Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Alzheimer Care Centre
Centre ID:	OSV-0000113
Centre address:	Swords Road, Whitehall, Dublin 9.
Telephone number:	01 837 4444
Email address:	seustace@highfieldhealthcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	J & M Eustace Partnership, T/A Highfield Healthcare
Provider Nominee:	
Lead inspector:	Nuala Rafferty
Support inspector(s):	Jim Kee, Shane Walsh
Type of inspection	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 residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 September 2015 09:30	09 September 2015 19:30
10 September 2015 05:30	10 September 2015 19:30

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

Outcome	Our Judgment
Outcome 01: Health and Social Care Needs	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliant
Outcome 05: Suitable Staffing	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 10: Suitable Person in Charge	Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered progress on some findings following the last inspection carried out on 5 February 2014 and to monitor progress on the actions required arising from that inspection.The inspection also considered information received by the Authority in the form of unsolicited receipt of information, notifications and other relevant information.
This was an unannounced inspection conducted by three inspectors over two days.

The provider had submitted a completed self assessment tool on dementia care to the Authority with relevant policies and procedures prior to the inspection. This information identified that the entire centre with the exception of one unit - Grattan Unit is a dementia specific service with 122 of the 154 bed places reserved for persons with a formal diagnosis of dementia. At the time of inspection, 117 residents who were residing in the centre during the inspection had a formal diagnosis of dementia.

The provider had assessed the compliance level of the centre but the findings of inspectors did not accord with the provider's judgements. Although some progress was made by the provider in implementing the required improvements identified on the registration inspection in February 2014, some of the findings at that time were again evident on this inspection.Risks associated with standards of clinical care and supervision of practice, nursing staffing levels and unsuitable aspects of the physical environment were found. Major non compliances were found under Outcomes 1 and 5 , moderate non compliance under Outcomes 2, 3 and 6. Outcome 4 was found to be compliant.

All of the findings were discussed at length throughout the inspection with the director of operations and quality, person in charge and clinical nurse managers. At the feedback meeting at the end of the inspection, these findings were also discussed with the provider nominee, consultant psychiatrist and a recently appointed quality and risk manager. Due to the number and nature of the findings and the level of major non compliances found, the provider was advised that immediate actions were required to mitigate the risks. A satisfactory written response detailing specific immediate actions to be taken was forwarded to the Authority following the inspection to mitigate risks identified and raise the standard of clinical care being delivered. Subsequently a detailed action plan response was received that indicated that many of the immediate measures had already been implemented and evidenced the providers committment to continuous improvement and future compliance.

The Action Plan at the end of this 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 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
A safe and suitable standard of care was not being delivered to all residents.
Access to medical and allied health professionals was available. The majority of residents had transferred to a local general practitioner (GP) clinic and visits by the doctors from the local clinics were regularly made on referral or on a needs required basis. Evidence of access to allied health professionals was also found with documented visits, assessments and recommendations by speech and language therapists; tissue viability nurse specialists and occupational therapist reviews. The inspectors met visiting doctors during the inspection. Private external dental, optical and podiatry services also routinely visited the centre to assess residents' needs and treat where necessary. In house consultant psychiatric services and access to community psychiatry of old age services were available and it was noted that many residents had been reviewed.

Samples of clinical documentation including nursing and medical records were reviewed these showed that all recent admissions to the centre were assessed prior to admission. The pre admission assessment was generally conducted by a liaison nurse who looked at both the health and social needs of the potential resident.

The arrangements to meet residents' assessed needs were set out in individual care plans and each resident had a care plan completed. A number of recognised assessment tools to check for risk of deterioration were used including; risk of falls, nutritional status, levels of cognitive impairment, skin integrity, pain, continence and communication. A number of care plans referred to family involvement in the care planning process, where family were consulted for decision making or to seek and give information relating to the resident.
A healthcare plan for every identified health or social care problem is required to be put in place by the nursing team to maintain residents' health and well being and monitor improvements or deterioration. However, it was found that care plans were not in place for all identified needs. Examples of healthcare needs, where care plans were not in place included chest pain; infections; weight loss and pressure ulcers. It was also noted that where plans were in place, they were not always implemented.

Inspectors found there were some negative impacts on residents' health and well being including;
- A sufficient number of nursing staff were not available on all units to supervise and ensure a safe standard of care delivery
- Weights and MUST scores (nutritional screening tool) food preferences, nutritional supplements, food fortification or recommendations by allied health professionals were not always referenced in care plans. Where they were included they were not always accurate and/or there was no evidence of them being implemented. Some residents were found to have lost significant amounts of weight over a six month period representing in some instances; 17%; 14.5%13% and 10% of body weight. Although few residents were assessed as being at risk of malnutrition based on their MUST scores at the time of inspection, consistent monitoring processes in line with the centre's policy on nutrition and management were not being implemented. These included food fortification where additional nutrients are added to food to increase calorie intake without increasing portion size and food diaries where staff record the food and/or fluid intake of residents at risk on a daily basis using agreed descriptions of portion sizes. In one instance a resident had been recently reviewed by the doctor but the recommendation for commencing a three day food diary had not been implemented.

Inspectors found that all residents were not being provided with their correct diet. Inspectors were told that the main diets consisted of soft/pureé/minced textures/normal and diabetic. Few other diets were identified with the exception of a celiac and some low fat. A good labelling system was in place to identify the diets for each resident on each unit. These labels were printed with the name of the residents for each unit and lunch/tea options indicated in tick boxes. The labels were then placed on the lids of the pre plated meals which are transferred in a hot Ban Marié to each unit. However, inspectors found that despite many residents being recommended for high calorie/ high protein diets to improve their nutrition, these were not included on their diet labels. Inspectors were told that updates to diet lists were sent to the catering department from the units as needed when diets changed. But there was no evidence of a structured review system on a regular basis to ensure residents were receiving their correct meals. In one instance, a resident with pressure ulcers and significant weight loss was being provided with a purée diet instead of the textured mince diet recommended by the speech and language therapist.

- Although there was an ample supply of nourishing varied and well presented food available in the centre, it was found that it was not always offered to residents. Inspectors observed breakfasts being served on some units, the majority of residents were given their breakfasts whist still in bed. Porridge was delivered to units in covered containers, these were then transferred onto trolleys with dispensing flasks of tea. Inspectors did not observe any resident being offered toast, bread, fruit or any other option as an alternative or accompaniment to the tea and porridge. Staff told the inspector that these would be given if residents asked, but as all residents had a diagnosis of dementia, there was no evidence that all would have the capacity to ask. It was also noted that the containers of porridge were not always covered in between serving each resident and as the trolleys were not heated, inspectors found that the porridge went cold prior to everyone receiving it. Temperature probes were not available on units to check the temperature of the food prior to or during service.

- Risks associated with poor management of nutrition includes pressure ulcer development amongst others. Care plans to maintain skin integrity and prevent, treat or otherwise manage pressure ulcer development were not detailed enough to guide healthcare staff. As a result, a good standard of basic care was not being provided to residents. Evidence of this was found where residents identified as at risk of pressure ulcer development and who required assistance to re-position their body on a regular basis were not always receiving this care. This care forms a key part in preventing development of pressure ulcers but was not found to be consistently delivered to residents across a number of units in the centre. Pressure distribution systems such as mattresses also forms part of prevention and treatment strategies and were available in the centre, however evidence of delays between the identification of a need for these mattresses and their provision was found. Reasons for this included the need for relatives to sanction their use, as charges for purchasing or renting applied to the use of these systems.
Treatments such as dressings were part of the treatment provided to those residents with ulcers which were classified as Grade 4 ulcers. This is the most serious level of ulcer and is very debilitating particularly for an older person. Care plans were in place for some residents who had developed pressure ulcers. In two cases, inspectors were told a resident had one grade 4 ulcer and had a lesser level of skin damage on another area. However, when inspectors checked the wound sites, it revealed that nursing staff were not correctly identifying the extent of damage to residents skin and were inaccurately grading some of these pressure ulcers. The inspectors viewed both unclassified areas of skin damage in the presence of either clinical nurse managers or the person in charge. One was found to be a grade 3 ulcer and the other was a grade 4 ulcer. Care plans or treatment regimes were not in place to manage or improve either of these wounds. Where care plans were in place, they were not effective or specific enough to manage and heal the ulcers. Frequency and type of dressings were not always referenced and it was found in both cases referenced earlier that dressings were not being consistently changed at regular periods to check the status of the wound or promote healing. In some instances, periods of between 5 and 11 days could pass without dressings been renewed. Although tissue viability nurse specialists were available and had reviewed the wounds, follow up reviews were not always sought particularly after hospitalisation or where wounds had deteriorated.

- Nurses' daily progress records did not provide enough detail on the overall status of residents. The notes did not always comment on the care delivered, signs of improvement or deterioration in physical emotional or psychological state. They did not indicate how the resident had spent their day. This meant that a general picture of each person's overall health and well being could be not be determined.

Medication Management
Residents were protected by the centre's policies and procedures for medication management but some improvements were required in relation to documentation and the use of PRN (as required) medicines within the centre. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of blister packed medication. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and

temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift.
Inspectors observed nursing staff administering medicines to residents during the evening administration rounds on one of the units. The nurse knew the residents well, and was familiar with the residents' individual medication requirements. Inspectors observed that the nurses took time to ensure each resident was comfortable before administering their prescribed medicines in a person centred manner. Nurses were observed to use alcohol hand gels appropriately throughout the process. Medication administration practices were found to adhere to current professional guidelines. However on another unit, an inspector observed that the medication administration round took nearly three hours to complete, as only one nurse was on duty at the time. This resulted in a risk of medicines being administered outside the prescribed time frame due to the length of time taken to complete medication administration rounds.

Medication management audits were conducted within the centre as part of the quality and risk management governance system in place. Medication reviews were also conducted by the prescribers' on a regular basis. The person in charge informed inspectors that there were plans to commence a review of the use of psychotropic medicines within the centre. Staff confirmed that pharmacists from the pharmacy who supplied medicines to the centre were facilitated to visit the centre and meet their obligations to residents as required by the Pharmaceutical Society of Ireland. There were posters on display within the centre advising residents of the next date the pharmacist would be available in the centre. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

The inspectors reviewed a number of the prescription and administration sheets and identified a number of issues that did not conform with appropriate medication management practices including:
- A number of residents required their medicines to be crushed prior to administration and this was documented on a separate page within the medication folder, and also at the top of the prescription sheet, however the prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
-The prescribed frequency of administration (for example once or twice daily) was not clearly indicated on the prescription sheet for all medicines and in some cases only the times of administration had been ticked
-The indication for use of PRN (as required) medicines was not consistently documented on prescription sheets and sufficient specific guidance for staff in the administration of these medicines was not available
-Where residents had been prescribed more than one psychotropic medicine on a PRN basis the prescription did not indicate when the medicines were to be used or which medicine was to administered first and there were no protocols in place to guide practice to ensure appropriate consistent administration
-The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet.

Judgment:
Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
There were procedures in place for the prevention, detection and response to abuse, and residents were provided with support that promoted a positive approach to the behaviours and psychological symptoms of dementia. However, inspectors found that the assessment and documentation relating to the use of lap belts/chair belts and bed rails within the centre required review. This is a recurrent finding from the last inspection.

Staff spoken to by the inspectors confirmed that they had received recent training on recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern. Inspectors spoke with a number of relatives during the inspection who were satisfied with the overall level of care being provided, and stated that any concerns they raised were addressed. The policy on the abuse of older people was in the process of being updated at the time of the inspection to reflect the national policy on safeguarding vulnerable persons at risk of abuse.

The inspectors reviewed the system in place to manage residents' money and found that it was sufficiently comprehensive to ensure transparency and security.

There were arrangements in place to review accidents and incidents within the centre, and residents who had fallen had falls risk assessments completed after the falls and care plans were updated.

There was a policy in place for behaviour that is challenging, and training on managing challenging behaviour had been provided to a number of staff, although the inspectors did note that not all staff had received this training particularly on units where there was the increased potential for such behaviours. Staff spoken to by the inspectors were knowledgeable regarding interventions that were effective in managing such behaviours including redirection and engaging with the residents. Residents had been regularly reviewed by their GP, and there was access to psychiatric services for further specialist input.

It was noted that there was a move towards changing the culture and promoting a restraint free environment. The use of bed rail restraint had reduced since the last

inspection and the use of alternative measures such as low low beds, mat and bed alarms had increased. There were risk assessments completed for residents who had bed rails in place, but of those reviewed, they did not consistently show that all considerations were explored and found to be unsuitable before a decision was taken to use bed rails. There were no comprehensive assessments in place for chair/lap belts that detailed the risk/benefit assessment conducted prior to their use or details of any alternative measures trialled or considered, or any necessary ongoing monitoring of this practice. The inspectors were informed that there were over 20 residents with chair/lap belts in use within one unit to maintain their safety while seated. Chair belts were included on the centre's enduring risk of harm forms which were signed by the next of kin, nurse in charge and consulting doctor. Inspectors also observed restraint practices by using tables on some units to prevent residents from leaving their chairs. These tables were positioned by staff to restrict movement when seated. Inspectors were told that some of these residents although they had limited mobility also had behaviours associated with restlessness such as wandering and were also at risk of falls.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Some evidence that residents with dementia were consulted with and actively participated in the organisation of the centre was found. Rights, privacy and dignity were respected with personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitor's in private. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the large open plan foyer which was bright and spacious with soft comfortable furnishings and a coffee dock which provides drinks and snacks.

Inspectors were told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling.
Inspectors observed that residents' choice was respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

Inspectors found that choice was not fully respected in that all residents were not given the choice of a bath or shower. Despite the availability of assisted sensory baths with

built in spa, it was found these were rarely used and on some units were never used. Inspectors observed that some of these bathrooms were instead used to store large boxes of incontinence wear or bed mattresses. It was also found that residents who were immobile were not offered baths or showers but were provided instead with a full body wash in bed every day. The rationale for not offering these residents a shower, despite the majority having access to an assisted shower ensuite was not clear.

The inspectors noted that staff were trying to deliver good care to their residents. Inspectors spent time observing interactions during the early morning, prior to, during and after lunch and in the afternoon. These observations took place in communal areas on all three units in the centre. Although several instances of person centred care were observed overall, it was found that care was primarily task oriented. Signs of restlessness, complaints of feeling cold and requests for tea were responded to by staff with reassurance. Some staff were observed to make eye contact use touch and gentle encouragement in low key moderate and supportive tone of voice.

All communal areas in the three units were supervised and apart from short periods at least one staff member was present to ensure resident safety. Where interactions between certain residents became unfriendly, staff acted promptly to intervene, distract and separate. The staff tried to create an atmosphere of relaxation by playing background music appropriate to the age and era of residents. Several of the residents were noted to enjoy the music singing along to Foster & Allen's' Molly Darling and The Mountains of Mourne'. Instances of warm and caring interactions between staff and residents were observed with some staff observed hugging residents and kissing their hands. Others were heard singing at the top of their voice with the resident whilst they were assisting them with personal care in their bedrooms. One resident had great fun choosing which top he wanted to wear with the staff member patiently putting on and taking off each one as they were rejected.

However, it was also observed that many staff did not engage residents in conversation except when task related. Staff were observed to pass through the sitting rooms without speaking to residents even where there were obvious attempts by residents to try and talk to the staff. Although staff seemed familiar with residents' basic physical care needs and some of their family background, efforts to chat to them about their family, previous interests or working life were not found. Opportunities to discover how they were feeling, how their mood was emotionally or psychologically were lost.
Overall observations of the quality of interactions between residents and staff in the communal area of each unit for a selected period of time indicated that the majority of interactions were of a neutral nature, in that for the majority of the residents in these communal areas, there were no interactions with staff and most residents were left staring into space, or asleep in their chairs with no stimulation for considerable periods of time.

During the lunch time period staff were observed to offer assistance in a respectful and dignified manner. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace by themselves with minimal assistance to improve and maintain their functional capacity. Although, there were also some instances observed when assistance

was not provided in a person centred manner and staff stood over residents when assisting with meals and drinks.

A team of activity coordinators were available and allocated to deliver a variety of activities in all units. A varied activities programme with 'fit for life', arts and crafts, pet therapy, aromatherapy and rummage boxes were available. The programme included dementia specific or orientated activities such as Sonas, massage, meditation or other sensory therapeutic sessions for those residents with advanced dementia and/or limited physical abilities. Reminiscence and Imagination Gym were therapies used to improve and maintain memory function. A cognitive stimulation group also took place weekly with an activities therapist and an occupational therapist. This group endeavoured to use a mix of practical hands-on skills and fun games which represented the interests of the participants to maintain and improve physical and cognitive function. Examples included art, baking, bingo quizzes. In conversation with activity therapists, nurses and care staff and on observation, inspectors learned that small groups of residents were brought out for walks in the grounds of the centre each morning, weather permitting. Where weather was inclement, an exercise group was held. However it was noted that these groups were small and therefore only a small number of residents on each unit could take part in the walk. This was due to a number of reasons including behaviours associated with risk of absconsion, aggression or risk of falls. The groups were also limited to one wheelchair user and the remaining (usually a maximum of four- five) had to be fully mobile.

Inspectors found that all activities in the weekly programme were delivered in group sessions. The programme ran from Monday- Friday. Weekend activities primarily depended on direct care staff having time to facilitate or supervise a session or revolved around visitors. Although care and nursing staff engaged to some extent with activities it was noted that this involvement was limited to singing along to background music, bringing some residents to the coffee dock or for short walks outside or assisting with setting up movie screens.
In conversation with them, review of documentation and observation it was found that in general direct care staff considered activities not to be part of their work and so residents were dependent on the activities team for meaningful occupation and engagement.
Inspectors observed an activities coordinator assisting a group of residents in a knitting based activity and short music sessions were provided by a lady playing the guitar and singing in several units throughout the day. A group of volunteers assisted the activities team to provide a variety of meaningful activities to residents including assisting with arts and crafts music sessions baking and cake decoration.
1:1 sessions were provided to residents who were immobile, spent most of their time in bed or in their bedrooms, were ill or recovering from illness, but it was found that activity staff were limited in their capacity to meet residents needs in this area. It was found that each activity person provided a 1:1 activity to, on average, 6 residents per week. These sessions lasted approximately 30 minutes. Inspectors learned that due to the deterioration in residents cognitive and physical abilities together with the aging profile, more residents, approximately 50% now require them but it would take a month to give every resident a 1:1 session. For some residents it had been between one month and six weeks since their last 1:1 session.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
A complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia, were listened to and acted upon. The process included an appeals procedure.

The complaints policy which was displayed met the regulatory requirements. Some residents and those relatives spoken to could tell inspectors who they would bring a complaint too. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

Findings:
Recruitment processes were reviewed on this inspection and on review of a sample of staff files these were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. This included garda vetting processes which were also in place for volunteers working in the centre.
Mandatory training was in place and staff had received up to date training in fire safety, moving and handling and safeguarding vulnerable persons.

It was found that at the time of this inspection, the levels and skill mix of staff were not sufficient to meet the needs of residents. Specifically this related to a lack of

appropriately qualified nursing staff, inspectors were told and it was observed that healthcare staff were very busy and often times stretched to meet residents needs in a timely manner. This was reflected in unsolicited information received in recent months by the Authority in the form of concerns from relatives of current residents.

As previously referenced under Outcome One, a good standard of safe and suitable care was not found to be consistently delivered to residents. The inspection team found that the current profile of residents in the centre were frail elderly with a high level of complex needs. 75% of all residents were assessed as being at high/ maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living. It was also noted that the assessment tool in use in the centre to determine the residents' dependency only considered residents physical functional abilities and not cognitive function, yet 80% of the resident population had a formal diagnosis of dementia.
Despite this level of complex need, adequate numbers of skilled nursing personnel were not available to deliver or supervise a high standard of care with resulting negative impacts on residents' health and wellbeing. This is referenced in detail under outcome 1.

In addition to mandatory training staff were provided with training on areas of practice such as infection prevention and control; cardio pulmonary resuscitation and basic food hygiene. However it was found that further training on aspects of care specific to the resident profile was needed such as; wound and pressure ulcer care; care planning and risk assessment; nutrition and management; person centred care practices and dementia specific care practices.
- although it was noted that some nursing staff were familiar with the residents on their respective units all did not have in depth knowledge of all of their residents needs, past history or current condition. Inspectors found that this was due to the inability of one person to provide safe levels of nursing care to up to 32 frail elderly persons with complex needs. It was also due in part to a recent high turnover of staff with new nursing and care staff personnel only recently recruited, some completing induction and regular use of agency staff. On one unit there were three agency staff, one supernumerary person on induction and one relief person who usually worked on a different unit. This meant that from a total staffing compliment of seven care staff only two were familiar with residents needs. In addition there was only one clinical nurse manger on duty. This nurse manager although a member of the regular team had been working on a care planning project, had not worked on the unit for two months and was not fully up to date with changes in residents' condition. On another unit there were two nurses and six care staff. But two of the care staff were agency staff, one of whom had no previous experience of working on this busy maximum dependency unit, and one who had worked on the unit for the first time on the previous day.
-work allocations and staff replacements further contributed to a lack of supervision of care delivery. Nurses were often replaced by care staff thus depleting appropriate skill mix. On both days of inspection there was only one nurse or clinical nurse manager on duty on 32 bed units and historical rosters showed where one nurse occasionally covered two separate 10 bed units. Where nurses were replaced by care staff inspectors were told an additional six hours of care staff hours were included on the roster but this was not found to consistently happen and did not happen on one day of inspection.
- the design and layout of the centre needed to be considered when reviewing the numbers of staff required to deliver safe and appropriate care. The size and layout of

the centre presented difficulties for staff to maintain adequate levels of supervision at all times, and during staff breaks most units had only one member of staff available to supervise the entire unit. On each of the six 10 bed units both day and night shifts there were two staff allocated to each unit (one nurse and one carer) although on night duty one care staff went off duty at 06:00 leaving two hours with only one staff on three units. On night duty there were two care staff and one nurse on two of the 32 bed units with only one nurse and one carer on one 32 bed unit. On this latter unit a number of the residents were deemed to be at risk of falls and some had experienced a number of falls over the preceding three months. The inspector reviewed the post falls assessments and although the need to consider 1:1 close monitoring was stated for some residents there was no evidence it had been implemented.
Health & Safety audits conducted by the management team and seen by inspectors showed that in the five months from January to May there had been a total of 148 slips trips or falls in the centre. 100 of these occurred in the larger units where staff have to cover greater distances to respond to residents needs. The layout of these larger units in terms of geographical spread is such that on the first floor from one end of a 32 bed unit to the other, which encompasses three corridors, measured approximately 162 metres.
- communication within units both verbal and written was not clear. Inspectors witnessed the early morning hand over's from night to day nursing staff and from the day nurse to the day shift care staff. Most of the information was summation and little specific information on progress or deterioration on current condition of any resident was given. Confusion between the verbal information received and poor documentation in care plans and progress notes meant that nurses were not sure whether residents had been referred to dietician services or whether food diaries recommended had been implemented.
-clinical governance by the clinical nurse managers or the senior management team was not sufficient or consistent enough to ensure safe and suitable care practices. Clinical nurse managers were assigned to various units but there was little evidence that they spent enough time to assess the standard of care delivery or provide direction guidance or support to staff. It is acknowledged that due to staff shortages these nurse mangers were replacing nurses in direct care provision on both day and night shifts and were therefore not available to provide guidance.
Senior management have been aware of these difficulties which were brought to their attention not only by staff but also by relatives who raised it at advocacy meetings. Inspectors were told that a recruitment drive was ongoing and there were 12 staff awaiting their nursing registration numbers.
But inspectors noted that the skill mix did not reflect recommended nurse; resident care ratios and were in fact at the very minimum of 1 nurse providing direct care to 32 residents in two units during the inspection and when staffing numbers were not being depleted the best nurse:resident ratio was at 1:10 on six units and 1:16 on three. Inspectors found that the numbers of nursing staff on duty providing direct care to residents were not sufficient to ensure a safe standard of care was delivered.
Due to the findings the inspector informed the provider nominee and the person in charge that an immediate response to mitigate the findings was required which at a minimum would improve nurse; resident ratios to two nurses on all 12 hour day shifts with nurse management oversight on all 32 bed units and a commitment to the principle of nurse for nurse replacement. A full review of all staffing within three months would also be required.

The provider submitted a written plan committing to an increase in nursing and nurse manager numbers and also to an increase in the level of supervision across all units on a daily basis to ensure an improved level and consistency of care.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
A large extension to the original 64 bed Alzheimer Care Centre was opened in 2012. The new extension comprises of a new extension to the nursing home and also includes psychiatric services formerly provided in Highfield Hospital, registration under the Mental Health Commission. The new build accommodates a distinct and totally separated division of facilities for people receiving care in both the older persons and psychiatric services. However, there are elements of shared facilities, principally catering services delivered from a central main kitchen to both services, large chapel, reception area with seating and servery for visitors, designated visitors toilets, staff (and separate catering staff) shower, toilets and change areas, staff training rooms, medical, allied health professionals administration and senior management team offices and rooms.
The extended facilities for older persons services consisted of;
On the ground floor there were four self-contained 10 bed units - Addison, Lindsay, Delville and Clonturk. Each have a similar layout.
On the first floor there were three separate units - Daneswell, Coghill and Farnham. The Farnham unit, which consists of 20 beds, is designated as a high dependency psychiatric unit and is registered under the Mental Health Commission.
On the second floor there was Drishogue which is a 30 bed unit. Overall the design, layout, provision of equipment, health and safety aspects, security, decorative features and attention to detail of the extended premises were found to be of a high standard and suitable for the proposed resident profile for persons with dementia.

The original building also on the ground floor contained two 32 bed units, Grattan and Ryall. Grattan consists of 32 single bedrooms and Ryall contains multi-occupancy rooms.

The Ryall unit contains multi-occupancy rooms consisting of four bed areas each containing eight beds radiating from a central day area where residents spend their day. Limitations to shower and toilet facilities remain, each of the eight bed areas contained only one wash room consisting of assisted shower, toilet and wash-hand basin. The size of the combined toilet/bath/shower room area was limited and pose difficulties to enable those residents with maximum physical limitations to access the current shower/bath. In addition, where a resident is receiving a shower this limits access to the toilet for other

residents. Both the sluice area and treatment room required review from a spatial perspective to ensure they meet their intended purpose. There are no separate dining, sitting or other recreational space available to residents or their visitors. All residents in this unit were assessed as maximum dependency both physically and cognitively and spend long periods of time in the same room.

With the exception of the Ryall unit the rest of the centre meets the requirements of the Regulations to a high standard.
The size and layout of the Ryall unit poses difficulties to provide for residents individual and collective needs in a comfortable and homely manner on a daily basis. Residents personal space is not designed or laid out in a manner to ensure safety, encourage or aid independence or assure privacy and dignity. Negative impacts include a limited amount of physical space between beds; limited access to shower/bathroom facilities which were also limited in terms of size, lack of separate dining, sitting or other recreational space available to residents or their visitors.

Findings on this inspection replicated the findings of the registration inspection in 2014
The provider informed the Authority in 2013 that as part of the action plan response to the registration report that plans, which included consideration of options for extension or full replacement of this facility, were being drafted and would be commenced to ensure compliance with the relevant regulations and standards by July 2015.
However on this inspection it was found that no further progress had been made to address these environmental issues. The provider informed inspectors that plans had been revised and requested a meeting to discuss new proposals.
But it was noted that on both Ryall and Grattan units, considerable efforts had been made by staff to make the units more homely. There was only one communal space available within the Ryall unit in which the residents spent the majority of their time, and this space was used for activities and dining. There was a large wall clock visible on the wall, and the placement of artificial fireplaces, bookcases, plants and other furniture had made this space feel more homely. There was also a large wall of photographs and pictures within this space and sections of the walls had been covered in wallpaper. The noise levels in this space during this inspection were kept at appropriate levels, and fans were used to ensure the temperature was comfortable for residents seated in this area. There was also access to an enclosed secure courtyard area with raised flower beds and seating.
In the Grattan unit, one of the communal spaces had been developed into an activities area with large amounts of residents' art work on display, and photographs of the residents up on the walls. The staff had decorated sections of the corridors, to make the unit more homely, and communal spaces included features such as fireplaces and comfortable furnishings. Residents also had independent access to an enclosed secure outdoor courtyard with facilities for gardening, seating and feeding the birds.

The premises were noted to be maintained to a good standard and evidence of ongoing maintenance, such as painting and repairs to the fabric of the building was found. In general, the building was found to be clean and walkways were free of clutter.

Although appropriate assistive equipment was broadly available to meet residents' needs, inspectors found that sufficient hoists and slings were not always available in all units. Hoists were being shared between several units due to some awaiting

repair/replacement and inspectors were told bathing slings were not available on one unit.

Judgment:
Non Compliant - Moderate

Outcome 10: Suitable Person in Charge

Theme:
Governance, Leadership and Management

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

Findings:
Recent changes to the clinical management team within the centre were found on this inspection with the person in charge commencing in post within recent months.
The fitness of the person in charge was assessed through interview to determine fitness for registration purposes and was found to have satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation.
The person in charge was a registered psychiatric nurse with relevant experience as required by the regulations.
She was found to be visible on units and both staff and residents were familiar with her.
She was also aware of the requirement in the regulations and standards to undertake a postgraduate qualification in dementia care and management.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Alzheimer Care Centre
Centre ID:	OSV-0000113
Date of inspection:	09/09/2015
Date of response:	06/11/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All the care needs of all residents were not being met and suitable safe and sufficient care was not being provided.

1. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

Please state the actions you have taken or are planning to take:
The weights of residents are being monitored on a weekly, 2 weekly or monthly basis based on risk assessment. At risk residents are being weighed weekly. This also includes recording of their Body Mass Index (BMI) and Malnutrition universal scoring tool (MUST) score. The dietician reviewed a number of residents referred on 1st October and appropriate actions have since been implemented for these residents. MUST training has been scheduled for nursing staff across units for 28th and 29th October. Surveillance of weight monitoring is ongoing and findings have been disseminated by nurse managers to nursing staff and continue to be reviewed on a weekly basis. Nutrition and weight monitoring are discussed at Quality and Risk Management Committee meetings to ensure the effectiveness of actions implemented.

An audit of all residents in the nursing home was carried out to assess for pressure ulcers. TVN training for staff took place on 28th September and 5th October. Pressure ulcer surveillance is discussed monthly at the quality and risk management meetings and changes to this process were have been made to this area to provide greater oversight and monitoring. Ongoing review of care plans is taking place across all units.

Proposed Timescale: 31/12/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessment, care planning and clinical care did not accord with current evidence-based practice.
Complete comprehensive nursing assessments were not carried out for each resident in respect of every identified need.

2. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Residents are undergoing comprehensive assessments to identify current and new needs since previous assessments. Assessments are covering key areas of need such as skin integrity, falls prevention, nutrition and dysphagia, fluid maintenance, incontinence and psychotropic medication.

Particular focus has been paid to nutritional and wound management assessments following inspection. All residents are being weighed monthly, fortnightly or weekly based on identified need. Interventions have been put in place as deemed appropriate for each individual. At risk residents have been put on food diaries and food fortification has been notified to the kitchen and diets of at risk residents are reviewed weekly by nurse managers. Medication has been reviewed for residents and rationalisation of

medication has taken place based on the assessed medical needs of residents. Medication usage reviews by the external pharmacist commenced on 12th October. Nutrition and tissue viability surveillance are discussed at monthly Quality and Risk management meetings. All necessary interventions are being put in place to address identified needs and are being documented in the care plans. Care plans continue to be updated to reflect residents' identified needs.

Proposed Timescale: 31/12/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence that all care plans were fully reviewed for effectiveness as residents needs changed was not found.

3. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
All care plans are reviewed at least every 4 months within the service. Residents and family are consulted as appropriate and in many cases sign care plans to reflect input. Comprehensive assessment of needs is being undertaken as identified in action 2 above and care plans are being updated to reflect current needs. Care plans have been updated as appropriate following recent reviews of weights and nutrition, wound management and medication usage to reflect changes in residents' needs. Care plans are being reviewed for effectiveness and updated to ensure that they accurately reflect current resident needs, interventions and goals. Care plans are also being reviewed to determine the effectiveness of existing interventions and whether alternative more effective interventions need to be put in place. Systems have been put in place to ensure more regular reporting and monitoring of key performance indicator data on falls, weights, tissue viability surveillance, incidents and complaints in order to determine the effectiveness of interventions being implemented as well as to facilitate the sharing of learning across the service on the efficacy of various interventions e.g. dressings applied for wounds. Where necessary, alternatives will be considered.

As part of our care plan review process, we are also considering piloting a new format of care plans. Additionally, we are aiming to introduce a new electronic patient information system in 2016 to facilitate ongoing monitoring and review of assessments and care plans.

Proposed Timescale: 31/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A high standard of evidence based nursing care was not being delivered to all residents to fully meet their personal social and healthcare care needs as evidenced by examples such as residents experiencing falls; significant weight loss; the clinical deterioration of pressure ulcers and institutional care practices that did not respect residents rights to full choice in all aspects of daily life.

4. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
We are undertaking comprehensive assessments and reviews of care plans. Weight monitoring and nutritional assessments have been carried out for residents considered at risk and care plans are being updated accordingly. All residents have been reviewed for pressure ulcers by medical staff and appropriate nursing and medical care has taken place.

Additional training has been delivered to staff by the TVN and MUST training has taken place to ensure that staff have a greater understanding of wound management and nutritional management. New nursing staff continue to undergo mandatory training.

Systems are in place to monitor the standard of care. Tissue viability and nutrition and weights are discussed monthly by the Quality and Risk Management Committee to monitor and evaluate the effectiveness of interventions implemented. All incidents which include slips, trips and falls are also reviewed at these meetings to ensure appropriate actions are taken to mitigate risk and to ensure the dissemination of any learning outcomes. Neuro obs are carried out within 24 hours of all unwitnessed falls. Slips, trips and falls are the most common form of incident in an older person service accounting for approximately 55% of all incidents within the service. Nursing home residents are at highest risk of falls, fractures and osteoporosis with a rate of hip fracture 3-11 times greater than age-matched community dwelling older people (HSE & DoH, 2008). In line with our policy on falls prevention, we consider it good practice for staff to record all falls regardless of whether the resident has sustained any injury. In the previous 4 months, only one fall resulted in any level of significant injury to a resident i.e. hip fracture. As per our policy, all residents have a falls risk assessment on admission and every 3 months thereafter or as the need arises following the reporting of an incident. A recent review has commenced of psychotropic medication and rationalisation of medication has taken place. This may lead to a reduction in the risk of falls for some individuals.

In addition to the above measures, the numbers and skill mix of nursing staff has been reviewed and continues to be reviewed on an ongoing basis. As a result, additional

numbers of qualified nursing staff have been put in place and additional nurse managers have been appointed across all units to oversee the standard of all nursing care delivered in lien with professional guidelines.

Proposed Timescale: 30/11/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The nutritional needs of all residents were not being met and some had experienced significant weight loss.
Specialised diets and food fortification as prescribed by specialist staff were not being followed or included in updated care plans based on nutritional assessments.

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

Please state the actions you have taken or are planning to take:
The nutritional needs of residents are being closely monitored based on need. Food diaries have been put in place for at risk residents. At risk residents have been reviewed by the dietician and specialised diets and fortified food have been implemented as appropriate. Residents are being offered extra snacks in one of the units where there has been some weight loss early in the morning, mid- morning and mid-afternoon in an effort to encourage maintenance of good nutritional health. All care plans have been updated to reflect nutritional assessment by the dietician and interventions being implemented. The clinical nurse managers are overseeing the implementation of these actions. Weights are being monitored on an ongoing basis in order to determine the effectiveness of interventions and to determine whether alternatives need to be considered. Nutrition and weight is then discussed monthly by the Quality and Risk Management Committee meeting to evaluate effectiveness of actions taken.

Proposed Timescale: 06/11/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of care was not sufficiently accurate or complete to provide an accurate record of residents current overall condition or determine that a high standard of evidence based nursing care was being delivered to all residents to fully meet their personal social and healthcare care needs.

Records of the food provided to residents were not maintained to enable a determination be made on the adequacy of the diet being provided as required under Schedule 4(5)

6. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
Greater efforts have been put in place to ensure that nursing documentation accurately reflects practice. The quality of progress notes are being reviewed to ensure that they accurately capture each resident's current overall condition and whether they have had a good or bad day. Improvements have also been made to communication handovers for nurses and care assistants on shifts so that staff have a greater understanding of residents' daily needs. Nursing assessments and care plans are being reviewed for effectiveness and updated to ensure that they accurately reflect current resident needs, interventions and goals. In terms of nutritional monitoring, food diaries have been competed for residents identified as at risk of malnutrition and appropriate interventions are documented and put in place.

All records required under schedule 2 (PIC and staff), schedule 3 (resident records) and 4 (other records) are in place in the centre and are available for inspection.

Proposed Timescale: 31/12/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Prescribing practices and supporting guidance on the appropriate use of all medications were not sufficiently specific to guide nursing staff to ensure the safe administration of all medication.

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

Please state the actions you have taken or are planning to take:
Medication Kardexes were reviewed with the pharmacist on 1st October and changes to Kardex have been agreed to meet requirements, including specifying maximum prn dose; specifying each medication to be crushed as opposed to any medication; and altering medication administration times. The addition of further nursing staff on each unit should also reduce the time taken to administer medication by allowing protected

time for nursing staff on medication rounds. Further protocols will be put in place for staff on indications for the use of prn medications. The pharmacist is due to complete a medication usage review in the nursing home in October. Medication audits have been conducted by the pharmacy in August and September in line with HIQA requirements.

Proposed Timescale: 15/11/2015

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence to show that all considerations were explored, in line with national policy as published on the Department of Health website, and found to be unsuitable before a decision was taken to use a form of physical restraint was not available.

8. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
Restraint is only used in accordance with the service's policy on restraint. Restraint is only permitted where there is an immediate risk to the resident's welfare and safety. The policy will be reviewed in the context of the use of chair/lap belts. This issue has been raised with nurse managers and the use of chair/lap belts will be reviewed and a similar approach will be adopted as that successfully taken in the past for the use of bed rails, where families were consulted. The record keeping and prescription sheet for their use will be reviewed to take account of risk assessments and consideration of alternative measures considered.

Proposed Timescale: 29/02/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that purposeful or meaningful activities for all residents with advanced dementia, deteriorating physical and cognitive abilities and/or limited mobility on a one to one basis were provided on a regular and consistent basis was not available.

9. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The service considers it the responsibility of all staff to engage with residents in a person-centred and meaningful way. Our workforce comprises of nurses, care staff, occupational therapists, activities therapists, and medical staff. The increase in clinical supervision on all units will help us to further promote our philosophy of care. In addition, dementia specific training is being run in October and November for new and existing staff to gain a greater understanding of the needs of our resident population.

We have a volunteer programme that we are currently greatly expanding and appointing a volunteer co-ordinator to enable more one to one interaction with residents based on their interests and capabilities particularly those with deteriorating cognitive and physical abilities. There is a small group of medium to high dependency residents who are now engaging in weekly Sonas programme on one of the units.

We currently run a full programme of activities on a weekly basis including fit for life, arts and crafts, singing, aromatherapy, beauty therapy, relaxation, imagination GYM and pastoral care. The activities therapists will review activities offered in order to align activities as much as possible to residents' preferences and interests and to identify any opportunities for more one to one interaction. Care assistants are being educated and encouraged to engage residents in one to one activities based on expressed interests. It is hoped that the expansion of our volunteer programme will enable more one to one interaction with residents. We will continue to guide and educate all of our staff and volunteers in the provision of person centred care and activity to promote a culture of meaningful engagement with all of our residents.

Proposed Timescale: 31/03/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some care practices did not respect residents rights to full choice in all aspects of daily life such as; full menu options at all meal times; maintenance of hot food at appropriate safe temperature; bath/showers.
Residents rights to the delivery of care in a respectful, dignified and person centred manner was not always upheld where; appropriate assistance not always provided with meals; lack of engagement in conversation; inadequate stimulation for long periods of time.

10. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

All aspects of this area are being fully reviewed and necessary changes are in the process of being implemented. Changes have been made to mealtimes in consultation with the catering staff and more emphasis has been placed on choice with meals. Residents are being offered extra snacks in one of the units where there has been some weight loss early in the morning, mid- morning and mid-afternoon in an effort to encourage maintenance of good nutritional health.

The dining area has been moved in one of the units to one main area to facilitate greater communal dining of residents together with more time spent over mealtimes. Residents are offered a choice of breakfast in their rooms or to come to the dining room to enable greater socialization. This communal dining will also enable greater maintenance of hot meals for the many residents requiring assistance with meals on this unit.

Highfield Healthcare operates a person-centred approach to the delivery of all aspects of care. In this regard, care staff are receiving ongoing education and support from nurse managers to promote this importance philosophy of care. More time is being spent over meals and engaging with residents in conversation.

We are continuing to work with care staff in the area of personal hygiene and educate staff on the importance of promoting full choice for residents in this area. In terms of baths and showers, residents are offered showers in accordance with their documented preferences in this area. As bathing can be distressing for residents with dementia we never force our residents to take baths (Radar et al, 2006). Refusal of baths or showers is documented and all residents are offered a full body wash as an alternative method of maintaining good personal hygiene in line with evidence based practice (Rader et al, 2006). Methods used for maintaining personal hygiene are determined by the resident's preferences which may be influenced by their cognitive abilities and general physical health.

Proposed Timescale: 30/12/2015

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of staff was not sufficient to meet the assessed needs of residents and did not take account of the size and layout of the centre.

11. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

A detailed action plan and manpower planning report were submitted in September regarding actions being taken to address staffing which includes the recruitment of additional nursing staff, care assistants and supernumerary nurse managers as well as retention efforts that have been put in place for existing nursing staff. All measures have been implemented as per the action plan submitted and continue to be ongoing.

Proposed Timescale: 31/07/2016

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of nursing staff on duty providing direct care to residents were not sufficient to ensure a safe standard of care was delivered.

12. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
We have implemented measures in line with our immediate action plan submitted in September, which has included the addition of more nursing staff on duty as well as the appointment of supernumerary nurse managers to oversee the standard of care. In addition we have introduced and are rolling out a computerised time management system (TMS) which provides real time data on staffing levels on duty at any given time. This will enable us to monitor our staffing levels on an ongoing basis and aid management in implementing appropriate measures to mitigate risk in times of unforeseen absences. Staffing is an ongoing item of discussion at management meetings and is included in departmental risk registers in efforts to implement necessary controls to mitigate risk.

Proposed Timescale: 31/07/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised to ensure that a good standard of care was delivered which met residents needs in accordance with their care plan.

13. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Since the inspection, three additional full-time supernumerary nurse managers at CNM2 and CNM3 level have been put in place across all units who work over seven days. These managers provide ongoing supervision to nursing and care staff to ensure that care is delivered in accordance with the needs of residents as identified in their care plans. The service intends hiring four additional CNM1's to work across units. We also have a new Person in Charge (PIC) commencing employment in November 2015.

Proposed Timescale: 31/12/2015

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the Ryall unit is not currently suitable for the purpose of achieving the aims and objectives set out in the statement of purpose.

Services and facilities available do not meet the assessed needs of all of the current resident profile.

14. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
Revised drawings for reconfiguration of Ryall have been developed by our architect and as discussed at the feedback meeting, we wish to schedule a meeting to further discuss proposed plans. We also wish to add that residents and families have been consulted on changes to the unit and are happy with the existing homely environment of this unit in spite of the concerns of HIQA.

Proposed Timescale: 30/09/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All units in the centre does not currently meet the requirements of Regulation 17 or Standard 25 (Physical Environment) of the National Quality Standards for Residential Care Settings for Older People in that; the physical design and layout of the premises does not meet the full needs of all of the current resident profile and all aspects of the premises are not sufficiently accessible or spacious. The premises do not fully conform

with all requirements of schedule 6 of the regulations.
Deficiencies in the provision of sufficient assistive equipment were identified such as hoists and bath slings.

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

Please state the actions you have taken or are planning to take:
As per action 14, new plans have been drafted. A review of slings and hoists is also scheduled and new staff are scheduled to receive training in this area.

Proposed Timescale: (review slings) 31st December 2015, 30th September 2016

Proposed Timescale: 30/09/2016