<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Alzheimer Care Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000113</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Swords Road, Whitehall, Dublin 9.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 837 4444</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:seustace@highfieldhealthcare.ie">seustace@highfieldhealthcare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>J &amp; M Eustace Partnership, T/A Highfield Healthcare</td>
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<tr>
<td>Provider Nominee:</td>
<td>Stephen Eustace</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Dulce Tagacanao</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Sheila McKevitt</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>149</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
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**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 his/her 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
- to carry out thematic inspections in respect of specific outcomes
- 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tr>
<td>05 February 2014 10:30</td>
<td>05 February 2014 17:30</td>
</tr>
<tr>
<td>06 February 2014 10:00</td>
<td>06 February 2014 16:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<td>Outcome 02: Contract for the Provision of Services</td>
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<td>Outcome 03: Suitable Person in Charge</td>
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<td>Outcome 04: Records and documentation to be kept at a designated centre</td>
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<td>Outcome 05: Absence of the person in charge</td>
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<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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**Summary of findings from this inspection**

This was an announced inspection and forms part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days and as part of the visit, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents and staff members of the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The nominated person on behalf of the
provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland throughout the inspection process.

The fitness of the nominated person on behalf of the provider and the person in charge was determined by interview during the previous registration inspection process and through ongoing regulatory work such as inspections.

A number of residents questionnaires were given to the inspectors during the inspection. The opinions expressed through both the questionnaires and conversations with the inspector on site were broadly satisfactory with services and facilities provided. In particular, residents and relatives were complimentary on the manner in which staff delivered care to them commenting on their good humour and respectful attitude. Overall, evidence was found that residents’ healthcare needs were met. Residents had access to general practitioner (GP) services and to community health services.

The inspector found there were aspects of the service that needed improvement such as risk management, care planning and aspects of the physical environment.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.
Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is 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.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
There was a written statement of purpose that described the service and facilities that were provided in the centre. The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre. It contained the information required by Schedule 1 of the Regulations. It was reviewed and changes in relation to the purpose and function of the designated centre were communicated to the Authority and updated in the statement of purpose.

Outcome 02: Contract for the Provision of Services

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
A sample number of the written contracts of care agreed with residents were reviewed. Of those reviewed it was found each resident had a written contract agreed with the provider within one month of admission, and signed by the provider, resident or their next of kin or nominated advocate. The contract included details of the services to be provided and the fees to be charged. Details of any additional charges were also
Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
The centre was managed by a suitably qualified and experienced nurse. She held authority accountability and responsibility for the provision of the service. The person in charge is a registered nurse with several years experience of working with persons with varying care needs in a range of settings. She works full-time in the centre. The person in charge was found to be engaged in the governance, operational management and administration of the centre on a daily basis.

During the inspection she demonstrated that she had knowledge of the Regulations. She was supported in her role by a management team consisting of a director of operations and quality, a clinical nurse management team, nursing staff, care staff, administration, maintenance, kitchen and household staff. Staff were familiar with the organisational structure and confirmed that good communication existed within the staff team. She and the staff team facilitated the inspection process by providing documents and having good knowledge of residents’ care and conditions.

Outcome 04: Records and documentation to be kept at a designated centre
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).

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Moderate
Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Records listed in Part 6 of the Regulations were available and kept in a secure place. The statement of purpose and Residents' Guide was complete and available. A copy of the insurance cover in place was provided which meets the requirements of the Regulations.

The directory of residents was reviewed and was found to meet the requirements of the Regulations and was up to date with records of admissions discharges and transfers maintained.

Although not all records were reviewed on this visit, it was found that general records as required under Schedule 4 of the Regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records and operational policies and procedures as required by Schedule 5 of the Regulations.

All records required under Schedule 3 of the Regulations were maintained in the centre and while improvements required from the previous inspection were noted, further improvements were required in respect of maintaining clinical records in accordance with professional standards and linking clinical assessments and risks with care plans to aid evaluation. This is referenced in detail under Outcome 11 of this report.

Variations in medication records were found. Times printed on medication prescription charts and administration records were inconsistent, and did not reflect the time that medications were administered.

The designated centre had completed written operational policies referenced in the previous report and as required by Schedule 5 of the Regulations. Policies including health and safety and risk management were available, and policies on the prevention, detection and response to abuse and management of complaints had been reviewed and updated. However, it was found that the adult protection policy did not provide sufficient guidance on how staff should manage an allegation of abuse against a senior member of the management team as identified in the last inspection report.

Other policies also required to be revised to ensure they gave sufficient guidance to staff, reflected evidence-based practice and the Regulations. These included; the medication management policy which did not specifically guide staff on the appropriate time frames within which medication should be administered to match prescription times and ensure the efficacy of the drugs being administered. The personal possessions policy did not reflect the Regulations in that it did not reflect the requirement to maintain up to date records of residents’ personal possessions.

It was further noted that all policies in place were not fully reflected in practice, examples included the policy on restraint which specified the circumstances under which restraint was not to be used in relation to falls and clearly identified restraint was not to be used unless the risk of falls was immediate. However, the policy was not being
Outcome 05: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge.

The person in charge has not been absent for more than 28 days which required notification to the Authority. The nominated person on behalf of the provider and person in charge were aware of their reporting requirements. The Director of Quality and Operations had been identified to replace the person in charge in the event of an unexpected absence. A clinical nurse manager had been identified to provide cover when the person in charge was not rostered for duty.

Outcome 06: Safeguarding and Safety
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.

**Theme:**
Safe Care and Support

**Judgement:**
Compliant

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

**Findings:**
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. In conversation with some staff members, the inspector found they were competent in their knowledge regarding reporting mechanisms within the centre and
what to do in the event of a disclosure about actual, alleged or suspected abuse. Although residents spoken too were unable to express feeling safe, inspectors observed they appeared comfortable with staff and did not exhibit behaviours associated with distress or anxiety.

The inspector discussed the management of notifications received by the Authority from the provider. On review of the documentation of investigations undertaken and communications between the person in charge, the resident and family during and further to completion of the investigations, it was found that management of the incident notified was appropriate and sufficiently robust to ensure resident safety going forward.

A transparent and thorough system was in place to manage small sums of monies on behalf of residents and their relatives to ensure their comfort. All transactions were appropriately documented and withdrawals were signed by two persons at all times. A bank account separate to the centre's main account was provided for the monitoring of monies belonging to residents and all transactions were appropriately recorded. Evidence that residents had access to review these accounts was found.

### Outcome 07: Health and Safety and Risk Management

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

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Policies and procedures relating to health and safety, and risk management were available in the centre. The health and safety statement was updated following the last inspection identifying safety representatives/officers associated with Highfield Healthcare and staff representatives working within the centre.

Risk management policies and procedures previously in draft form were now implemented throughout the centre and reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre were found. An emergency plan was also available and staff were found to be aware of its contents.

A risk register was maintained and available which in general covered the identification and management of risks in the centre.
The entrance to the centre was secure and a visitors’ log was in use to monitor the movement of persons in and out of the building. Inspectors observed this record to be in use.

The environment was noted to be clean and clutter free and there were measures in place to control and prevent infection. Adequate precautions against the risk of fire, including the provision of suitable fire equipment were found. Arrangements were in place for the maintenance of the fire alarm system and equipment within this centre. Staff were knowledgeable in relation to fire evacuation procedures and staff training was provided on an ongoing basis and at induction. Written confirmation from the provider and a competent person that all the requirements of the statutory fire authority have been complied with was received prior to registration of this centre.

Smoke detectors were located in all bedroom and general purpose areas. Emergency lighting and fire exit signage was provided throughout the building. The inspector reviewed service records which showed that fire equipment, the fire alarm system, emergency lighting and were regularly serviced. Fire escape routes were unobstructed. Fire alert action notices and building layout plans showing evacuation routes were displayed throughout the centre.

Records were maintained regarding the servicing of fire equipment, the fire alarm system and fire officer’s visits. Check lists were also maintained to ensure fire exits remained clear and fire equipment and alarms were tested. Maintenance of equipment was verified through invoices viewed for equipment such as regular servicing of beds, wheelchairs pressure relieving equipment water heating and call bell system.

Although improvements to risk management processes were found on this visit and no serious risks to residents safety were observed, recurrent issues in respect of restraint and moving and handling practices in the centre were found. Training for staff in the moving and handling of residents was provided, however, practices observed were in not line with current evidence-based practice.

The remainder of the findings relating to use of restraint are referenced further under Outcome 11 in this report. Many of the bed rails in use during this visit were independently attached to the residents beds. Although the bed rail risk assessment form indicated that the rails were located within safe dimensional limits, records to evidence that a full assessment of the safe positioning of the rails using a recognised assessment tool was not available. An audit of the positioning of independently attached bed rails was required as an action following the last two inspections in the centre and has not yet been addressed and is a recurrent failure.

**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Safe Care and Support
Judgement:
Non Compliant - Moderate

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

**Findings:**
Evidence that the processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation were found and systems were in place for reviewing and monitoring safe medication practices. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and appropriate procedures for the handling and disposal for unused and out-of-date medicines.

Observation of medication administration practice was satisfactory and in the sample of medication prescriptions reviewed inspectors noted that these were in line with best practice. A record of nursing staff signatures and initials were maintained in line with best practice.

However, variances were found in relation to the prescription template time of prescribed medication, the template for administration time, the actual time recorded and actual time medication was administered. Guidelines on best practice to determine an appropriate 'time window' for the safe administration of medication, limit the risk of errors and which also ensures the efficacy of the drug is required as referenced under Outcome 4.

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**Outcome 09: Notification of Incidents**

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

**Theme:**
Safe Care and Support

**Judgement:**
Compliant

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

**Findings:**
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector. Quarterly notifications had been submitted to the Authority as required and within the appropriate time frame. A recommendation to identify the name of the specific unit where incidents which require notifications occur was made to enable improved and prompt follow up where indicated by the Authority.
### Outcome 10: Reviewing and improving the quality and safety of care

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

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
A system for reviewing care practices was established, including areas such as falls management and medication management. Audits were also carried out on aspects of care such as care planning and tissue viability. The person in charge told inspectors that the results of these audits were discussed by the quality and safety committee and with the nursing team at regular staff meetings but this was not recorded. Evidence that the findings of the audits were analysed, improvements identified and implemented was not available.

The systems in place did not include a clear analysis of the outcomes of the audits to ensure a continuous quality improvement which includes trend identification and actions taken to improve the quality and safety of care delivered to residents.

This is a recurrent finding from the previous inspection.

### Outcome 11: Health and Social Care Needs

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.

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate
Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Residents had good access to general practitioner (GP) services. A GP visited the centre during the inspection to review residents. There was evidence of access to specialist and allied health care services to meet the diverse care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, physiotherapy and dietician services was reported as available. However, access to other allied health professionals such as occupational therapy or speech and language were on a private basis only.

The arrangements to meet residents’ assessed needs were set out in individual care plans and each resident had a care plan completed. Risk assessment tools to evaluate levels of risk for deterioration were also completed. Although in general care plans reflected the care delivered, further improvements were found to be required. Risk assessments and care plans were not always linked or revised in all instances to determine their effectiveness and care plans were not always reviewed in response to changes in residents’ health.

Falls risk management
Clinical documentation was inconsistent in determining falls risk ratings, in the case of one resident three separate risk assessments inconsistently rated the risk of falls as low, high and one stated there was no history of falls. Care plans in place referencing interventions in place to manage mobility and safe environment were not reviewed to reflect recent deterioration in overall health status and within the same care plan inconsistencies between the problem identification and intervention to manage the problem variously rated the risk of falls as both, at ‘very high risk’ and ‘not high risk’.

Restraints such as bed rails were found to be in use for a number of residents. The documentation referencing the need for restraint did not always identify whether the restraint used was suitable for the residents needs without restricting the resident unnecessarily. Risk assessments that determined the intervention was in the best interests of the resident, was the least restrictive solution and was being put in place as previous less restrictive interventions had failed had not been completed.

Inspectors observed that there was a limited amount of alternative equipment available to staff to provide alternative person-centred options that maintain dignity and a level of independence in a safe manner. For example, low low beds were not available for all residents and sufficient space to enable staff utilise crash mattresses at resident’s bedsides was not available in all units.

Evidence of regular access to and facilitation of showers and baths for immobile residents assessed as high or maximum dependency was not found. Inspectors were told that residents could not be provided with a bath or shower in some units as appropriate equipment to meet this need was not available.
Several residents were identified as being nursed on full-time bed rest, in discussions with staff it was found that an evaluation of the suitability or appropriateness of these residents requiring 24 hour bed rest had not been made. Furthermore care plans to evidence the rationale for the bed rest were not in place and considerations of risks associated with long term bed rest had not been assessed. These decisions had not been reviewed since implementation.

Overall, areas for improvement were identified in the documentation of care given and there was a need to develop a system to ensure that care plans reflected the care delivered and were reviewed in response to changes in residents’ health and that care plans and clinical evaluations were appropriately linked to give a clear and accurate picture of residents’ overall health and condition.

Outcome 12: Safe and Suitable Premises

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.

Theme:
Effective Care and Support

Judgement:
Non Compliant - Major

Findings:
Issues identified with the design and layout of the physical environment of the centre previously identified and which have been outlined in reports of inspections conducted between 2010 and 2013 are restated here.

A large extension has been added to the original Alzheimer Care Centre building on the existing site.

This new extension comprises of a new extension to the nursing home and also now 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 extension consists of a front entrance leading into a large reception area. The existing Alzheimer Care Centre 64 bed unit is situated to the right of the new main entrance. Units comprising new facilities for the former Highfield and Hampstead Hospitals are situated to the right and behind reception. The left wing of the new build
contains the facilities for older persons services. This wing is divided into three levels, ground, first and second floors.

Extension ground floor
This comprises four self-contained 10 bed units - Addison, Lindsay, Delville and Clonturk. Each have a similar layout. The units are paired to share (between 20 residents) some facilities such as sluice, clinical room, medical treatment rooms, clean and dirty laundry store, wheelchair stores, activities room and cleaners room. Five designated visitors meeting rooms, designated visitors toilets, lifts and staff toilets were situated on the corridors leading to the ground floor units.

First Floor
Facilities and layout are similar to the ground floor. On the first floor there are 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 the Drishogue is a 30 bed unit. Six larger bedrooms measuring up to 16m² are available and are proposed to be allocated to those residents who require end-of-life care or require strict infection prevention and control measures to be in place. These rooms are envisaged to be large enough to allow relatives to remain with their loved overnight when ill or at end of life.

All bedrooms measure or exceed the minimal usable floor space of 12.5m², required by the regulations each contains wardrobe, desk (with lockable drawer) and chair, electric hi-lo bed with integrated side rail, bed table and locker, call bell, over bed light (extendible), wall mounted TV and access points for telephone, radiator with adjustable heat, non-slip flooring. En suites include shower, toilet, wash hand basin, assisted rails, wash and hand drying facilities for staff.

Each unit contains a separate assisted bath or shower room. Communal day rooms include, sitting area, dining space and tea station. The room is divided by a wall mounted decorative fire enclosed in safety glass which separates the sitting and dining space. The tea station features a small domestic style kitchenette with small sink, hob, fire blanket and cupboards to meet dementia specific requirements for residents’ profile. Each communal area also contains a self contained smoking area with mechanical extraction ventilation and call bell. A kitchen servery is located at the end of the day room appropriately fitted for heating, serving and clearing up after meals.

Corridors are sufficiently wide to allow access to power wheelchair users and contain side rails, they also provide small cushioned seats at regular spaced intervals along the length of the corridor for residents use.

Hand gel dispensing units were located at appropriate points along all corridors in each unit and a toilet approximately 3.5m² was located in close proximity to the communal day area.

Appropriate colour cueing is used throughout the facility with walls, flooring bedroom and bathroom doors coloured to prompt residents to the function of the room.
Externally residents in each unit can access separate enclosed courtyard area with seating, landscaped shrubberies and raised plant beds, the area is covered by a ‘cushioned’ type of coloured tarmac to minimise impact of potential falls. Access is restricted by a swipe card operated gate.

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.

Although the design and layout of the recent extension meets the requirements of the Regulations to a high standard, some aspects of the premises still do not meet the requirements of the Regulations or the Standards, specifically the pre-existing Ryall unit.

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 in terms of cognition and physicality, consequently residents spend long periods of time in the same room.

On this visit, the negative impact of limited physical space in the multi-occupancy rooms on meeting residents needs was found. The limited space between beds prevented staff from meeting residents care needs in an appropriate, holistic and evidence-based manner. Examples of this related to the use of restraint outlined under Outcome 7 and Outcome 11. Staff explained how it was not possible to utilise alternative measures such as crash mats as there was insufficient space between beds to facilitate their use. It was also noted that lack of access to appropriate equipment such as shower trolleys also prevented staff from meeting residents personal care needs in an individual and holistic manner as referenced under Outcome 11.

The layout of this area renders it difficult to provide for residents individual and collective needs in a comfortable and homely manner on a daily basis. Residents personal space is not designed and laid out in a manner to ensure their safety, encourage and aid their independence and assure their privacy and dignity.

**Outcome 13: Complaints procedures**

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.

**Theme:**

Person-centred care and support
**Judgement:**
Non Compliant - Minor

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

**Findings:**
There was a written operational policy and procedure relating to the making, handling and investigation of written complaints. This was displayed in a prominent position. The procedure identified the nominated person to investigate a complaint and the appeals process. There is also a nominated person who holds a monitoring role to ensure that all complaints were appropriately responded to, and records were kept. Some aspects of the policy required clarification such as the title of ‘ombudsman’ designated to the role of the independent monitor. Also in the statement of purpose the persons identified in the role of the complaints officer and appeals officer differed to the those displayed in the centre.

The inspector examined the complaints' record and this showed that both verbal and written complaints were promptly investigated, detailed the outcome for the complainant and indicated actions taken to resolve the issues. However, arrangements to ascertain the satisfaction or otherwise of the complainant with the response nor a review within a reasonable time frame to the overall management of the complaint was not found. The benefits and importance of such reviews to identify trends and improve practice was reflected particularly in relation to the management of residents personal possessions whereby items which were missing had not been included on the residents property list. This is also referenced under Outcome 17.

**Outcome 14: End of Life Care**
*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
A small number of residents were receiving 'end of life' or 'comfort care' during this visit. A sample number of care plans were reviewed. Care plans in place reflected that residents at the end of life should have their needs met in a manner which respected their dignity and autonomy. Arrangements to meet religious and spiritual needs were initiated through visits by the centre's chaplain.
Inspectors were told and observed that changes to the system of assessing, implementing and documenting the provision of end of life care were under way currently in the centre and staff were in the process of reviewing the care plans in place.

There was access to specialist palliative care services, if appropriate. However, although staff strived to meet the preferences of residents family and friends and were keenly aware of their specific needs at this time, the physical environment in some areas limited the ability of staff to meet their needs in full.

It was noted that arrangements to ensure as far as practicable that residents family and friends were facilitated were not documented or identified, similarly for those residents in multi-occupancy rooms the provision of a single room to maintain privacy and dignity at end of life could not be assured in all cases and alternatives were not identified.

**Outcome 15: Food and Nutrition**

*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 discrete and sensitive manner.*

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

**Judgement:**
Compliant

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

**Findings:**
Residents were provided with food and drink at times and in quantities adequate for their needs. Food was properly served and was hot and well presented. The inspector observed that assistance was offered to residents in a discreet and sensitive manner.

Menus showed a variety of choices for starters and main courses and there was a large selection of dessert choices on offer. The two week rolling menu in place provided a variety of meals to residents. Drinks such as juices, milk, tea and coffee were available and staff were attentive to the needs of all residents. Meals were served in a pleasant and helpful manner. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate.

Comments on some residents questionnaires received during the inspection indicated satisfaction with the quality of the food provided. A robust communication process to ensure catering staff were aware of the changing dietary needs of all residents was in place and the system in place to ensure the delivery of the correct diets to the correct unit was colour coded and included the name of the resident, unit and specific diet. The diet sheet from each unit was copied and attached to the trolley and returned to the unit. The head chef was familiar with residents who were identified as requiring
improved nutrition and was observed providing options to ensure fortified diets were provided where required.

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

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
There was evidence that a residents consultation process was in place and a satisfaction survey was conducted in 2013 to determine residents and relatives views on the services provided. Staff were observed to respect residents were observed to respect residents privacy and dignity through ensuring the appropriate use of screening in communal bedrooms and closing doors when providing assistance with personal care.

The inspector observed that residents were addressed by staff in an appropriate and respectful way and that there were mutually warm interactions between residents and staff.

It was noted that residents choice and independence was promoted and enabled and this was confirmed in conversations with residents.

Residents had opportunities to participate in activities appropriate to their interests and preferences. A varied programme of social and recreational activities were scheduled weekly to take place throughout the centre and were led by a team of designated activities coordinators. Detailed social care assessments were completed for all residents that determined likes/dislikes and previous interests. Residents were observed engaged in a variety of activities such as attending prayer services, reading, watching television, playing games or entertaining their visitors. Residents who spent long periods in bed were visited by the activity coordinators and stimulation of the senses by touch smell was provided using hand massage and conversation. Efforts to create areas of interest for residents through reminiscence was noted in the Ryall unit where several corner windows were dressed to reflect different rooms in times past.
### Outcome 17: Residents clothing and personal property and possessions

*Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

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

**Judgement:**
Non Compliant - Minor

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

**Findings:**
The inspector saw that there was adequate space provided for residents personal possessions and clothing was noted to be neatly and appropriately stored. Residents had a locked facility in their bedrooms. There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents. In a sample of those reviewed a record of residents personal possessions was not in place or had not been updated.

### Outcome 18: Suitable Staffing

*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.*

**Theme:**
Workforce

**Judgement:**
Compliant

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

**Findings:**
The inspectors found that at the time of this inspection, the levels and skill mix of staff were sufficient to meet the needs of residents. Inspectors checked the staff rota and found that it was maintained with all staff that work in the centre rostered and identified. Annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement.
The inspector observed staff and residents interactions and found that staff were respectful patient and attentive to residents needs. It was noted that staff provided reassurance to residents by delivering care to them in a quiet confident manner.

Training for all staff in areas of practice which require mandatory training such as fire safety, moving and handling and prevention of elder abuse were found to be delivered, further training was noted to be provided in areas of clinical practice such as medication management, infection prevention and control dysphagia and first aid. A training plan for 2014 was also in place.

A sample of staff files were reviewed and found that the requirements of Schedule 2 were met. It was found that all the requirements were met and evidence of robust recruitment practices such as three references, qualifications and evidence of medical/physical fitness were available on all records reviewed.

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

**Report Compiled by:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Alzheimer Care Centre</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000113</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>05/02/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>28/02/2014</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with 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.

Outcome 04: Records and documentation to be kept at a designated centre

Theme: Leadership, Governance and Management

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

Improvements were required in respect of maintaining clinical records in accordance with professional standards and the regulations in terms of their accuracy and completeness.

Action Required:
Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Please state the actions you have taken or are planning to take:
PIC will endeavour care plan improvements to reflect the care delivered to the residents. PIC will ensure that Clinical assessments and evaluations will give a clear and accurate picture of the resident’s overall health and condition through a fortnightly care plan audit and ensuring that deficiencies will be rectified immediately following the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
audit. PIC will also continue to have care plan workshops to support and guide staff on ensuring a person centered care plan is in place and up to standard. Any variation in the medication records will also be highlighted in the monthly medication audit and will be reverted back to staff on the monthly staff meeting.

**Proposed Timescale:** 30/06/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all the policies and procedures in place were sufficiently specific to guide staff, reflected current evidence based practice or the requirements of the Regulations, specifically, the prevention of elder abuse policy, medication management policy, possessions and restraint policies and require to be reviewed.

**Action Required:**

Under Regulation 27 (2) you are required to: 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.

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

Elder Abuse policy has now been updated to reflect sufficient guidance on how staff should manage an allegation of abuse against a senior member of the management team. Staff have been asked to read and sign the policy folder once they have read and understood the policy. Elder Abuse training is due again on the 4th, 5th and 6th of March and the update on the policy will be discussed. A copy of the policy will be sent to the Authority with this report.

The Medication Management Policy has been updated to guide staff on the appropriate time frames within which medication should be administered to match the prescription times. A copy of the policy will be sent to the Authority with this report.

The Resident’s Property policy have been updated. A draft copy was in place at time of the inspection which has now been signed off. The policy reflects the need to maintain an up to date record of the resident’s possession. A Resident’s possession register in each of the wardrobes has now been implemented for each individual resident and this will be checked on a monthly basis by the staff. A copy of the policy will be sent to the Authority with this report.

The Restraint Policy has not been changed however, there is now an ongoing individual assessment for the use of bedrails. This was communicated to staff and CNM’s at the monthly staff meeting. Residents families are also being advised, however this has been met by a number of families negatively and they do not wish the removal of the bed rails. The restraint assessments and bedrail assessments however has now been modified and updated to reflect thorough assessments. We will continue to liaise with families who have great concerns about the safety of their relative.
### Outcome 07: Health and Safety and Risk Management

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The policies and procedures in place in relation to restraint were not being consistently implemented throughout the centre.

**Action Required:**

Under Regulation 31 (1) you are required to: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

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

The Restraint Policy has not been changed however, there is now an ongoing individual assessments for the use of bedrails. This was communicated to staff and CNM’s on the monthly staff meeting. The restraint assessments and bedrail assessments however has now been modified and updated following the inspection to reflect thorough assessments including safe dimensional limits. The safe positioning of the independently attached bedrail will be checked every night to ensure safety of the residents.

Manual Handling refresher courses were in place in February and a full day Manual Handling Trainings will commence in April. Following the need to follow evidence based practice, 2 more Manual Handling Instructors have been appointed for continuous review of practices within the Home.

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### Proposed Timescale: 30/06/2014

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Moving and handling practices observed were not in line with current evidence-based practice.

**Action Required:**

Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

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

Manual Handling refresher courses were in place in February and a full day Manual Handling Trainings will commence in April. Following the need to follow evidence based practice, 2 more Manual Handling Instructors have been appointed for continuous review of practices within the Home.
### Outcome 08: Medication Management

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Variances were found in relation to the prescription template time of prescribed medication, the template for administration time, the actual time recorded and actual time medication was administered.

**Action Required:**
Under Regulation 33 (1) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Following HIQA inspection, all cardexes and murs sheet were audited by the PIC and pharmacy to highlight variances found and was rectified immediately. All staff nurses are made aware of this at the staff meeting and are encouraged to be more vigilant. Staff nurses are encouraged to check and refresh on the ABA guidelines on medication management. The Medication Management Policy has been updated to guide staff on the appropriate time frames within which medication should be administered to match the prescription times. A copy of the policy will be sent to the Authority.

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

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The systems in place did not include a clear analysis of the outcomes of the audits to ensure a continuous quality improvement which includes trend identification and actions taken to improve the quality and safety of care delivered to residents.

**Action Required:**
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

**Please state the actions you have taken or are planning to take:**
Monthly audits will now be graphed for easy analysis and identify improvements needed. This will be communicated to staff on the staff meetings and will also be discussed in the committee meetings. A time frame for follow up and resolution will be
The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Restraints such as bed rails were found to be in use for a number of residents. The documentation referencing the need for restraint did not always identify whether the restraint used was suitable for the residents needs without restricting the resident unnecessarily. Risk assessments that determined that the intervention was in the best interests of the resident, was the least restrictive solution and was being put in place as previous less restrictive interventions had failed had not been completed.

Action Required:
Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

Please state the actions you have taken or are planning to take:
An on going care plan workshop will commence from the 11th of March with the PIC to guide staff on revising and linking assessments to the resident’s care plan to ensure that it will reflect in the resident’s changing health. The care plan workshop will include consistency on the clinical documentation and improve on the problem identified against the intervention planned which will give a thorough reflection of the resident’s overall health status.

The Restraint Policy has not been changed however, there is now an ongoing individual assessments for the use of bedrails. This was communicated to staff and CNM’s on the monthly staff meeting. The restraint assessments and bedrail assessments however has now been modified and updated to reflect thorough assessments.

Less Restrictive interventions like low beds and crash mattresses will be trialled as the individual assessments are on going and will be reflected in the individual care plans.

Deficiencies such as shower trolleys has been addressed. This is to ensure that residents who are immobile and are deemed to be maximum dependent are cared for with their personal needs in an individual and holistic manner.

Residents who are identified to need more bed rest will be assessed for their appropriateness and the rationale for such need will be reflected in their care plans and will be reviewed on a three monthly basis or if resident’s condition changes.

Proposed Timescale: 30/06/2014
**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An evaluation of the suitability or appropriateness of those residents requiring 24 hour bed rest had not been made.

**Action Required:**
Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.

**Please state the actions you have taken or are planning to take:**
PIC will continue care plan improvements to reflect the care delivered to the residents. PIC will ensure that Clinical assessments and evaluations will give a clear and accurate picture of the resident’s overall health and condition.

**Proposed Timescale:** 13/03/2014

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**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Risk assessments and care plans were not always linked or revised in all instances to determine their effectiveness and care plans were not always reviewed in response to changes in residents’ health.

**Action Required:**
Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

**Please state the actions you have taken or are planning to take:**
PIC will endeavour care plan improvements to reflect the care delivered to the residents. PIC will ensure that Clinical assessments and evaluations will give a clear and accurate picture of the resident’s overall health and condition. Care Plan reviews will be dependent on the changing need of the residents.

**Proposed Timescale:** 13/03/2014

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**Outcome 12: 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 aspects of the centre was not entirely suitable for the stated purpose and function. These deficiencies relate principally to the limitations of physical
space in the multi-occupancy rooms, lack of adequate toilet and shower facilities and communal space. A costed and timeframed management plan is required to address these deficiencies by July 2015. Such plan should also address provision of appropriate equipment required to ensure all residents’ needs are fully met.

**Action Required:**
Under Regulation 19 (1) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Highfield Healthcare is completing revised plans in relation to one of its existing building Ryall built in 2002 which accommodates thirty two maximum dependency residents who are diagnosed with end stage dementia in order to achieve compliance with the environmental standards. These plans consider the option of extension or full replacement of this facility. This work is nearing completion for this facility and a detailed plan is being drawn by Highfield Healthcare which includes costing and implementation plan. It should be noted that the Alzheimer Care Centre is 154 bedded facilities and that the remaining 122 are all single room in compliance with the latest standards.

Deficiencies such as shower trolleys and crash mattresses has been addressed. Highfield Healthcare will also purchase few more low beds to ensure that resident’s needs are met.

**Proposed Timescale:** 30/09/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Structural improvements to the physical environment of the pre-existing Ryall unit continues to be required to meet all of the challenges posed by the limitations of the current environment to meet all resident's needs such as a lack of adequate private, communal and recreational and showers and toilet facilities.

**Action Required:**
Under Regulation 19 (3) (a) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Highfield Healthcare is completing revised plans in relation to one of its existing building Ryall built in 2002 which accommodates thirty two maximum dependency residents who are diagnosed with end stage dementia in order to achieve compliance with the environmental standards. These plans consider the option of extension or full replacement of this facility. This work is nearing completion for this facility and a detailed plan is being drawn by Highfield Healthcare which includes costing and
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout and design of the multi-occupancy rooms continue to pose difficulties to provide for resident's individual and collective needs on a daily basis and sufficient alternative communal areas to provide areas of diversional interest were not available.

Action Required:
Under Regulation 19 (3) (e) part 1 you are required to: Provide adequate private and communal accommodation for residents.

Please state the actions you have taken or are planning to take:
Highfield Healthcare is completing revised plans in relation to one of its existing building Ryall built in 2002 which accommodates thirty two maximum dependency residents who are diagnosed with end stage dementia in order to achieve compliance with the environmental standards. These plans consider the option of extension or full replacement of this facility. This work is nearing completion for this facility and a detailed plan is being drawn by Highfield Healthcare which includes costing and implementation plan. It should be noted that the Alzheimer Care Centre is 154 bedded facilities and that the remaining 122 are all single room in compliance with the latest standards.

Proposed Timescale: 30/09/2014
Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The resident's personal space in the Ryall unit is not designed or laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort, privacy and dignity.

Action Required:
Under Regulation 19 (3) (f) you are required to: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Please state the actions you have taken or are planning to take:
Highfield Healthcare is completing revised plans in relation to one of its existing building Ryall built in 2002 which accommodates thirty two maximum dependency residents who are diagnosed with end stage dementia in order to achieve compliance with the
environmental standards. These plans consider the option of extension or full replacement of this facility. This work is nearing completion for this facility and a detailed plan is being drawn by Highfield Healthcare which includes costing and implementation plan. It should be noted that the Alzheimer Care Centre is 154 bedded facilities and that the remaining 122 are all single room in compliance with the latest standards.

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<th>Proposed Timescale: 30/09/2014</th>
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**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Provide such equipment as is necessary to meet all residents needs. Address deficiencies such as the lack of sufficient equipment such as alternatives to the use of restraint and provision of suitable equipment to ensure residents personal care needs are met for example provision of shower trolleys.

**Action Required:**
Under Regulation 19 (3) (n) you are required to: Make suitable adaptations, and provide such support, equipment and facilities, including passenger lifts for residents, as may be required.

**Please state the actions you have taken or are planning to take:**
Deficiencies such as crash mattresses and shower trolleys has been addressed to ensure that resident’s personal care needs are met in an individual and holistic manner.

Higfield Healthcare will also purchase few more low beds to ensure that resident’s needs are met.

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<th>Proposed Timescale: 30/06/2014</th>
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**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As previously stated the design and layout of the physical environment in the Ryall unit was not suitable to ensure the needs of all residents were met in a manner that ensures their safety and respects their privacy and dignity.

Only four toilets and three shower/baths were available to meet the needs of 32 maximum dependency residents. All of the toilet/shower/bath facilities on the unit were combined thereby limiting access to residents.

**Action Required:**
Under Regulation 19 (3) (j) part 1 you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Highfield Healthcare is completing revised plans in relation to one of its existing building Ryall built in 2002 which accommodates thirty two maximum dependency residents who are diagnosed with end stage dementia in order to achieve compliance with the environmental standards. These plans consider the option of extension or full replacement of this facility. This work is nearing completion for this facility and a detailed plan is being drawn by Highfield Healthcare which includes costing and implementation plan. It should be noted that the Alzheimer Care Centre is 154 bedded facilities and that the remaining 122 are all single room in compliance with the latest standards.

**Proposed Timescale:** 30/09/2014

<table>
<thead>
<tr>
<th>Outcome 13: Complaints procedures</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
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<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
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<tr>
<td>A record of the satisfaction of the complainant was not maintained.</td>
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<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 39 (7) you are required to: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>A quarterly audit of the Complaints register will now be in place. This will help ascertain the satisfaction and provide room for review of the complainant. The audit will also help identify trends and improve practice. Complaints are now being discussed as well at the Risk Management Meeting for best practice.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 13/03/2014</td>
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<tr>
<th>Outcome 14: End of Life Care</th>
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<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
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<tr>
<td>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>All residents do not have a choice as to the place of death, including the option of a single room.</td>
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</tbody>
</table>
**Action Required:**
Under Regulation 14 (2) (d) you are required to: Identify and facilitate each residents choice as to the place of death, including the option of a single room or returning home.

**Please state the actions you have taken or are planning to take:**
126 residents have single rooms which allows them this privacy however in the Ryall unit this is not always possible. In so far as is able residents requiring end of life care will be facilitated in a vacant single room within the Alzheimer Care Centre and where this is not possible all consideration will be given to the resident and other residents and families.

A visitor / relative chair is available for families who wishes to spend the night with their resident.

**Proposed Timescale:** 30/06/2016

**Outcome 17: Residents clothing and personal property and possessions**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A record of residents personal possessions was not in place or had not been updated for all residents.

**Action Required:**
Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

**Please state the actions you have taken or are planning to take:**
The Resident’s Property policy has been updated. A draft copy was in place at time of the inspection which has now been signed off. The policy has now reflected the need to maintain an up to date record of the resident’s possession. A Resident’s possession register in each of the wardrobe has now been implemented for each individual residents and this will be checked on a monthly basis by the staff. A copy of the policy will be sent to the Authority.

**Proposed Timescale:** 13/03/2014