<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Adare House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000001</td>
</tr>
<tr>
<td>Centre address:</td>
<td>4/5 Tivoli Terrace South, Dun Laoghaire, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 280 1345</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:breegemuldowney@hotmail.com">breegemuldowney@hotmail.com</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>Adare Nursing Home Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>26</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 03 May 2018 10:30
To: 03 May 2018 17:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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Summary of findings from this inspection
This inspection report sets out the findings of a dementia thematic inspection which focused on six specific outcomes of care and welfare.

The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspector followed up on the findings from the last inspection carried out on 12 December 2016 and considered notifications submitted and unsolicited information received by the Health Information and Quality Authority (HIQA) since the last inspection. The actions plan response from the previous inspection had been completed and was being progressed within the timeframe specified.

The centre did not have a dementia specific unit and at the time of inspection nine of the 26 residents had a formal diagnosis of dementia. Prior to the inspection the
The provider had submitted a completed self-assessment questionnaire on dementia care in their centre along with schedule 5 policies requested. The provider had assessed the centre as compliant in the outcomes examined within the self-assessment.

The inspector focused on the experience of residents with dementia and met with management, staff, residents and relatives to assist in the inspection process. Practices and interactions between staff and residents were observed and discussed with staff and residents. The journey of a number of residents with dementia and their access to health and social care was tracked. Documentation such as clinical assessments, care plans, medical and allied health care reports, medication, complaints and property was reviewed. Staff rostering, training, meetings and recruitment records were also reviewed.

The centre provided a service for up to 27 residents accommodated over three floors. The centre offered respite and long-term care and a contract of care was completed with the terms and conditions of their stay.

The inspector spoke with all residents, either individually or in groups. They were positive about the centre and the staff team. Relatives of four residents spoke with the inspector and were also very complimentary of the care services provided and support available from the staff team. Residents confirmed to the inspector they felt safe, were respected and consulted with and could choose how they spent their day. There were systems in place to support residents making choices and decisions about them. Opportunities to provide feedback, comment on the service or complain were available, known and advertised.

The layout of the premises and practices of staff supported residents’ privacy and dignity, and encouraged social engagement and furnished akin to a domestic house. Plans to extend and improve the premises were described as being progressed since the previous inspection.

Staff were heard offering residents the choice to join others for meals and to attend activities. Staff also respected residents’ choice to refuse to join others and in treatment plans recommended. Mostly positive person centred care was observed.

Staff were seen to work in a calm atmosphere and were friendly towards all residents and respectful towards them. A relevant programmed of staff training was delivered and on-going and the numbers and skill mix on the day of inspection was adequate.

Overall the centre has sustained a high level of compliance in the outcomes examined and is striving to improve the service it offers. The management team were responsive to address any issues raised by the inspector during the inspection.

An improvement required following this inspection related to ensuring all staff have completed Garda Vetting prior to their commencement on duty which is set out in the action plan for response. In addition, management agreed to follow up on the directional signage and assemble point seen advertised in the rear garden to ensure it was appropriate.
A summary of the findings from this inspection are discussed within the body of the report.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self-assessment tool (SAT) completed by the provider was rated as compliant in this outcome with no areas for improvement highlighted.

The inspector focused on the experience of residents with dementia. Residents’ journey prior to and from admission was examined. Specific aspects of care such as nutrition and weight monitoring, wound care, mobility, access to health care and supports, medication management, end of life care and maintenance of records was reviewed.

Arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge visited prospective residents prior to admission. This arrangement gave the resident and or their family an opportunity to meet in person, provide information and assess or determine if the services and centre could adequately meet the needs of the resident.

Systems were in place in relation to transfers and discharge of residents and hospital admissions. The files of residents examined had appropriate information about their health, medications and their needs in relation to activities of daily living and requirements.

The admission policy available was reflected in practice. Residents’ files examined held a copy of their hospital discharge or transfer letters documents that included a copy of the Common Summary Assessments (CSARS), which details assessments undertaken by allied health care professionals.

Residents had a comprehensive nursing assessment on admission which was subject to reviews. The assessment process involved the use of validated tools to assess each resident’s dependency level, risk of malnutrition, falls, skin integrity and their level of cognitive impairment.
Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to General Practitioners (GP), allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, dental, ophthalmology and podiatry services were facilitated on a referral basis. Residents had good access to mental health services upon referral.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Functional assessments were carried out prior to and on admission of residents. A care plan was developed following admission based on the residents identified and assessed needs. Arrangements were in place to evaluate existing care plans routinely on a four monthly basis or as changes occurred. Residents and or family, where appropriate, GPs, allied health care professionals and staff team were involved in the care planning process.

'End of life' care plans for residents outlined the physical, psychological and spiritual needs, including residents' preferences and expressed wishes. Access to a palliative care team was available upon a GP referral. Staff outlined how religious and cultural practices were facilitated within the centre. Religious services were held regularly and visiting ministers attended.

Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as pressure relieving mattresses and cushions. No residents had pressure ulcers. Two residents had chronic wounds that were subject to regular assessment and direction by a tissue viability specialist and consultant.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and reviews. Records and care plans were in available detailing residents' individual food preferences and the recommendations of dieticians where appropriate. A choice of meals was offered and available to residents. There was a system of communication between nursing and catering staff to support residents with special dietary requirements. Residents dined in rooms of their choice.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. A system was in place to highlight and communicate the risk rate to all staff and a care plan specific to the identified falls risk was in place and updated following any fall.

Residents had access to a pharmacy and a general practitioner (GP) of their choice. There were operational policies and procedures relating to the ordering, prescribing, storing and administration of medicines for residents. Arrangements were described that involved the pharmacist, GP and person in charge or deputy's participation in the review and management of medication.

Judgment:
**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
The self-assessment tool (SAT) completed by the provider for this outcome was rated compliant.

A safeguarding vulnerable adult’s policy referencing the National Policy ‘Safeguarding Vulnerable Persons at risk of Abuse’ (HSE, 2014) was in place that resembled the overall processes and procedures to be implemented.

Staff who spoke with the inspector confirmed they had completed relevant training and were knowledgeable about the various types of abuse, and were familiar with the reporting structures in place. Management demonstrated knowledge and responsibility to notify relevant Authorities or parties in accordance the policy. Training records indicated that the majority of staff had completed training on the prevention, detection and response to abuse and further training was planned and to be provided 9 May 2018 for new staff and refresh existing staff.

The staff team were well known to residents and their relatives visiting. Staff confirmed that there were opportunities to raising issues of concern which were addressed promptly. Systems and arrangements were in place for safeguarding resident’s finances and property. The action required on the previous inspection was addressed. A separate bank account had been set up for a resident whom the provider was a pension agent for.

A comprehensive policy entitled responding to and managing responsive behaviours was available. It defined responsive behaviours and included assessment protocols, pathways and guidelines for staff in the management of responsive behaviours. Training specific to dementia and responsive behaviours had been completed by staff and was being provided onsite during this unannounced inspection. Eight staff attended the training provided by an external facilitator. Staff were familiar with interventions required to promote a positive behavioural support to residents’ with responsive behaviours. Care plans were in place to direct care and promote a consistent approach to care.

A restraint policy and associated procedures in accordance with National policy were in place. Restraint was used as a last resort when alternative measures had failed. A restraint free environment was promoted. The use of bedrails by two residents was
reported and recorded. Risk assessments had been completed and records of decisions regarding the use of bedrails were available to show the decision was made in consultation with the resident or representative, and staff. Decisions were also reflected in the resident's care plan and subject to review.

The use of psychotropic medicines PRN (a medicine only taken as the need arises) was rarely used and all medicines were subject to regular reviews by nurses, a pharmacist and the resident's general practitioner (GP).

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
A comprehensive communication policy was in place that included information to promote communication with residents and relevant others. It provided good guidance for staff in relation to interventions to optimise meaningful communication for residents.

Arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day basis were described. Staff were allocated to care and support residents on a daily basis. Staff knew residents and their relatives well, and residents were familiar with the governance and management team, and staff members. Access to advocacy services was available and advertised.

Satisfaction surveys were completed annually to evaluate services and inform improvements. A structured resident forum was facilitated by the activity co-ordinator on a quarterly basis. Due to the size and layout of the centre all residents had opportunity to meet and discuss issues relating to the operation of the centre on a regular basis.

Arrangements were in place to promote residents' privacy and dignity, and many residents were supported to make personal choices and to be independent. There were opportunities for residents to participate in group or individual activities that suited their interests and abilities.

Facilitating the social needs of residents and engagement with their families was fundamental to the values of the centre. There was a variety of activities available to residents in the centre, organised by the activity and care staff. Throughout the inspection staff were observed delivering positive connective meaningful care and encouragement.

The quality of life for many residents in the centre was enhanced by their engagement
with visitors on a regular basis and by their participation in meaningful activities such as sonas, mass, games, gardening, and arts and crafts or by engagement with external entertainers and musicians. Residents expressed satisfaction with the activities and staff support available to them.

Outings and trips were arranged in accordance with residents' wishes and abilities. Trips in 2018 to a city centre theatre, the 'Gardai band' and garden parties were reported. Religious feast days and birthdays are celebrated. Open access to an enclosed garden where raised flower beds and plants that had been planted by residents interested in gardening.

Care staff supported by the activity staff member considered residents’ wishes when planning activities and events. The daily routine for some residents' was informed by their wishes and preferences communicated to staff. During the inspection mostly positive person centred care was observed during formal observation of interactions between staff and residents.

The communications policy aimed at optimising communications between the resident and relevant others. Residents had a clear communication plan in place, and the staff were seen to know each residents needs well. For example, their life experiences, relationships and those visiting and involved in their life.

Relatives were seen in the centre throughout the inspection. Relatives and residents confirmed they were free to receive and meet visitor at times that suited them. Staff were heard welcoming and greeting visitors on arrival. They offered residents and their visitors a choice of hot drinks while visiting. Relatives were complimentary of the care and service provided.

Functional aids such as a picture menu, photos, signage and the use of contrasting colours and devices were available to support effective communication for residents with dementia. Each resident had an individual TV in their bedroom and a large screen TV was in the main sitting room that had internet and app settings. There were newspapers, radios, DVDs, films, books and magazines available for residents to access if they choose. A portable phone and an Ipad (property of the centre) were also available to aid communication arrangements should residents request this.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The complaints procedure was prominently displayed in the reception area and was included in the resident’s information booklet and the statement of purpose.

Unsolicited information received by the authority since the last inspection highlighted issues of concern in relation to the contract of care, premises and supervision arrangements. The matters reported were communicated to the person in charge and management team who told the inspector that complaints of this nature had not been received. This was reflected in the complaints register maintained that included verbal and written complaints received.

The matters raised in the unsolicited information received were considered in the overall context of this thematic inspection and were not substantiated. The management team were to review the matters in the context of their on-going governance and management arrangements.

A complaint register was maintained. It included four complaints that were received by the complaints officer since the last inspection. Verbal and written complaints were logged and managed promptly using the complaints process to inform service improvements. Records showed the outcome and satisfaction of the complainant, as required.

**Judgment:**
Compliant

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
There was a clear organisational and management structure in place. All staff were familiar with the reporting relationships.

The person in charge and deputy were available for the supervision of staff and care, and oversight of the service delivered to residents.

There were a variety of meetings held in order to ensure that staff had appropriate knowledge of residents’ needs and outcomes. Staff handover meetings formed part of the daily practices at the change of shifts.

Recruitment procedures were in place. This process included induction and probationary periods for staff. Documentation in relation to staff working in the designated centre was maintained. Staff appraisal and performance management was undertaken annually. Samples of three staff members’ files were reviewed. While reviewing staff files, the inspector noted that a staff member had been employed for three weeks
before their Garda Vetting (GV) disclosure was completed. The risk was mitigated somewhat by the fact that the staff member was supervised during this period. The provider was required to review GV for all staff and provide written assurance that all staff had GV.

The inspector found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents' health and social care needs. Trained staff were observed implementing appropriate social and recreational activities to meet residents’ needs.

There was a planned staff roster in place. The staffing in place on the day of inspection was reflected in the roster. The inspector found that there were opportunities for staff to participate in education and training relevant to their role and responsibility.

Staff had completed appropriate training. Mandatory training was in place and staff had received training in fire safety, moving and handling, Cardio pulmonary resuscitation, food safety and safeguarding vulnerable persons.

Training in dementia and responsive behaviour was being delivered onsite to eight staff during this inspection and further mandatory and relevant training was planned for staff to attend.

The staffing arrangements provided for the supervision of residents in communal rooms and staff who communicated with the inspector were knowledgeable of residents’ conditions, abilities, needs and preferences.

Volunteers were not in the centre at the time of the inspection.

**Judgment:**
Substantially Compliant

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

**Findings:**
The premises met the needs of the existing residents in its layout, and design. The design was homely and residents said they found it comfortable. The inspector followed up on the provider's response to the previous inspection report in relation to the premises that had a timescale of January 2019. The Inspector was told that an architect was engaged and planning permission was recently granted subject to objections. The progress and status of this plan to extend the centre is to be communicated to HIQA as it progresses.
Each resident had a single or twin bedroom some had an en-suite facilities as described in the previous inspection report December 2016. Bedrooms had been personalised to each individual's preference. Some bedrooms had personal and religious artefacts and family photographs, and signs were in place to support residents, including those with dementia, to find their way and to identify their bedroom.

The corridors also allowed for residents to walk unimpeded. Furniture was provided in each room, including a comfortable chair, bed-table, wardrobe and lockable drawer. Residents were able to bring additional items with them if they chose to. There was a call bell located by the bed and in the en-suite if they needed to call for assistance. Windows were generally large in size and provided good levels of natural light and views outside. There was overhead and bedside lighting for residents to use as they chose. Bathroom and toilet doors were a different colour to support residents to identify these rooms, there was also a clear number and if residents chose they could have their picture and name on the bedroom door also.

Two communal day spaces on the middle floor and the conservatory on a lower level were available for resident dining and lounging. They were decorated in a homely way and seating was arranged to provide different options, for example watching the television or looking out of the window. There was a range of seating available including comfy sofas, high backed chairs, and chairs with arms to support individual preference but also to take account of residents differing mobility needs. There were chair lifts to each level on one of internal stairwells. The inspector observed and staff said that only three of the current residents used the chair lift between levels and all other resident used the stairs independently or with staff assistance.

There was a visitor’s area and seating area in the reception areas that people were seen to be using. Visitors also used the conservatory to meet residents.

A programme of refurbishment and decorating was on-going and planned to commence 5 May 2018. A maintenance schedule was maintained to ensure issues to be addressed were logged, reported and completed. On the day of the inspection the centre was a comfortable temperature, well lit and ventilated. There were handrails on both sides of corridors and grab rails in the showers and bathrooms. Flooring was seen to be non slip and free from trip hazards. There were aids and adaptations available in the centre to meet the needs of the existing residents and sufficient storage to put them away when not in use.

The household team was seen to be working to ensure the centre well-maintained and clean throughout. Relatives and residents were satisfied with the laundry arrangements and care of their belongings.

There was a rear garden that was planted with flowers, had a range of seating and was accessible through unlocked doors from the lower level by the conservatory and smoke area. Residents accessed these areas as desired.

**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:

Sonia McCague
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

<table>
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<tr>
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<tr>
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<td>Date of inspection:</td>
<td>03/05/2018</td>
</tr>
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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 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 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A staff member had been employed for three weeks before their Garda Vetting (GV) disclosure was completed.

The management group agreed to review staff files and implement the centre's policy in future to ensure staff members complete Garda vetting prior to their commencement date.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The provider is to provide written assurance that all staff had GV.

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

**Please state the actions you have taken or are planning to take:**
Going forward all our new staff members will only commence work when their garda vetting disclosure has been completed. All garda vetting disclosures will be audited by management on regular basis.

**Proposed Timescale:** 18/05/2018