational policies and procedures relating to the health and safety.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.	
Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.	
Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving 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: A Risk Management Policy, Reporting Accidents and Incidents, has been sent to the Chief Inspector to cover identification, recording, investigation of any serious or untoward incidents involving residents. The Health and Safety Document is currently under review and the Inspectors were shown the document on the day of the Inspection.	04/09/2013 ongoing

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: There was poor documentation available with regards to the carrying out fire drills. The person in charge and staff spoken with confirmed that they had never completed a mock evacuation from the centre, to reinforce the theoretical training provided to ensure they were confident of the procedure, to be followed in the case of a fire, including how all residents would be evacuated from the building if necessary. Emergency lighting was provided throughout the building however one of the inspectors noted that there were deficits with this.

Emergency Plan
Inspectors found some staff were not aware of the contents of the emergency plan and did not know if a place of safety was identified and if it was where it was located, some staff described different locations.

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:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

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: We have clear flow charts circulated in all areas on how to respond to a fire. All staff are trained by way of theory and practice. Drills will continue until all staff have completed the drill and are confident in carrying out the drill. Residents will be included in drills where possible. Emphasis at fire training is on horizontal evacuation and getting residents to safety as opposed to the use of the equipment which we feel conforms with standard 26 as there is arangements for detecting containing and extinguishing fires and fire fighting equipment is maintained. The fire officer lives on the grounds and would be the person responsible for use of this equipment while clinical staff progress with horizontal evacuation. Standard 26.17 specifies staff must undertake fire training and evacuation annually. Our Maintenance Manager is our Chief Fire Warden, he lives on the grounds and is available 24hrs in case of Major Incident. He also provides emergency maintenance cover, after hours, every second week. He successfully passed a three day Fire Awareness Instructors course with A.I.D Training and Operations Ltd. in	 03/09/2013 Ongoing

London. The course qualifies him to train in the following subjects: • Causes of workplace fires • The fire triangle • Action in the event of fire • Fire fighting • Fire extinguishers • Practical fire extinguishing • The fire action plan • The role and duties of the Fire Marshall • An overview of fire warning systems. The Chief Fire Warden is a member of our Fire safety Committee and liases closely with our Fire Consultant, Theo Devanney of Fire Element Engineers. Theo is a chartered engineer with Engineer Ireland, specialising in fire safety engineering. He has 17 years fire safety Experience.	

Outcome 7: Health and safety and risk management

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

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:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

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: The monthly bedrail audit has now been reviewed and updated to include the safe positioning of the bedrails and ensure the safety and protection of the residents.	02/09/2013 ongoing

Outcome 8: Medication management

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

The dose prescribed was different to the dose to be administered which may increase the risk of errors. The dose documented was the dose of the table dispensed, for example, 10 mgs was recorded on the medication administration chart but a quarter of a tablet 2.5 mgs was administered to the resident.

Where medication was withheld, the reason was not documented.

Where medication was administered on an as required basis the time of administration was not recorded.

Crushing of medication was prescribed generically.

There was no evidence available that dissolvable or liquid preparations were available to decrease the need for crushing of medication.

In one instance medication was being crushed which the pharmacist had deemed was not suitable for crushing on the 20 June 2013.

A medication management audit has been undertaken but this had not identified some of the omissions noted above.

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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.

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Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

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

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Provider's response:

There is a clear written operational policy on ordering, prescribing, storing, and administration of medicines to residents. The procedures have been highlighted at the last Staff Nurses meeting held on the 13th August and will again be discussed on the 2nd September Nurses Meeting to ensure clear guidance and understanding of the procedure. All Nurses complete Compentency assessments on administering and the control of medications within the work place.

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02/09/2013 and ongoing

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Outcome 9: Notification of incidents

The person in charge is failing to comply with a regulatory requirement in the following respect: The centre has reported a substantial amount of notifications with regard to allegations of abuse between residents. Most of these allegations are as a result of behaviour that challanges.The inspectors spoke with the person in charge with regard to these who agreed that she will discuss this practice with the management team to ensure that it reflects a true and accurate picture of the situations.	
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The practise has been to make notification to HIQA when there is altercation between residents, however following this inspection it will not be made if the incident has been deemed to be that of behaviour that challenges. A discussion with the Management Team has clarified the practice with regards to notification of abuse amongst residents. The team will ensure that there is a clear identification of abuse amongst residents or whether these are result of behaviour that is challenged. An accurate description is necessary to establish what needs to be sent in for Notification to the Authority. PIC will ensure that notice is given to the Chief Inspector for Any allegation, suspected or confirmed abuse of any resident following thorough investigation of any incident to establish and identify abuse or a behaviour that is challenged.	02/09/2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect: It was not clear to the inspector how the information collected was been used to improve the service for residents. Further work is required to review the statistical data collected and use it to identify possible trends and areas for improvement and ensure that the review results in improvements in the quality and safety of the service for residents. Although forums were established for residents/relatives the inspector did not see any evidence that information collected as a result of audits or reviews was conveyed to residents. A report on reviews conducted for the purpose of Regulation 35 - Quality and Safety of Care and Quality of Life was not available.	
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.	
Action required: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.	
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.	
Action required: Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.	
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: A recent satisfaction survey has been sent to all residents/families and responses are in the process of being returned. Resident meetings are held regularly and the Residents Advocate is available at any time to talk to a resident. Appropriate action will be taken in response to any concerns with regards to resident's care through a robust Care Plan Audit. A new handover form will commence to help in the identification of immediate concerns. Monthly Audit reports will be discussed in the Risk Management Committee.	30/10/2014

Outcome 11: Health and social care needs

The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

There was poor evidence that where care plans were commenced or reviewed that the resident and/or their relative/s had been consulted.

Some care plans were written in narrative format and it was difficult to elicit the specific care that was required to meet the identified need of each resident.

Inspectors noted that the assessments did not consistently inform the care plans and where a reassessment was undertaken the care plan was not reviewed. Care plans were not linked together to give a global view of the residents care.

While care plan audits had been carried out these did not identify deficits with regard to the care planning process.

The inspectors noted that reviews were not used to appropriately evaluate the care plan. Where reviews were completed and these detailed changes that had occurred the care plan was not updated to reflect these changes.

The inspectors spoke with nursing staff regarding care plans and formed the view that training in care planning for nurses was required.

Social care
A social care assessment was not completed for each resident.

Action required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Action required:

Provide a high standard of evidence-based nursing practice.

Action required:

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

Make each resident's care plan available to each resident.

Action required:

Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.

Action required:

Revise each resident's care plan, after consultation with him/her.

Action required:

Notify each resident of any review of his/her care plan.

Action required:

Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A regular review of the care plan will be implemented to include the changing needs of the resident and identify any deficit. Further training on Care Planning will commence from the 9th of September. An action plan will be developed following care plan audits to reflect the improvement needs and will be highlighted to specific Nurses. Residents who have capacity are advised of care plan reviews however these are in the minority and families are contacted to be part of this process. All residents have access to activities with 5 activity therapists employed.	30/10/2013

Outcome 11: Health and social care needs

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

Some staff informed the inspector that they had not received training on restraint. Care plans in relation to restraint were not reflective of best practice.

There was poor evidence of alternatives of less restrictive options being tried prior to the use of restraint.

The centre was using monitoring bracelets but there was no evidence available of consent from the resident with regard to their use. There was also no information available as to whether these were deemed a restraint measure or an enabler.

Inspectors were informed that there were no residents with challenging behaviour at the time of inspection; however the centre had submitted a high level of notifications with regard to behaviour that challenges to date.

Wound Management
Wound prevention and management was not in line with contemporary evidenced-based practice.

Action required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

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. Further Training on Nutrition, Wound Management and Restraint will be organised this month to improve evidence based practice. The Resident Wandering System that has been in place will be documentated in their care plan to deem their use as an enabler rather than as a restraint.	02/09/2013 ongoing

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.

There was no call bell in the smoking room on Addison unit.

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: A call bell in the Addison Unit Smoking Room will be in place in the next 2 weeks. As advised at our previous inspection 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 issues above and we are still in discussions with our bank.	 20/09/2013 2014

Theme: Person-centred care and support

Outcome 15: Food and nutrition

The person in charge is failing to comply with a regulatory requirement in the following respect: There was not a robust system in place to ensure that if a resident was losing weight unintentionally that this would be actioned appropriately. Inspectors found that a resident whose weight monitoring clearly showed substantial loss of weight but the staff failed to review the care of the resident and ensure appropriate procedures were put in place for example review by a dietician, accurate food and fluid recording thereby minimising the risk of continued unintentional weight loss. Inspectors requested at the feedback meeting that the centre confirm to the Authority when this residents is seen by the dietician. Nutritional care plans were not updated in response to the changing needs of residents.	
Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policy on Nutrition has been updated to include a flow chart which has been displayed and explained to staff on the units as a guide on the proper procedure to follow to reflect the resident's changing needs. A Nutrition training will be held on the 3rd of September 2013.	02/09/2013

Theme: Workforce

Regulation 17: Training and Staff Development

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

Staff required education and training to enable them to provide care in accordance with contemporary evidence-based practice in relation to wound care, restraint practices, care planning, nutritional intake, emergency procedures and to ensure residents were provided with contemporary evidence-based care in respect of these areas and the person in charge needs to ensure that staff are competent post training.

Action required:

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.

Reference:

Health Act, 2007
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 6: Genaral welfare and Protection
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff have access to education and training. A 9 monthly staff appraisal is conducted to determine their need for further training. Clinical Nurse Managers and Night Nursing Officers supervise staff on a regular basis pertinent to their roles. Any deficit identified will be brought to the attention of the Person in Charge.	02/09/2013