<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Marian House Alzheimer Unit</th>
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<tr>
<td>Centre ID:</td>
<td>0358</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Main Street</td>
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<tr>
<td></td>
<td>Ballindine</td>
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<tr>
<td></td>
<td>County Mayo</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>094-9364101</td>
</tr>
<tr>
<td>Fax number:</td>
<td>094-9364946</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:mhouserespite@eircom.net">mhouserespite@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>□ Private  ☒ Voluntary  □ Public</td>
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<tr>
<td>Registered provider:</td>
<td>John Grant</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Marian Navin</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>31 March 2010</td>
</tr>
<tr>
<td>Time inspection took place:</td>
<td>Start: 06:30 hrs  Completion: 18:00 hrs</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Bríd McGoldrick</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Damien Woods, Catherine Connolly Gargan</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>☒ Registration  □ Scheduled</td>
</tr>
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<td></td>
<td>☒ Announced  □ Unannounced</td>
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About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

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

Description of services and premises

Marian House Alzheimer Care Centre is a purpose-built single-storey building, providing care for up to 12 residents with a diagnosis of dementia or Alzheimer’s disease.

Care is provided on a respite basis for periods of one to two weeks and day care is provided for up to four residents on a daily basis.

Marian House consists of four single bedrooms and four double bedrooms, none of which have en suite toilets but all have hand washing facilities.

Residents have access to two communal toilets, one shower room and one assisted bathroom.

Additionally, there is a dining room with adjoining kitchenette, two separate communal seating areas, a nurses’ office, visitors’ room and a combined laundry / sluice area. There is also a small staff changing room.

There is ample car parking facilities for relatives, visitors and staff with a number of designated parking places for disabled people provided close to the main entrance.

The providers have applied for planning permission to construct a day care facility and administrative offices on the same site.

Location

Marian House is located on the Main Street of the village of Ballindine, County Mayo.

<table>
<thead>
<tr>
<th>Date centre was first established:</th>
<th>1999</th>
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<tr>
<td>Number of residents on the date of inspection</td>
<td>12 + 1 day care resident</td>
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<td>Number of vacancies on the date of inspection</td>
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<table>
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<th>Dependency level of current residents</th>
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<td>4</td>
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The providers are the Western Alzheimer’s Association Board of Directors (a registered charity, charity number 11416). John Grant, the Chief Executive Officer of the association, was nominated to represent the providers.

Marian Navin, the Person in Charge, reports directly to Ray McGreal, the Services Manager and is supported in her role by a deputy person in charge, staff nurses, care attendants, kitchen, laundry, household and maintenance staff.

<table>
<thead>
<tr>
<th>Staff designation</th>
<th>Person in Charge</th>
<th>Nurses</th>
<th>Care staff</th>
<th>Catering staff</th>
<th>Cleaning and laundry staff</th>
<th>Admin staff</th>
<th>Other staff</th>
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<td>1</td>
<td>4</td>
<td>1</td>
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* Maintenance person
Summary of findings from this inspection

This was an announced registration inspection of Marian House Alzheimer Unit. The provider had applied for registration under the Health Act 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 (as amended). An essential aspect of the registration process is the requirement that the provider satisfies the Chief Inspector of Social Services that he is fit to provide the service and that service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors met with residents, relatives, the provider, person in charge, deputy person in charge, staff nurses, carers, catering staff, cleaning staff and the chaplain who attends the centre. Documentation examined included fire safety records, health and safety documentation, operational policies and procedures, staff files, care plans, medical notes, medication and assessment records.

The provider and person in charge completed fit person interviews during the inspection. Documents completed for the registration process were reviewed by the inspection team, these included the fit person self assessment document, key management staff profiles, statement of purpose, and other associated registration documentation.

The centre has good relationships with general practitioners (GPs) in the area and this enhanced the quality of care for residents.

A good corporate management structure is in place to support the person in charge and staff.

Residents and relatives expressed satisfaction with the care they received. They were appreciative of the efforts made by staff to maintain their quality of life.

A full review of the overall quality of care provided is urgently required to develop an ethos of promoting autonomy, choice, independence and an inclusive approach within a social model of care.

Significant concerns for the care and safety of residents, rights, privacy and dignity, risk management and management of behaviour that challenges were highlighted during the inspection. There were inadequate facilities, such as bathing or showering facilities, activities room and sluicing. An immediate action letter was issued to the provider on 01 April 2010.

The response submitted by the provider did not adequately address the issues outlined in the action plan and a subsequent meeting was held with him on 28 April 2010.

The provider is now working proactively to address the actions required to achieve compliance with the legislative requirements.
Improvements were also required in relation to staffing and the supervision of vulnerable residents.

Staff training in the areas of challenging behaviour and dementia care was needed to meet the needs of the current resident profile.

Required improvements are detailed in the Action Plan at the end of this report.

Comments by residents and relatives

During the inspection, the inspectors spoke to residents and they confirmed that they knew the staff and liked them. One lady said she was comfortable and felt happy. Another resident told inspectors while eating her lunch that she enjoyed the food provided and especially liked the ham she was eating.

Inspectors received 37 completed pre-inspection relatives’ questionnaires. The feedback from relatives was positive. They wrote that that the staff were kind and welcoming. Many wrote that they felt their relative was safe, happy and well cared for.

Inspectors also spoke to two relatives who were visiting. They commented on the ‘very friendly and attentive staff’. Another relative who was visiting her husband stated that ‘staff are very good and the person in charge is also good’ and that she enjoys the break when her husband is in respite care because “the care is so good” and “I know that he is well looked after”.

Areas identified for improvement by relatives included the care of residents clothing and the need for more activities. One resident commented on the need for larger windows, so residents who cannot walk around the centre can see outdoors. While some residents and relatives were involved in the development of the care plan for their relative, others reported that they were not consulted regarding the development of their relative's care plan.
Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

There was a clear management structure in place. Many of the residents knew the provider well and called him by name. A corporate management structure was in place to support and develop the service. A five year development plan was devised for the years 2006-2011.

The centre was managed by a suitably qualified and experienced registered nurse with established authority, accountability and responsibility for the provision of the service. She demonstrated knowledge of the National Quality Standards for Residential Care Settings for Older People in Ireland and was working towards their implementation.

Staff were able to describe to inspectors the reporting arrangements and lines of accountability. A senior nurse supported the person in charge. In the absence of the person in charge and senior nurse, the staff nurse on duty was responsible for the delivery of care.

Fire evacuation plans and evacuation notices were posted throughout the centre. Inspectors spoke with staff who were able to outline their responsibilities in the event of fire.

Inspectors read the maintenance records and confirmed that fire alarms and fire equipment were serviced regularly. In addition, staff completed a daily checklist called a ‘fire accountability checklist’ which noted the names of residents and staff on duty.

Residents’ records, care plans and personal information were stored in a safe and secure place. Residents’ medical and nursing files were locked in a cabinet at the nurses’ station.

There was a written directory of residents’ available, which was maintained, complete and up to date in accordance with legislative requirements.
The provider had valid insurance cover, which included indemnity for the property of residents up to €1,000.

**Some improvements required**

Knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) was not reflected in all areas of practice, for example with regard to risk management procedures.

Residents did not receive a contract of care on admission. The person in charge stated that this was because of the short nature of the admission and the “fast turnover of residents”. Residents stayed at the centre for one or two weeks at a time.

Inspectors reviewed the centre’s policy document on “Security of Residents’ monies, personal and financial affairs”. It said that at the ‘end of the respite stay families would submit full payment’. These monies were then stored in the safe in the centre until transferred to the Western Alzheimer's headquarters by the centre’s administration personnel.

The inspectors reviewed a copy of the statement of purpose and function. Although a copy was provided for each resident, all requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were not sufficiently documented. For example, the names of management staff, room size or the emergency procedures were not included.

There were inadequate procedures to manage risk or to assess emerging trends to improve the quality of life and safety of care for residents.

While the person in charge told the inspector that she carries out regular audits of complaints, accidents, incidents and near misses, the outcome of these audits were not documented. Routine audits of medication practices were not undertaken. While residents were assessed for the risk of falls and individual risk assessments were reviewed routinely, there was no collection of data through audit to ensure ongoing quality monitoring.

The person in charge informed inspectors that fire training was regularly provided for all staff. The person in charge monitored attendance and ensured all staff completed this training. However, a review of training records evidenced that 25 percent of staff had not attended fire training.

There was no missing person policy, photographic identification or profiles for each resident were not available. A drill had not been carried out to enable staff exercise the procedures to be followed in the event of a missing resident.

While there was a property list compiled on admission, it was not reviewed with residents or their representative at the time of discharge. As a result, a number of resident belongings were not always returned to them. For example, inspectors noted a number of rings kept in a box in the centre. During discussions with the night staff, inspectors were informed that these rings belonged to previous residents.
Significant improvements required

Risk management policies and procedures put in place did not adequately protect residents.

A comprehensive resuscitation policy was in place. However, evidence of full implementation of that policy was not found. For example appropriate and full documentation of the consultation process with families, the factors to be considered and dates of regular reviews were not documented for all residents.

While a health and safety statement was available, it had not been implemented to include a comprehensive identification and assessment of all risks throughout the building, with the provision of appropriate controls for risks identified. Additionally, near-misses were not documented and analysed as part of risk assessment procedures.

There was no visitors log and no system in place to monitor the movement of persons in and out of the centre, which could impact negatively on the safety and security of residents.

Notifications of incidents were not submitted to the Chief Inspector of Social Services as required by legislation.

In the event of an emergency, all persons in the centre were not facilitated with an unobstructed escape through the designated fire exit doors. All exterior doors to the building were locked, the keys were held by the nurse in charge. There was no equipment available to evacuate dependent residents. Furthermore, there was no individual assessment of residents as to how they would be evacuated if there was an incident or a fire.

External doors were all locked with no bell or knocker in situ. Inspectors had to telephone the centre and visitors were observed looking through a number of windows in the communal areas and knocking on these windows to attract the attention of staff in order to gain access. An assessment of the impact of this practice on the privacy and dignity of residents had not been assessed.

The major emergency policy was not centre-specific as it referenced a lift (this is a one storey building). The plan did not specify a designated person within the management structure to contact in the event of all emergencies. Various defined emergencies were identified yet there was no clear procedure outlined to indicate where residents would be accommodated in the event of evacuation.

The range of policies, procedures and guidelines available did not meet the criteria set out in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

There was no documented procedure to assist with determining staffing levels to reflect the assessed needs of residents and the size and layout of the centre. Inspectors found that the current staffing mix and levels at night did not ensure the
safety of residents. There was one nurse and two care assistants on duty. Inspectors observed night attendant staff showering residents in the early morning and then going to the kitchen to prepare the breakfast before they finished their shift.

The provider and person in charge confirmed that they depended heavily on the use of Closed Circuit Television monitoring (CCTV) in residents’ bedrooms to assist them with preventing residents from falling.
2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Throughout the provision of person care, the privacy and dignity of residents was maintained. Respect for the privacy and confidentiality of written and verbal information regarding residents was observed by inspectors.

Throughout the day, nutritional drink supplements and juices were distributed to the residents. Inspectors noted that all residents looked well hydrated.

There was a positive approach towards visitors coming to the centre, and on the day of the inspection there were several relatives present. The visitors were warmly received by staff who were familiar with them.

A chaplain was available to provide spiritual support to residents, he was observed spending time with residents and their relatives on an individual basis. The chaplain celebrated mass and all residents were observed to be engaged during the entire period of time mass was in progress. Most joined in the prayers and hymns. Large print hymn sheets were distributed to encourage participation. All residents attended mass and all staff stayed with them providing assistance where required. One resident said it was the highlight of her stay in the centre.

Staff were very patient with residents while they ate, they assisted where required but took advantage of moments of good concentration by residents who prompted or gave staff cues of a desire to feed themselves. This encouraged independence and self esteem.

Access to the kitchen was via a half door which enabled residents see into the kitchen and smell the food cooking, and also prevented unauthorised access by vulnerable residents or others. Residents said they knew dinner was ready by the smell of food circulating through the centre. Modified consistency diets were arranged in individual portions.

The kitchen was spacious, clean and bright. It was well equipped and was well-stocked with fresh and frozen vegetables, fresh fruit, bread, milk and meats.
The chef kept records of the dietary requirements of each resident, and these were updated regularly.

A corridor to the front of the building also functions as a sunny seated area, where residents were observed sitting with their families. Residents spoken with said they loved this area to relax in.

### Some improvements required

The person in charge outlined the activity programme which includes bingo, Sonas (multi-sensory programme), music and exercise therapy.

Inspectors observed an exercise therapy session taking place. However, inspectors observed that the activities provided for residents were limited. They also noted that some residents were sitting without any meaningful engagement for prolonged periods of time.

There was a detailed complaints policy that outlined the principles of good complaints management and a flow chart that summarised the varied steps to be taken from the time a complaint was made to resolution. The person in charge was the nominated person to deal with all complaints. However, another person had not been identified to ensure complaints were appropriately responded to and that a record of all complaints was maintained in accordance with legislation. Staff did not have access to training on the management and handling of complaints.

### Significant improvements required

Inspectors read the policy on abuse and the policy statement on ‘protected disclosures’ which supported staff to disclose any concerns they may have had regarding resident safety. However, all staff had not received training in the protection of vulnerable adults. The provider, person in charge and staff did not have good knowledge of their own policy and did not understand fully their role in responding to episodes of challenging behaviour which involved an assault of one resident by another.

One resident who had episodes of challenging behaviour had physically assaulted another resident; this incident had not been notified to the Authority as required by regulation. Staff did not recognise that the outcome of the episode of challenging behaviour of a resident constituted abuse of another resident. Residents were not adequately protected from the potential risks of such further episodes, as the resident concerned was not referred for appropriate medical assessment or on-going behaviour management.

The inspectors reviewed the policy on the management of challenging behaviour. It did not guide staff on how to protect residents when they have been exposed to or affected by aggressive incidents, nor on what actions to take to manage a resident whose aggressive physical behaviour had caused injury to another resident. Furthermore, the document did not outline contemporary based practice in the management of behaviour that challenges.
Staff training records confirmed that staff did not have access to contemporary evidence-based training on the management of a resident who has behaviour that challenges.

The daily routine and care practices impacted negatively on residents’ quality of life. Residents’ autonomy and choice was not reflected in their daily routines. Care staff were observed cutting up residents’ food while standing over the resident, and residents were not offered a choice for lunch, everyone had ham. Lunches were served plated with the ham already diced in some cases. Sauce was poured over residents’ meal without the residents being asked if they wished to have sauce.

Daily routine and care practices observed did not enable independence or promote person-centred care. The use of CCTV in residents’ bedrooms impinged on their privacy and dignity. The doors of the centre were locked and residents could not exit the centre or the enclosed yard at the side of the building which was identified as being for their use, unless supervised by staff.

There was a risk management policy but this was not specific to the centre. It described the maintenance of a risk register but this was not in place and it did not detail the full range of relevant risk factors.

The use of bedrails was not fully documented and bedrails were not regarded by the provider as a form of restraint. The use of other options to maintain safety before the decision to use this restraint measure was not evident in documentation reviewed. The risk assessment tool did not adequately describe the need for restraint, the type of restraint that was most appropriate or the review / monitoring system in place to ensure that restraint was only used in exceptional circumstances, monitored carefully and not used for prolonged periods.

The laundry service did not promote residents’ dignity as some of the clothing was not marked and was lost as a result.

Contemporary evidence-based dementia care research and recommendations were not reflected in the residents' bedrooms, they were not personalised and bed linen and curtains were all the same colour and design. Staff made reference to some residents not recognising their rooms.

While preliminary plans were in place to set up a residents’ committee, no meetings had taken place. An external advocacy service was not available to residents to assist them to communicate their views or make a complaint.

There was no information to support or encourage residents’ input in the running of the centre although relatives and main carers (friends) communicated their total satisfaction with the service. There were no documented efforts made to obtain feedback from residents on their satisfaction with the quality and suitability of this service in meeting their needs.
3. Healthcare needs

Outcome: Residents’ healthcare needs are met.

Healthcare is integral to meeting individual’s needs. It requires that residents’ health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

All residents had a care plan, which were up-to-date and reflective of the residents’ assessed needs. All care plans were reviewed on each admission or readmission which was documented. Inspectors reviewed the care plans for four residents. Nurses used a range of recognised assessment tools to plan the care provided to these residents, including falls risk assessments, nutrition, pressure sore and dependency level assessments.

The assessments and the care plans had been reviewed regularly, at least every three months, and more often when required. A falls risk assessment identified actions for each low, medium and high score.

The person in charge and nursing staff had put in place a system for identifying the dependency levels of residents and were able to tell inspectors the dependency of each resident.

Inspectors found that healthcare observations were carried out by nursing staff. Records viewed by inspectors showed that residents’ individual weights and vital signs were monitored and there was a proactive approach to the recording and monitoring of food and fluid intake.

Medical services were provided by a team of local general practitioners (GPs). Residents were encouraged to retain their own GP following admission. GPs visited the centre and reviewed the residents as required. An out of hours doctor service was also available when required.

Staff were present in communal areas and were seen to react promptly when call bells were activated.

Staff confirmed that residents have access to chiropody and a fee is charged for this service.
Residents had a comprehensive profile in their file which was completed by their main carer. However, these were not updated to keep pace with new developments or symptoms exhibited.

Admission policies and procedures for emergency admission were inadequate. Staff told inspectors that on many occasions they were aware that the residents coming in the centre had deteriorating mental health, due to their underlying diagnosis with associated adverse symptoms. However, treatment of serious instances of challenging behaviour focused on the immediate medical management and did not initiate a request for review by the community mental health services to support quality of life.

Investigation results, changes in treatment and review dates were not clearly documented in care plans. For example, a resident with a wound infection did not have sufficient information documented to enable staff to provide continuity of care.

A resident with documented incontinence did not have a continence assessment in line with contemporary evidence-based practice. Staff training records confirmed that they did not have access to training in this area.

Whilst there were procedures in place to notify the coroner of all residents’ deaths, there was no documented procedure for staff to follow in relation to the verification of death ensuring that best practice standards are adhered to.

Care plans focused on physical nursing problems and evaluations of care were also noted to be focused on the physical aspects of the person. Relatives and main carers were not involved in the development or review of the care plans.

The medication management policy did not include a procedure for disposal of used medication, responding to and reporting of medication errors and conducting an audit of medication practices.

There was no evidence of monitoring, review or ongoing audit to ensure the quality and safety of care. A procedure for recording, reporting and analysing medication errors had not been implemented.

The wound management policy did not meet current evidence-based practice. The risk assessment tool for wound care did not reference actions to take reflecting the degree of risk identified. As a result, wound assessment was inconsistently documented and appropriate contemporary evidenced-based treatment options were not implemented.

Some episodes of challenging behaviour were described to the inspector, and these were being monitored and well managed, according to staff. However, the inspector noted that the care records did not reflect the range of behaviours exhibited or the
difficulties that staff were encountering. The support of the specialist mental health services, while good when in place, was in some instances not promptly available to ensure comfort and appropriate interventions for residents. Supplementary assessments and advice was not available to residents and staff through regular visits by the community psychiatric nurse.

An emergency plan was not available to respond to medical or other emergencies which would necessitate an immediate response in order to ensure the care, safety and welfare of residents. The person in charge informed inspectors that not all staff had been trained in basic life support, although training was scheduled for June 2010. An evaluation of the adequacy of emergency equipment had not been carried out. Inspectors noted that the centre did not have a suction machine readily available in the event of a resident choking, as some residents had swallowing difficulties. There was no documentary evidence of discussion with residents or their representative with regard to end of life wishes, although the person in charge stated that this discussion had taken place.

**Minor issues to be addressed**

The pre-admission process was not robust. The provider did not have policies or arrangements to undertake a full assessment of all prospective residents before admission to avoid inappropriate placements.

While the person in charge told inspectors that she would speak to relatives prior to admission to determine the residents needs, all prospective residents were not assessed prior to admission.
4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents’ individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

A range of assistive equipment and fittings were provided to meet the needs of residents, including grab rails in all corridors and bathroom areas, hoists and wheelchairs. All rooms had a call bell.

The provider ensured that assistive equipment and all other equipment was kept in good working order and serviced regularly. Inspectors viewed the contracts for the servicing and maintenance of plumbing and electrics and all assistive equipment and found all to be up to date.

Hot water was tested by hand and found to be at a safe temperature.

The provider and person in charge had taken measures to control the risk of infection. Alcohol gel, gloves and aprons were available. A good level of cleanliness was maintained throughout the building. Staff were able to describe the measures they took to control the risk of infection to inspectors, such as the use of colour-coded mops and cleaning clothes for designated areas of the centre.

Some improvements required

There was no lockable storage available for residents to store personal belongings. The policy document “security of residents’ monies, property and financial affairs” states that lockable storage is not a practical solution when residents have cognitive impairment. There was no evidence of consultation or choice with residents, relatives or main carers (friends) on the matter.

Significant improvements required

The fenced area at the side of the building known as the secure garden was inadequate and could not be accessed easily and safely by residents. It was not secure and the fencing used was inappropriate and too high, as it was six feet tall. There was no evidence of the use of contemporary evidenced-based dementia care information / best practice on sensory therapy in this area, e.g., a sensory garden. There was no adequate external seating or shelter provided.
There was no cleaning room provided with a sink and wash hand basin for staff to wash cleaning equipment and store chemicals.

There were inadequate sluicing facilities, cleaning of bedpans and laundry was done in the same room. Bedpans were washed manually in a large bath in the absence of an automatic bedpan washing machine which is in line with contemporary evidence-based disinfection and infection control procedures.

The room where laundry was carried out was cluttered, contained many inappropriate items such as residents assistive equipment, was poorly laid out with a limited amount of worktop space and areas to segregate soiled laundry and store clean laundry. Infection control and prevention practices were compromised as residents’ freshly laundered clothing was stored in this dual purpose room before being distributed back to the residents. There was also a lack of suitable storage space for assistive devices, for example, assistive equipment used by residents.

Residents’ safety was compromised due to cleaning chemicals not being securely stored and hazardous areas were not locked. For example, the door to the hot press was unlocked, the sluice / laundry area was accessible and cupboards were not secured in this area, posing risk of the ingestion of hazardous chemicals to vulnerable residents. Inspectors saw cleaning chemicals being stored in an unlocked press in the sluice area.

Residents were not afforded adequate space to eat their meals comfortably. The dining space was crowded for the number of residents. A person receiving day care at the centre also joined the residents for lunch. Residents could not move freely around the dining room space which posed a risk of trip, fall and injury as a result. Staff also had difficulty manoeuvring between the residents.

There were insufficient independent and assisted toilet facilities to meet the needs of the twelve residents, and up to four day care residents. There were two toilets available, only one of which was suitable for residents with disability, located in the assisted shower room.

Two internally located twin bedrooms did not have access to external ventilation as the windows from both these rooms opened on to an internal corridor in the centre. There was no information to support completion of an assessment of the adequacy of ventilation or lighting in these rooms.

There was no door bell or knocker on the front door of the centre. A receptionist dealt with enquiries at the door and screened visitors during the week. However, there was no reasonable means of alerting staff to the presence of relatives or visitors at the front door wishing to access the centre other than knocking on windows or telephoning the reception out of hours. There was no shelter over the front door, while inspectors were waiting to access the centre they found that this area was cold and draughty for vulnerable residents who may be entering or exiting the centre.
5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents’ and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents’ privacy is respected.

Evidence of good practice

Families completed a fact sheet regarding the resident’s likes and dislikes and provided the centre with a comprehensive profile on their behalf prior to the first admission.

The person in charge and the services manager were actively involved in the management of the centre on a day to day basis. They reported a clear working relationship with the chief executive officer. Meetings took place monthly and more frequently if required.

The chief executive was in constant contact with the centre in relation to services and ongoing developments and funding.

The person in charge held meetings with staff on a monthly or bi-monthly basis and minutes were available for inspectors to view.

Residents had easy access to television and radio, and residents told inspectors that they could have their choice of newspaper if desired.

Residents’ records were stored securely, ensuring that confidentiality was maintained.

Inspectors observed many positive interactions between staff and residents. Staff successfully and respectfully communicated through their interactions with residents.

Some improvements required

There was no evidence of a quality review to examine if residents were satisfied with the menu provided or the choice offered, the activities schedule or daily routines provided. There was also lack of attention to environment in the provision of cues and aids for those with dementia.
Significant improvements required

A residents’ guide was available. The contents did not meet the requirements as outlined in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This document although called a ‘residents’ guide’ referred to relatives and / or main carers. This document was in small print and was not suitable for readers with cognitive needs.

Communication procedures were not robust. Residents receiving treatment such as wound care in the community did not have a documented process to enable staff provide continuity of care in the centre. Residents’ discharge summary information was given to the relative or main carer. However, the nature of this information on occasion would have required professional input to meet the residents’ medical needs. This practice compromised continuity of on-going community medical care.

While inspectors were informed by the person in charge that regular feedback was promoted and received from residents and carers, no records of these meetings were maintained.

Copies of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland were available in the centre. However, during discussion with inspectors, staff demonstrated only a limited understanding of the legislation and standards.

There was no communication policy, as required by the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended), to inform staff of effective ways to communicate with residents with cognitive deficits.

Inspectors concluded that staff required suitable training in understanding the communication difficulties of residents with dementia, to support and facilitate residents’ communication needs in an individualised manner.

There was insufficient communication aids available, such as talking mats. Although there were picture cues in some areas, all areas of the centre looked the same. All corridors were the same colour; doors to rooms were all the same. There was no sensory therapy area. Toilet and shower furniture was all white.
6. **Staff: the recruitment, supervision and competence of staff**

**Outcome: Staff are competent and recruited in sufficient numbers to meet residents’ needs**

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

**Evidence of good practice**

Staff were approachable and able to describe to inspectors their varied roles and duties and how they contributed to residents’ welfare. Staff said that there was a good team spirit and that they were well supported by the person in charge who was described as having an approachable management style. This team spirit and concern for each other was observed by the inspection team.

Inspectors were satisfied that the person in charge and the nursing staff were clear in their purpose and responsibilities. Nurses were clear about their supervisory responsibilities for care staff and inspectors observed continuous communication between care staff and nurses.

There was a detailed staff recruitment policy which outlined the principles of good recruitment practice and the steps taken by the providers when staff were being recruited for the service.

There was a record maintained of An Bord Altranais Professional Identification Numbers (PIN) for registered nurses. Thirty three care staff were employed, of whom nineteen had completed Further Education and Training Awards Council (FETAC) training level five and twelve had achieved level three.

Inspectors were told that agency staff were not used and when shortfalls occurred. Existing staff, particularly those who worked part-time, were able to do extra shifts. This arrangement was observed in the staff duty rota.

**Some improvements required**

The staff rota was reviewed by inspectors, which detailed the staffing complement on duty during the day and at night. However, a review of staff rotas indicated there was a number of staff who worked permanently on nights, which resulted in them working continuously without supervision. There was no separate planned and actual staff rota maintained. While the staff duty rota was planned a week in advance, a separate, actual copy was not maintained. The planned duty rota was written over in pen when changes occurred, which made it difficult to read.
There was no documented nursing on call arrangement to contact a senior staff member for advice or in an emergency. While contact numbers were available for the person in charge, no other senior staff member was rostered on the staff duty rota to ensure there was a nominated person in charge for each 24-hour period.

The staff facilities were inadequate to meet the needs of staff.

**Significant improvements required**

Inspectors observed poor moving and handling practices which impinged on residents’ safety. Staff training records indicated that not all staff had attended training in this area. Residents were not risk assessed to determine their moving and handling needs.

The sample of staff personnel files reviewed by inspectors did not contain all the information required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Three references, evidence of medical fitness and outcomes of Garda Síochána vetting were not available. However, the person in charge told inspectors that this information was being collated.

A training analysis had not been completed and a number of staff had not received contemporary evidence-based training to meet the current profile of residents. On review of staff training records, there was no evidence of training on the management of incontinence and constipation in residents’ with dementia or Alzheimer’s’ disease.

Other mandatory training requirements, such as elder abuse recognition and management, moving and handling and procedures for saving life such as cardiopulmonary resuscitation (CPR) training had not been completed by all staff.

The person in charge advised inspectors that she was in the process of reviewing individual staff performance needs and planned to request funding for training and staff development from the providers.

The induction process was not robust. There was no documented evidence of reviews during the probation period. There was no performance review to assess staff competence and fitness to meet the requirements of their role in this very vulnerable resident group.

The person in charge told inspectors that monthly assessment of dependencies was carried out and she had documentary evidence to support this. However, there was no linkage of the dependency levels to the changing needs of residents. Staffing arrangements did not take account of the complex cognitive, physical, psychological and social needs of residents with dementia.
Minor issues to be addressed

Staff wore uniforms which were not reflective of contemporary evidence based care principles of dementia care where the philosophy is underpinned by a social model of care in all respects.
Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider, person in charge and deputy manager to report on the inspectors’ findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

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

Report compiled by:

Bríd McGoldrick
Inspector Manager
Social Services Inspectorate
Health Information and Quality Authority

31 March 2010
**Provider's response to inspection report**

<table>
<thead>
<tr>
<th>Centre:</th>
<th>Marian House Alzheimer Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>0358</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>31 March 2010</td>
</tr>
<tr>
<td>Date of response:</td>
<td>5 August 2010</td>
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</table>

**Requirements**

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care settings for Older People in Ireland.*

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

   All reasonable measures were not taken to protect residents from abuse.

   **Action required:**
   
   Put in place protective measures for all admissions.

   **Action required:**
   
   Provide training to all management and staff working in the centre on what constitutes abuse of vulnerable persons.

   **Action required:**
   
   Provide a programme of training for staff that care for residents with dementia and challenging behaviour.
**Action required:**

Ensure that allegations of abuse are managed in accordance with regulations, best practice standards and local policies and procedures.

**Reference:**

Health Act, 2007  
Regulation 6: General Welfare and Protection  
Standard 8: Protection

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td><strong>Provider’s response:</strong>&lt;br&gt;(A) We have designed a new pre-admission form and sent it to all GPs in Galway, Mayo and Roscommon. We have encouraged all GPs to complete this form in detail and return it prior to admission to allow us to plan the best possible care plan during their stay in Marian House. It will allow us to put in place protective measures if necessary and aspects of their time in Marian House is comfortable safe and secure for everybody in the home. We will rely on this completed form to enable us to provide the best possible level of care. Prior to all new admissions we contact the public health nurse to find out all we can regarding the new person being admitted. We have always received a letter from the GP. We speak directly to the main carer / family member specifically regarding any aspects of behaviour that need special attention and record this in the persons care plan. &lt;br&gt;(B) As stated we have designed a new pre-admission form which asks the GP all the relevant questions. This form is one of the main sources of quality information that we work from in planning the person’s care. We see all the residents at a maximum level of dependency as all have Alzheimer’s / dementia and need constant care. We in Western Alzheimer’s have never refused anyone the care and respite that is always so badly needed by the sufferer and the main carer. &lt;br&gt;(C) Training on what constitutes abuse of vulnerable people was delivered for employees on 12 April 2010. &lt;br&gt;(D) Training was delivered for employees on ‘Challenging Behaviour’ for residents with dementia on 23 June 2010.</td>
<td>Complete</td>
</tr>
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</table>
2. The provider is failing to comply with a regulatory requirement in the following respect:

The registered provider did not ensure that risk management policy had controls in place to deal with assault, aggression, violence and accidental injury to residents and staff. There were no arrangements in place for the identification, recording, and investigation and learning from serious or untoward incidents or adverse events involving residents.

**Action required:**

Draft risk management policy in line with regulations and good practice.

**Action required:**

Provide a high standard of evidenced based nursing practice. Provide staff access to training on challenging behaviour pertinent to their role and responsibilities. Implement a competence assessment to ensure staff can demonstrate skills appropriate to their role to manage and respond to behaviour that is challenging. Furnish the inspection team with copy of competence assessment when complete.

**Action required:**

Put in place standardised assessment tool to assess behaviour that is challenging in line with contemporary evidence-based practice.

**Action required:**

Put in place a system for the identification, recording, and investigation and learning from serious or untoward incidents or adverse events involving residents who experience behavioural disturbances.

**Reference:**

- Health Act, 2007
- Regulation 31: Risk Management Procedures
- Regulation 6: General Welfare and Protection
- Standard 21: Responding to Behaviour that is Challenging

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

**Timescale:**
Provider’s response:

(A) A risk management policy has been developed.  

(B) All our nursing staff are qualified, competent and experienced. Our caring staff are qualified, competent and experienced. All employees have received training in challenging behaviour. We will complete a competence assessment form and to highlight skills and more importantly the competencies needed to care and respond to challenging behaviour.

(C) We are studying the ABC assessment tool to identify challenging behaviours and, if suitable, we will educate our staff.

(D) We are devising a system to identify, record and learn from any adverse events involving residents who may experience behavioural disturbances.

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<tr>
<td>Provider’s response:</td>
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<tr>
<td>(A) A risk management policy has been developed.</td>
<td>August 2010</td>
</tr>
<tr>
<td>(B) All our nursing staff are qualified, competent and experienced. Our caring staff are qualified, competent and experienced. All employees have received training in challenging behaviour. We will complete a competence assessment form and to highlight skills and more importantly the competencies needed to care and respond to challenging behaviour.</td>
<td>October 2010</td>
</tr>
<tr>
<td>(C) We are studying the ABC assessment tool to identify challenging behaviours and, if suitable, we will educate our staff.</td>
<td>October 2010</td>
</tr>
<tr>
<td>(D) We are devising a system to identify, record and learn from any adverse events involving residents who may experience behavioural disturbances.</td>
<td>November 2010</td>
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3. The provider has failed to comply with a regulatory requirement in the following respect:

The provider did not ensure that resident’s privacy and dignity were respected at all times. CCTV was in use 24 hours daily in resident bedrooms.

**Action required:**

The use of CCTV in resident private bedrooms shall cease.

**Action required:**

Put policy and procedure on CCTV usage taking cognisance of data protection legislation.

**Action required:**

Arrange for signage to be erected to advise all persons living, working and visiting the home that CCTV is in operation.

**Reference:**

Health Act, 2007  
Regulation 10: Residents’ Rights, Dignity and Consultation  
Standard 4: Privacy and Dignity

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

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<td>Please state the actions you have taken or are planning to take following the inspection with timescales:</td>
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<td>Timescale:</td>
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Provider’s response:

(A) The CCTV system is now turned off in all bedrooms.

Note: We carried out a survey with all the families of the residents that use Marian House and all without exception want the cameras in use in the bedrooms.

(B) We will put a policy in place to reflect the new restricted usage of our CCTV system.

(C) We will procure and erect signs in Marian House that inform all persons that CCTV is in operation.

We will adhere to the request to turn off the cameras in the bedrooms. But we are aware from the evidence received that the families would rather the cameras were left on in the bedrooms.

<table>
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<th>Complete</th>
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<tr>
<td>August 2010</td>
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4. The provider is failing to comply with a regulatory requirement in the following respect:

Adequate arrangements were not in place to ensure that all appropriate health care was facilitated and that each resident was supported to achieve the best possible health.

**Action required:**

Individual care plans to be devised for each resident to address their end of life wishes and to ensure sufficient care to maintain each resident’s welfare and wellbeing.

**Action required:**

Ensure all staff receives up to date training and assessment of competence in life saving procedures such as cardiopulmonary resuscitation techniques.

**Action required:**

Develop a policy for staff on how to respond to medical emergencies.

**Action required:**

Develop a protocol for the management of anaphylaxis.

**Reference:**

- Health Act, 2007
- Regulation 6: General Welfare and Protection
- Regulation 14: End of Life Care
- Regulation 31: Risk Management Procedures
- Standard 16: End of Life Care
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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tr>
<td>Provider’s response:</td>
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<tr>
<td>(A) We have a care plan for all of our Alzheimer’s patients that use Marian House. Because we are respite, we do not specifically include ‘end of life’ wishes as our experience is that this is not what relatives and carers want as it upsets them to think of their loved one approaching ‘end of life’. We do include this as part of our long stay home but not respite as the person may only be in the home for a day a week or at most two weeks.</td>
<td>Complete August 2010</td>
</tr>
<tr>
<td>(B) Training has been given on cardiopulmonary resuscitation.</td>
<td>December 2010</td>
</tr>
<tr>
<td>(C) We will develop a policy on how staff respond to medical emergencies.</td>
<td>December 2010</td>
</tr>
<tr>
<td>(D) We will develop a protocol for managing anaphylaxis.</td>
<td>December 2010</td>
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</table>

5. The provider has failed to comply with a regulatory requirement in the following respect:

Fire drills did not include regular simulated evacuation practices to ensure all staff can safety evacuate residents.

<table>
<thead>
<tr>
<th>Action required:</th>
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<tr>
<td>Implement fire drills to enable all staff to participate in an evacuation procedure.</td>
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<thead>
<tr>
<th>Action required:</th>
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<tr>
<td>Conduct an individual assessment of all residents and provide necessary equipment to safely evacuate them if there is a serious incident or a fire.</td>
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<th>Action required:</th>
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<tr>
<td>Put a visitor log in place to record visitors and others entering and exiting the centre.</td>
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<table>
<thead>
<tr>
<th>Reference:</th>
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<tr>
<td>Health Act, 2007</td>
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<tr>
<td>Regulation 32: Fire Precautions and Records</td>
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<tr>
<td>Regulation 6: General Welfare an Protection</td>
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<tr>
<td>Standard 26: Health and Safety</td>
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<tr>
<td>Please state the actions you have taken or are planning to take with timescales:</td>
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</tr>
<tr>
<td>Provider’s response:</td>
</tr>
<tr>
<td>(A) We have conducted internal fire drills. We plan to conduct a full scale evacuation procedure by end of September 2010.</td>
</tr>
<tr>
<td>(B) The individual assessment will have to be done at admission. As all of our residents are at maximum dependency and our home provides respite i.e. their stay in the home is always very short. <strong>Note:</strong> All beds are fitted with a fire blanket which is under the mattress on each bed. These blankets are fitted with handles for safe and prompt evacuation of residents.</td>
</tr>
<tr>
<td>(C) A visitors’ log will be placed in the outer entrance to the home.</td>
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</table>

6. The provider has failed to comply with a regulatory requirement in the following respect:

Assessment procedures were not adequately applied to address all challenging behaviours that staff were managing. The appropriate interventions were not sufficiently detailed in care records.

<table>
<thead>
<tr>
<th>Action required:</th>
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<tbody>
<tr>
<td>Provide staff with robust training in prevention strategies, recognition and management of challenging behaviour.</td>
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<th>Action required:</th>
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<tr>
<td>Specifically detail the responses of staff to effectively care for residents who present challenges.</td>
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<th>Action required:</th>
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<tbody>
<tr>
<td>Ensure the timely support of the specialist mental health services to ensure the comfort and well-being of the resident.</td>
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</table>

**Reference:**

- Health Act, 2007
- Regulation 9: Health Care
- Standard 13: Healthcare
- Standard 21: Responding to Behaviour that is Challenging
Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider's response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Already provided detailed training on challenging behaviour and we plan to arrange further in strategies to deal with behaviour that is challenging by December 2010. This training will take place in the Nursing and Midwifery Education Centre in Castlebar.</td>
</tr>
<tr>
<td>Timescale: December 2010</td>
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</tbody>
</table>

(B) The responses to challenging behaviour we in Marian House support are as follows: calm intervention via direct communication to the person while ensuring the safety of all other residents and staff. Stay (at a distance) with the person to diffuse or distract to get the person calm. At this point the GP may have to be informed. In extreme cases the local Gardaí will be called to the home.

(C) If the resident has been referred by specialist mental health services we work closely with this department in caring for the patient/resident. We communicate by phone regularly during the person’s short stay with us in Marian House.

Note: 75% of the people we care for are referred to us by the HSE.

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

No non-verbal communication system was in place. It was not possible to facilitate and encourage communication with residents who could not express themselves verbally.

**Action required:**

Devise an alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre.

**Action required:**

Provide communication aids to assist residents to express their wishes.

**Reference:**

Health Act, 2007
Regulation 11: Communication
Standard 2: Consultation and Participation
Standard 21: Responding to Behaviour that is Challenging
Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Our Sonas programme is a very good non-verbal tool we use to great effect. We have won two national awards for our implementation of this programme. We have also won a UK and Ireland award for the best plan.</td>
</tr>
<tr>
<td>November 2010</td>
</tr>
<tr>
<td>(B) Talking mats. Two of our activity coordinators will be attending a course on talking mats in Dublin on 13 October 2010. On successful completion of this course our activity coordinators will in turn train other staff members. This is provided it is suitable for our residents and there is a clear benefit to be gained.</td>
</tr>
</tbody>
</table>

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

The policy relating to residents’ personal possessions was not reflective of practices. Residents’ property lists had not been updated on an ongoing basis to reflect the management of personal belongings.

**Action required:**

Redraft the policy on managing residents’ personal property / finances to reflect current practices.

**Action required:**

Maintain an up to date property list in respect of each resident.

**Action required:**

Review current system of labelling clothes to ensure that residents clothing are identifiable and not lost.

**Reference:**

Health Act, 2007  
Regulation 7: Residents’ Personal Property and Possessions  
Regulation 13: Clothing  
Standard 9: The Resident’s Finances
Provider’s response:

(A) We will re-draft the policy on personal property / finances to include new tagging and sign out procedure. Family responsible. As a respite home and a registered charity we cannot afford the more expensive tagging system that long stay homes opt for. We will contact local suppliers to explore any new cost effective tagging systems that would suit our specific needs.

(B) Each resident has a new property list drawn up by a member of staff on each respite visit. This list will be signed off on discharge by relative / carer to ensure the resident is leaving the home with all of their personal belongings. Our respite residents do not bring valuables with them into the home as there is no need to as their time in the home is so short. Families are responsible for labelling of all clothes and other personal possessions.

(C) We are reviewing the current tagging system and as stated above we are seeking to procure a cost effective method that will meet the standard required.

(D) We intend to extend Marian House and provide extra laundry facilities. This is dependant on financial support from the HSE as we are a registered charity.

| 9. The provider has failed to comply with a regulatory requirement in the following respect: |
| Daily routines and care practices did not reflect residents’ autonomy and choice or allow for meaningful interaction and engagement. |
| Action required: |
| Review the daily routine and provide flexibility and variety to reflect residents’ autonomy and choice and where possible, suit residents previous interests and capacities. |
| Action required: |
| Ensure that care practices do not negatively impact on opportunities for residents to engage in meaningful and purposeful activities. |
| Reference: |
| Health Act, 2007 |
| Regulation 10: Residents’ Rights Dignity and Consultation |
| Standard 18: Routines and Expectations |
### Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>(A) We pride ourselves on our activity programme that continues throughout the day. We incorporate specific activities that highlight the past. We work very hard to involve each resident by knowing their personal history and interests. All of our activities include all religions / experiences and if a resident wants to opt out - they can. Our regime allows each resident space and time to come and go and sleep and rise when suits them best.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>(B) Our core ethos is to engage with the resident at all times even during daily routine duties. This is a practice we hold dear to us as we believe when dealing with dementia it is important to stay engaged with the resident at all times.</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

**Note:** We have invested / trained two full-time activity coordinators. Both have won two national awards.

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

The quality of residents’ life in the centre did not enable independence or promote a person-centred approach.

**Action required:**

Establish and maintain a system for reviewing the quality and safety of care and the quality of life of residents at regular intervals.

**Action required:**

Complete an evaluation and plan to address issues of communication, person-centred care, enablement, inclusion and involvement of residents and relatives or advocates in daily decision making and participation in their care and the organisation and delivery of services provided.

**Reference:**

- Health Act, 2007
- Regulation 35: Review of Quality and Safety of Care and the Quality of Life
- Standard 17: Autonomy and Independence
- Supplementary Criteria for Dementia Specific Residential Care Units for Older People
Please state the actions you have taken or are planning to take with timescales:

Provider’s response:

(A) We are establishing a forum to include a third party advocate and residents’ representatives / carers twice yearly to review the quality and safety of care and the overall quality of life of the resident. The first meeting of this forum is scheduled for Wednesday 28 September 2010 in the conference room in the head office in Ballindine.

(B) As a respite centre where the maximum stay would be two weeks we feel the best way to gather this information would be to send a specially designed questionnaire to include the following: communication, person-centred care, enablement, inclusion and the involvement of the families / carers in the delivery of their care.

Timescale:

- September 2010
- October 2010

11. The provider has failed to comply with a regulatory requirement in the following respect:

Failed to ensure that mealtimes were a social and engaging occasion. Residents were not informed of the menu or afforded a reasonable choice about their food. The dining room was crowded and residents could not move about freely.

Action required:

Facilitate residents to have a choice and to be informed of the menu on a daily basis.

Action required:

Conduct an assessment of the space available and comfort afforded to resident and staff assisting them in the dining room.

Reference:

- Health Act, 2007
- Regulation 20: Food and Nutrition
- Standard 19: Meals and Mealtimes

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

Provider’s response:

(A) We have a planned and printed weekly menu, however when dealing with dementia sufferers only a tiny minority of people would understand the menus and almost all would not be able to articulate

Timescale:

- Ongoing
their choice. We would always be guided by the main carer as to the likes and dislikes of the respite resident. The Dementia patient’s preferences are captured on the meals card which is filled in on admission for each respite resident and placed on menu board in the kitchen. This is being included to include beverages.

(B) Space is restricted to the existing dining room however we have received planning permission for an extension to Marian House and this includes making the dining room bigger.

<table>
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<tr>
<th>12. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>Not all staff were trained in moving and handling of residents.</td>
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</table>

**Action required:**

Ensure all staff are trained in safe moving and handling of residents.

**Action required:**

Carry out and document moving and handling risk assessments on all residents to ensure that their needs in this area are adequately and safely addressed.

**Reference:**

Health Act, 2007  
Regulation 31: Risk Management Procedures  
Standard 24: Training and Supervision

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

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<tbody>
<tr>
<td>(A) All staff are trained (with the exception of two employees) in the safe moving and handling of patients. These will receive the training on the next training session planned for Autumn this year. We are ensuring all staff receive training on this important topic.</td>
</tr>
<tr>
<td>(B) A new moving and handling assessment sheet is now being filled in and is informing staff on all aspects of moving and handling. It is monitored by staff (every two hours maximum) to ensure best practice.</td>
</tr>
</tbody>
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<tr>
<th>Timescale:</th>
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<tr>
<td>September 2010</td>
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<tr>
<td>September 2010</td>
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</table>
13. The provider is failing to comply with a regulatory requirement in the following respect:

The sluice room and laundry area was not safeguarded to prevent access by visitors and vulnerable residents.

Sluicing facilities were inadequate as the area designated as a sluice was in use as a storage area for soiled linen and cleaning equipment and there was no bedpan washer available.

Laundry facilities were not adequate.

**Action required:**

Ensure areas containing chemicals are secure and not accessible to vulnerable residents or visitors.

**Action required:**

Upgrade the premises to include necessary sluicing facilities as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Action required:**

Remove inappropriate items stored in the area designated as a sluice.

**Action required:**

Provide suitable laundry facilities with adequate worktop space to facilitate sorting, folding and ironing of residents clothing.

**Reference:**

Health Act, 2007
Regulation 19: Premises
Regulation 30: Health and Safety
Standard 25: Physical Environment
Standard 26: Health and Safety

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
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<tbody>
<tr>
<td>(A) Some chemicals are now locked in a cupboard in the sluice room and most are stored in our new storage shed outside the building at the rear. Furthermore, the sluice room itself has an added lock at the top of the door providing extra layer of security.</td>
</tr>
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<tr>
<th>Timescale:</th>
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<tbody>
<tr>
<td>Complete August 2010</td>
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</tbody>
</table>
(B) We have received planning for a new extension to Marian House and this will allow us to provide extra sluicing facilities as required by the Health Act 2007.

(C) We have removed all items that are not appropriate to be stored in the sluice room. *Note*: There are other items i.e. hoists and bed bath trolley stored in the sluice room until such time as we extend the existing building.

| Ongoing |

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

The risk management policy did not include a protocol for responding to a resident who goes missing.

A missing person description record was not completed to include a photographic identification.

**Action required:**

Revise risk management policy to include protocol for responding to a resident who goes missing.

**Action required:**

Put arrangements to have resident profiles for each resident for use if required.

**Action required:**

Missing person drills are to be undertaken on a routine basis to enable staff to become familiar with the procedure and to identify improvements to it where necessary.

**Action required:**

Revise emergency plan so that it is centre specific and provide staff training on the revised plan.

**Reference:**

- Health Act, 2007
- Regulation 31: Risk Management Procedures
- Standard 26: Health and Safety

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

<p>| Timescale: |</p>
<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>(A) We will revise the existing risk management policy to include a protocol for missing persons.</td>
<td>November 2010</td>
</tr>
<tr>
<td>(B) A detailed profile of each resident is contained in the resident chart. This information is also kept on computer.</td>
<td>August 2010</td>
</tr>
<tr>
<td>(C) We will conduct a missing drill and document the feedback by December 2010. We have never had an instance of a missing person.</td>
<td>December 2010</td>
</tr>
<tr>
<td>(D) We will review the emergency plan. We will amend to include all the necessary contact details of local voluntary groups that will assist in the safe implementation of the plan. We will have all the necessary negotiations concluded and agreed by December 2010.</td>
<td>December 2010</td>
</tr>
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<tr>
<th>15. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tr>
<td>The statement of purpose did not contain all the required information such as the size of the rooms, the professional registration and qualifications of the provider and person in charge.</td>
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<tr>
<th>Action required:</th>
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<tr>
<td>Outline a statement of purpose that includes all the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Reference:</th>
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</table>
| Health Act, 2007  
Regulation 5: Statement of Purpose  
Standard 28: Purpose and Function |

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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</thead>
</table>
| Provider’s response:  
We will update the statement of purpose to include all aspects of Schedule 1 of the Health Act 2007. All 17 elements will be included. | September 2010 |
16. The provider is failing to comply with a regulatory requirement in the following respect:

There was no documented process of audit in place to analyse for example incidents, falls, complaints clinical procedures and medication.

**Action required:**

Put in place a system for reviewing the quality of documentation to ensure the safety of care and the quality of life of residents.

**Action required:**

Draft a report in respect of these reviews and improvements and provide a copy of these reports within three months of receipt of this inspection report.

**Reference:**

Health Act, 2007  
Regulation 35: Review of Quality and Safety of Care and Quality of Life  
Standard 30: Quality Assurance and Continuous Improvement

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

| Timescale: |
|---|---|
| **Provider's response:** |
| (A) A new process has been agreed between our two existing homes to audit each others processes with specific focus on the following: falls, complaints, and clinical procedures and medications. The first audit will take place in the month of September. | September 2010 |
| **Note:** We need training in the area of auditing which is delivered from time to time by an external provider in Castlebar. | |
| We will attend the first available course. | |
| (B) After completing the audit we will compile a report based on our findings highlighting any areas of improvement in each of the areas mentioned above. | October 2010 |

17. The provider has failed to comply with a regulatory requirement in the following respect:

Individual care plans were not developed in partnership with each resident or their representative and were not made available to residents / representative.
**Action required:**

Revise the care planning process to reflect the individual needs and preferences of residents. Include consultation with residents and a process to amend any changes to their care plan. Provide resident and representatives with access to care plan when required.

**Action required:**

Provide staff with training in care planning.

**Reference:**

Health Act, 2007  
Regulation 8: Assessment and Care Plan  
Standard 11: The Resident's Care Plan

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<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
<td><strong>Ongoing with each respite admission</strong></td>
</tr>
<tr>
<td>(A) All care plans are developed directly from the information given by the main carer / family member and GP. The care plan is put together with the main carer from the information on the assessment sheet which is a detailed listing of the needs of the person. The main carer is present when the care plan is being documented and agreed. <strong>Note:</strong> Owing to our residents having Alzheimer’s disease only a tiny fraction (if any) would be able to engage in a meaningful way in their own care plan. Also some families have requested that the resident would not be present as it can be upsetting.</td>
<td></td>
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</tbody>
</table>
| (B) The local centre for nursing education do provide training in care planning and we are awaiting their current brochure for the coming semester. Staff will be booked on the next course entitled: “Assessment of Care Needs of Older People” |  August 2010  
November 2010 |

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

The risk assessment tool for wound care did not reference actions to take reflecting the degree of risk identified.

**Action required:**

Action required:

Revise the policy and / or procedures for decubitus ulcer prevention and management referencing regular evidence based risk assessment for all residents that informs appropriate actions to take to prevent decubitus ulcer formation.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

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

Provider’s response:

(A) We have sourced the document mentioned above on wound management and are reviewing it to identify any gaps. Our existing wound management policy will be updated based on the findings from the Best Practice Document 2009 from the HSE, ISBN 978 – 1 – 906218 – 29 – 4 Oct. 2009.

(B) We will revise the wound management policy referencing the prevention and management of decubitus ulcers and the risk assessment factors.

Note: We are sourcing a training course on risk assessment and when sourced will enrol members of key staff to ensure we are conducting risk assessments properly.

As we are respite care (maximum two weeks) all appropriate wound dressings come with the resident.

Note: We will contact the tissue viability nurse in our area in late August with a view to her visiting to observe and inform us on wound types and care.

Timescale:

August 2010

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

Failed to ensure that at all times staff members have access to education and training to enable them to provide care in accordance with contemporary evidence based practice

Action required:

Complete a training needs analysis for all staff based on the needs of residents in the centre.

Ensure deficits are addressed by way of training and education.
**Action required:**

Implement a programme of education and training to address any deficits in knowledge, skills and on-going development in line with contemporary evidence-based knowledge.

**Reference:**

- Health Act 2007
- Regulation 17: Training and Staff Development
- Standard 24: Training and Supervision

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

Provider’s response:

(A) A training needs analysis was carried out in November 2009 in Marian House which captured all the needs of the staff at the time. This training has now been delivered. Our training is and has always been focused on the needs of the residents. As a charity our funding is very low and we will always provide as much training as we possibly can. Our HSE allocation has again been cut this year but we are committed to provide as much training as we can.

(B) As mentioned we will provide as much training as is possible. We are lucky there are some free courses given by our local nurse education centre. We will avail of as may free course as possible owing to our HSE allocation for 2010 being cut.

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

There were inadequate external links with specialist mental health support services for older people to provide advice, guidance and support for the care of residents with dementia.

**Action required:**

Develop suitable and adequate links with external support services to promote the care and welfare of residents with dementia.

**Reference:**

- Health Act, 2007
- Regulation 9: Health Care
- Standard 13: Healthcare
- Supplementary Criteria for Dementia Specific Residential Care Units for Older People
Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>We are organising a trip to St. James Hospital to meet and discuss current best practice methods of care and stimulation for Alzheimer’s sufferers. This we believe will be of great benefit. We participate actively with groups such as Active Age, Geriatricians in Galway, Mayo and Roscommon plus our local Psycho Geriatrician in Castlebar. University of Stirling is also a good source of current thinking on care of Alzheimer’s. We regularly participate jointly with all local Geriatricians in conducting carers meetings throughout our region. Cutbacks in the HSE have led to difficulties in accessing direct links with local specialist dementia services in certain parts of the west.</td>
<td>October 2010</td>
</tr>
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</table>

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

There was no formal nursing on call arrangement to contact a senior staff member. A number of nursing and care staff worked on nights permanently resulting in staff working without supervision on a continuous basis. There was not a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Action required:**

Ensure there is a nominated person in charge for each 24-hour period on the off duty rota.

**Action required:**

All staff members are supervised on an appropriate basis pertinent to their role.

**Action required:**

There was not a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Reference:**

- Health Act, 2007
- Regulation 16: Staffing
- Regulation 17: Training and Staff Development
- Standard 23: Staffing Levels and Qualifications
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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
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<tr>
<td>(A) There is a printed contact list on the notice board outlining the names of the off duty management. This list will be updated to cover a whole 24 hour period i.e. There will be one nominated person in charge on the off duty rota for every 24 hour period.</td>
<td>October 2010</td>
</tr>
<tr>
<td>(B) There will be a documented procedure outlining the line of supervision for all employees on duty and highlighting the person in charge overall for the period in question.</td>
<td>October 2010</td>
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<tr>
<td>(C) The staff rota is planned and documented on a weekly basis. This will include the night staff.</td>
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<tr>
<th>22. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>The numbers of staff on duty may not be appropriate to meet the care welfare and safety needs of residents at all times as residents had to wait for long periods for assistance with care and eating.</td>
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<tr>
<th><strong>Action required:</strong></th>
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<tbody>
<tr>
<td>Using appropriate evidence-based tools, review the staffing levels on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, their assessed needs and ensure that residents can be safely evacuated in case of fire.</td>
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<tr>
<th><strong>Action required:</strong></th>
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<tbody>
<tr>
<td>Provide the inspection team with a proposal which demonstrates that staffing levels are adequate and appropriate at all times to meet the needs of residents in the centre.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Reference:</strong></th>
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<tbody>
<tr>
<td>Health Act, 2007</td>
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<tr>
<td>Regulation 6: General Welfare and Protection.</td>
<td></td>
</tr>
<tr>
<td>Regulation 16: Staffing</td>
<td></td>
</tr>
<tr>
<td>Standard 23: Staffing Levels and Qualifications</td>
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</tr>
</tbody>
</table>
Provider’s response:

(A) We in Western Alzheimer’s have always made sure our staffing levels were not only adequate but were higher than the accepted levels in the HSE and all local similar nursing homes. This is a vital element of the care we pride ourselves in being able to give to the very vulnerable group of maximum dependency Alzheimer’s sufferers. As part of our evacuation procedure we are meeting with various local groups that are willing to be named on our emergency response list.

(B) We will compile a staffing rota to include the levels of staff that are appropriate throughout the 24 hour cycle of care in the home.

<table>
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<tr>
<th>23. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>The health and safety statement had not been updated to include a comprehensive identification and assessment of all hazards and risks to residents, staff and visitors to the centre.</td>
</tr>
</tbody>
</table>

**Action required:**

Develop and update the health and safety risk statement for the centre.

**Reference:**

- Health Act, 2007
- Regulation 30: Health and Safety
- Standard 26: Health and Safety

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
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<tbody>
<tr>
<td>We will review our health and safety statement and amend it to include any potential hazards to residents, our employees and visitors that visit our home.</td>
</tr>
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</table>

Timescale: November 2010

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<tr>
<th>24. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>The medication management policy did not include a procedure for disposal of medication, responding to and reporting of medication errors and conducting an audit of medication practices.</td>
</tr>
</tbody>
</table>
**Action required:**

Develop a policy on the procedure for disposal of medication, responding to and reporting of medication errors and conducting an audit of medication practices.

**Reference:**

Health Act, 2007  
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines  
Regulation 25: Medical records  
Standard 14: Medication Management

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

Provider’s response:

Our policy for medication management in caring for our maximum dependency Alzheimer’s sufferers is that all medicines as prescribed by their GPs are brought to our home by their carer - and administered by our nursing staff during their stay - and taken home by their carer on discharge. This is a frequent process as the maximum stay in our respite home would be two weeks.

| Timescale: | Ongoing |

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

Failed to provide adequate staff changing facilities and storage for personal belongings.

**Action required:**

Put in place suitable facilities and accommodation to enable all staff in the centre to comply with legislative hygiene requirements and best practice standards.

**Action required:**

Provide suitable staff facilities to include toilet, changing and storage areas.

**Reference:**

Health Act, 2007  
Regulation 19: Premises  
Standard 26: Health and Safety

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

| Timescale: | |
## 26. The provider is failing to comply with a regulatory requirement in the following respect:

The range of policies, procedures and guidelines available in the centre had not been updated to reflect the provisions of Schedule 5 of the Health Act (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2009 (as amended).

### Action required:

Revise polices and procedures to comply with current legislation, regulations and Standards.

### Reference:

- Health Act 2007
- Regulation 22: Maintenance of Records
- Regulation 27: Operating Policies and Procedures
- Standard 29: Management Systems

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

#### Provider’s response:

We have reviewed Schedule 5 of the Health Act and note in particular numbers 1, 2, 4, 5, 10, 11, 12, 14, 15, 16, 17 and 18. These areas we have addressed in this action plan. We will conduct an overall review of our existing policies and procedures and amend them as appropriate.

#### Timescale:

November 2010

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

The facilities provided in the unit were not based on contemporary evidence-based dementia care and environmental design.
**Action required:**

Evaluate the lay-out and model of the dementia specific unit is specific to its stated purpose and adheres to evidence-based principles on dementia care and design. Put a programme in place to address deficits.

**Reference:**

Health Act, 2007  
Regulation 19: Premises  
Standard 25: Physical Environment  
Supplementary Criteria for Dementia-Specific Residential Care Units for Older People.

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

<table>
<thead>
<tr>
<th>Provider's response:</th>
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</table>
| Marian House is Ireland’s first purpose built Alzheimer Home for maximum dependency sufferers. When it was commissioned, built and opened in 1999 there were no suitable designs available and the only available designs for dementia-specific homes were in Australia. Most Alzheimer’s units are ‘add ons’ to existing healthy elderly homes. We in Western Alzheimer’s have been asked to contribute to the design of many of the newer homes, based on our experience.  

We are planning to have firstly our nursing staff visit some other dementia Homes to glean new ideas on design and layout to provoke more engagement from the existing design in our home. We are compiling a list of possible homes that would be worth a visit.  

*Note:* We are delighted that the design of Marian House has proved to be very suitable to the respite care of maximum dependent Alzheimer sufferers. |
| Timescale: |
| November 2010 |

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

The provider failed to provide a separate cleaning room appropriate to the size of the centre.

**Action required:**

Provide a cleaning room appropriate to the size of the centre for use by cleaning staff to store equipment, to prepare and to dispose of cleaning solutions.
### Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tbody>
<tr>
<td>Provider’s response:</td>
<td>Ongoing</td>
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</table>

As a charity operating on a limited funding stream but with positive plans to extend in future we will provide adequate space for all cleaning equipment. This will be in a separate area. We have built a storage shed detached from the home that stores larger containers of chemicals and other agents that are needed in the home in the past year.

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<tr>
<th>29. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>Contracts of care were not issued to residents.</td>
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**Action required:**

Provide all residents with contracts of care confirming their agreement with terms and conditions by obtaining their signature or signature of their representative on this documentation.

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<tr>
<th>Reference:</th>
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<tbody>
<tr>
<td>Health Act, 2007</td>
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<tr>
<td>Regulation 28: Contract for the Provision of Services</td>
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<tr>
<td>Standard 7: Contract / Statement of Terms and Conditions</td>
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<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>Provider’s response:</td>
<td>October2010</td>
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</table>

We have a long stay home in Athenry, County Galway where they issue contracts of care. We will evaluate the suitability of this contract of care to see if it is suitable for our respite home. It will need amending to suit respite.
30. The provider is failing to comply with a regulatory requirement in the following respect:

The complaint policy does not contain all the procedures outlined in the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

**Action required:**

Ensure the complaints procedure is revised to meet the requirements of the legislation.

Nominate a second person to ensure all complaints are appropriately responded to and records are maintained.

**Action required:**

Provide staff access to training on managing and handling complaints.

**Reference:**

Health Act, 2007  
Regulation 39: Complaints Procedures  
Standard 6: Complaints

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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</table>
| (A) We will revise the complaints procedure to ensure it is comprehensive and appropriate records are kept. Raymond McGreal, operations manager, will be the second nominated person to ensure all complaints are dealt with and documented. The procedure will be updated to reflect this amendment.  
(B) All staff will be included in an internal training session to highlight and deal with the handling of complaints. | November 2010  
November 2010 |

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

Not all the required documentation to be held in respect of persons working in a designated centre in accordance with Schedule 2 of the Regulations was available.

**Action required:**

Provide full employment history details, three written references, evidence of relevant qualifications, photographic identification, confirmation each staff member is medically fit to work.
| Reference: | Health Act, 2007  
|          | Regulation 18: Recruitment  
|          | Standard 22: Recruitment |

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>Provider’s response:</td>
<td>March 2011</td>
</tr>
<tr>
<td>Almost all of our staff have been with us since the early 1990’s and very few have left us. Most of our staff did not have a CV or any references. All staff are currently having their CV's typed up and are getting a copy of their driving licence or their passport. We have received some and there are more to come in. Also Garda vetting has been sought for all staff. There is a three to four month waiting list according to the Garda vetting office in Templemore. Upon receipt of all personal information for all of our employees a file will be set up for each one. The Managers details will be kept in the head office and all other staff members will be kept in the home.</td>
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<tr>
<th>32. The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>The policy on end of life care and care of the dying did not contain a documented procedure for staff to follow in relation to the verification of death.</td>
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<table>
<thead>
<tr>
<th>Action required:</th>
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<tbody>
<tr>
<td>Implement a procedure for nurses to verify death.</td>
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</table>

| Reference: | Health Act, 2007  
|          | Regulation 14: End of Life Care  
|          | Standard 16: End of Life Care |

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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>Provider's response:</td>
<td>October 2010</td>
</tr>
<tr>
<td>We will amend the existing end of life policy to reflect a verification of death. In such circumstances (three times in the history of the home) we would always get final certification from a doctor. In 'out of hours' we contact an external doctor service to verify death.</td>
<td></td>
</tr>
</tbody>
</table>
33. The provider has failed to comply with a regulatory requirement in the following respect:

The provider has failed to put a comprehensive contemporary evidence based restraint policy in place whereby the consent of the resident or their family is given and there are processes in place for monitoring the on-going need for use of the restraint.

**Action required:**

Develop and implement a comprehensive policy detailing all aspects of restraint management for residents in the centre.

**Action required:**

Put processes in place where residents have an in-depth assessment of the requirement for restraint and ensure restraints are used as a last resort measure for the least amount of time.

**Action required:**

Put adequate procedures in place where the resident who is restrained has a comprehensive person-centred care plan referencing frequency of monitoring, review and progress.

**Action required:**

Obtain the residents consent for use of restraint before it is put in place. Where the resident is incapacitated, discussion should take place with all individuals involved in care provision including the family.

**Reference:**

Health Act 2007  
Regulation 31: Risk Management Procedures  
Standard 21: Responding to Behaviour that is Challenging

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) We will develop a restraint policy on all aspects of restraint. The main carer/family members always sign the restraint form and all residents are monitored on an ongoing basis. Restraint is only used when necessary. Copy of the restraint form is attached at Appendix 9.</td>
<td>November 2010</td>
</tr>
<tr>
<td>(B) It is our ethos and a key element of our culture to restrain residents only when necessary and for the least amount of time.</td>
<td></td>
</tr>
</tbody>
</table>
(C) The restraint sheet we use will now be augmented by a new sheet that describes the frequency of movement and at what agreed time intervals. These sheets are used in conjunction with the toilet book.

(D) We seek and gain a signature from the main carer / family member prior to the use of restraint for any of our maximum dependent residents.

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

Failed to notify the Chief Inspector of Social Services of incidents and to submit quarterly returns of all incidents, accidents and near misses in the centre.

**Action required:**

Notify the Chief Inspector of Social Services of all occurrences as required by the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Reference:**

Health Act, 2007  
Regulation 36: Notification of Incidents  
Regulation 38: Notification of periods when the Person in Charge is absent from a Designated Centre  
Standard 26: Health and Safety

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

Provider's response:

We are recording all incidents and accidents etc in the incident and accident books. All incidents / accidents have been notified to the Chief Inspector up to and including 31 July 2010.

Our next notification will be end of October 2010.

**Timescale:** Ongoing
35. **The provider is failing to comply with a regulatory requirement in the following respect:**

The provider and staff lacked understanding of the provisions of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The provider failed to make a copy of the Regulations available to staff in the centre.

**Action required:**

Put in place a training schedule to inform all staff of the provisions of the Health Act 2007, all care and welfare Standards and Regulations for Residents’ and their impact on the role of the centres staff.

**Action required:**

Copies of all relevant documents to be made available to staff.

**Reference:**

- Health Act, 2007
- Regulation 17: Training and Staff Development
- Standard 29: Management Systems

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

<table>
<thead>
<tr>
<th>Provider’s response</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) We will bring all of our employees together and inform them of the Health Act 2007 and amendments 2009 and the Sections included which detail the thirty two standards.</td>
<td>September 2010</td>
</tr>
<tr>
<td>(B) We will have the Health Act available to all employees in an ‘open to view’ area in the home.</td>
<td></td>
</tr>
</tbody>
</table>

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

The admission policy in place was inadequate to address emergency admission procedures.

**Action required:**

Assess residents' health, personal and social care needs prior to admission. In the case of an emergency admission, carry out the assessment as soon as possible and within 72 hours of admission.
**Action required:**

Develop and implement a comprehensive admission procedure.

**Reference:**

Health Act 2007  
Regulation 8: Assessment and Care Plan  
Standard 10: Assessment

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| (A) We have always received a letter from the residents GP or Doctor for Mental Health Services however the letter did not always provide sufficient detail. We have now designed a new pre-admission form and have contacted all GP's in the counties of Galway, Mayo and Roscommon and urged them to fill this form in detail to allow us design a comprehensive care plan. The information we receive from their GP and the main carer is the most important information for us. If there are emergency (not normal) admissions we will carry out the assessment within 72 hours.  
(B) Allied to our pre-admission we invest significant time in the actual admission of the resident. We believe in spending adequate time (circa three hours) speaking with the carer / family member and attending to the paperwork. If the admission is the first time the family is availing of respite extra time is given as the carer / family member usually needs great re-assurance that their loved one is settled and is in good spirits. | Ongoing |

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

The provider failed to document induction process and guidance for new staff members.

**Action required:**

Develop a comprehensive induction process in consultation with current staff in the centre and make available for all new staff to the centre.

**Reference:**

Health Act, 2007  
Regulation 17: Training and Staff Development  
Standard 24: Training and Supervision
<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
</tr>
<tr>
<td>The person in charge and the operations manager will develop an induction process to include: history of organisation, ethos of care, HIQA regulations and guided tour. Furthermore we intend to organise a mentoring system to help with ongoing orientation. Eventually we intend to provide an Employee Booklet to include all the above and extra relevant information for all employees.</td>
</tr>
<tr>
<td><strong>January 2011</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38. The provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The provider failed to provide secure storage space for residents’ personal belongings and possessions in their rooms.</strong></td>
</tr>
<tr>
<td><strong>Action required:</strong></td>
</tr>
<tr>
<td>Provide suitable secure storage facilities for use by residents’.</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
</tr>
</tbody>
</table>
| Health Act, 2007  
Regulation 7: Residents’ Personal Property and Possessions  
Standard 25: Physical Environment |
| **Please state the actions you have taken or are planning to take with timescales:** |
| **Provider’s response:** |
| We understand this would be a requirement in a healthy elderly home but when dealing with maximum levels of dependency as with Alzheimer’s disease our residents do not require storage space that is lockable and this is discussed and agreed with their families. The only items residents may wish to bring in would be a bag with no valuables contained. This process and procedure is discussed and agreed at admission with the main carer / family member. This is the most practical way to handle residents’ personal items as their time is so short in our home. The main carer / family member takes full responsibility for labelling and signing out all items belonging to the resident. |
| **Timescale:** |
| Ongoing | Ongoing |
39. The provider has failed to comply with a regulatory requirement in the following respect:

To provide residents with external grounds that are suitable for and safe for use by residents with a diagnosis of dementia or Alzheimer’s disease and are appropriately maintained.

**Action required:**

Complete a comprehensive risk assessment of the external environment.

**Action required:**

Put a documented maintenance and cleaning programme in place for the external areas.

**Action required:**

Put a system in place whereby residents who have been assessed as safe to use the garden are facilitated to do so.

**Reference:**

Health Act, 2007  
Regulation 19: Premises  
Regulation 31: Risk Management Procedures  
Standard 25: Physical Environment  
Standard 26: Health and Safety

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

<table>
<thead>
<tr>
<th>Provider’s response</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) A requirement of our Insurance is that we have an external wall that is secure. Within the boundary we have adequate space for residents to move freely and enjoy the surrounds particularly in good weather. Even in this safe and controlled environment our carers would always be with our residents owing to the unpredictable nature of Alzheimer Patients. We will assess any risks in the outside area to ensure all of our residents are safe at all times.</td>
<td>Complete</td>
</tr>
</tbody>
</table>
| (B) We have implemented a cleaning rota (one day per week) for our maintenance person. This will cover all areas of the outside of the home.  
*Note:* We have an extra person on the grounds for the summer months. | Ongoing |
| (C) It is our ethos to be fair and equitable in providing access to all of our facilities i.e. access to the garden. We feel that allowing | |


people out to the garden can be a very positive remedy to normal mood swings associated with Alzheimer’s disease.

<table>
<thead>
<tr>
<th>40. The provider has failed to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was no communication policy in the centre as required by the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended) to inform staff of effective ways to communicate with residents with cognitive deficits.</td>
</tr>
</tbody>
</table>

**Action required:**

Implement the communication policy providing instruction to staff on all aspects of communication within the centre.

**Action required:**

Provide all staff with training in managing challenging behaviour.

**Reference:**

Health Act, 2007
Regulation 11: Communication
Standard 2: Consultation and Participation
Standard 21: Responding to Behaviour that is Challenging

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s response:</td>
<td></td>
</tr>
<tr>
<td>(A) We have a policy on communication ‘Resident Communication Education and Consent Policy’. This policy outlines the main areas of verbal and non verbal communication and focuses on the key areas for our staff and our residents.</td>
<td></td>
</tr>
<tr>
<td>(B) As mentioned earlier in section one of this action plan we have held training sessions on challenging behaviours on 23 June 2010.</td>
<td></td>
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<tr>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>23 June 2010</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>41. The provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was also a lack of suitable storage space for assistive devices e.g. assistive equipment used by residents.</td>
</tr>
</tbody>
</table>
**Action required:**

Provide appropriate, safe and accessible storage facilities for all equipment.

**Reference:**

Health Act, 2007  
Regulation 31: Risk Management Procedures  
Standard 25: Physical Environment

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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</thead>
</table>
| Provider’s response:  
We have built a new storage shed outside the home which we store assistive devices in. We do have a small number of devices in the home which are needed ‘close at hand’ due to the nature of illness of our residents. We will include in our new extension more space for this equipment. | September 2010 and ongoing |

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

The provider has failed to provide a residents’ guide that meets the legislative requirements.

**Action required:**

Produce a written guide, ‘the residents’ guide’ that contains all the information required by the legislation in an accessible format to all residents.

**Reference:**

Health Act, 2007  
Regulation 21: Provision of Information to Residents  
Standard 1: Information  
Supplementary Criteria for Dementia-Specific Residential Care Units for Older People

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Provider’s response:  
A residents’ guide is now being prepared to include all areas of information needed for residents, carers and families. It will be available for all residents, carers and families. | September 2010 |
As our respite residents are maximum dependency the guide will be used mainly by the main carer / family member.

<table>
<thead>
<tr>
<th>43. The provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to provide adequate assisted toilet and washing facilities to meet the needs of all residents in the centre.</td>
</tr>
</tbody>
</table>

**Action required:**

Provide a sufficient number of toilets having regard for the number of dependent persons and wheelchair users in the centre and in line with the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

**Reference:**

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

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

<table>
<thead>
<tr>
<th>Provider's response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the toilets in the home are suitable for wheelchair assisted residents. We do not have the capacity to add any new toilets at this time but we will in the new extension and this is dependent on funding being available.</td>
</tr>
</tbody>
</table>

**Timescale:**

Ongoing with new building extension

<table>
<thead>
<tr>
<th>44. The provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were no arrangements to facilitate consultation and participation with residents / relatives in the organisation of the centre.</td>
</tr>
</tbody>
</table>

**Action required:**

Develop a forum to ensure that residents are consulted and participate in the organisation of the centre.
**Action required:**

Seek feedback from residents, their relatives and/or main carers on an on-going basis to inform future planning.

**Reference:**

Health Act, 2007  
Regulation 10: Residents’ Rights, Dignity and Consultation  
Standard 2: Consultation and Participation

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
<td></td>
</tr>
<tr>
<td>(A) We will be inviting residents’ relatives to our first forum meeting on 28 September 2010 in the head office meeting room. We sought carers/families that were representative of the geography we operate in i.e. Galway, Mayo and Roscommon. Five have initially agreed to participate in the forum.</td>
<td>September 2010</td>
</tr>
<tr>
<td>(B) Our open door policy encourages open and direct feedback to us in the home. We also have designed and sent out questionnaires to all carers/families and it produced great sources of relevant feedback to inform our action plans. We are planning another such survey in September 2010.</td>
<td>September 2010</td>
</tr>
</tbody>
</table>

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

Permanent ventilation to the external air and lighting both natural and artificial was not adequate in all parts of the centre used by residents.

**Action required:**

Evaluate the permanent ventilation to the external air and lighting both natural and artificial in the centre and put remedial action in place to address deficits.

**Reference:**

Health Act, 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
Provider’s response:

We have ample windows to the outside of the building thus allowing air circulation and light. All of the windows have fly-screens installed.

We are exploring the option of relocating a portion of our office space (swapping an office for a bedroom) and assessing the implications for fire safety and evacuation.

February 2011

<table>
<thead>
<tr>
<th>46. The provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to facilitate residents to freely enter and exit the centre into a safe area.</td>
</tr>
<tr>
<td>Residents’ visitors were required to wait, for prolonged periods for staff to unlock the door.</td>
</tr>
</tbody>
</table>

**Action required:**

Put a system in place whereby all relatives and visitors can access the building without undue delay.

<table>
<thead>
<tr>
<th>Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry out an assessment to ascertain the impact of lack of shelter at the front door for residents and their relatives and / or main carers.</td>
</tr>
</tbody>
</table>

**Reference:**

- Health Act, 2007
- Regulation 10: Residents’ Rights, Dignity and Consultation
- Regulation 12: Visits
- Regulation 19: Premises
- Standard 17: Autonomy and Independence
- Supplementary Criteria for Dementia-Specific Residential Care Units for Older people

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

<table>
<thead>
<tr>
<th>Provider’s response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) The first and key principle of care for us in Western Alzheimer’s is safety. It would not be responsible to allow residents to exit the building on their own. If a resident is assessed as being able to go outside for a walk - they will be assisted by two carers. There is the exception where there is only one carer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timescale:</th>
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</thead>
<tbody>
<tr>
<td>Ongoing</td>
</tr>
</tbody>
</table>
There is a bell at reception to alert staff if there if our reception is unattended. The keys to the front door are kept in the nurses / reception area therefore access is controlled.

We have in recent weeks met with two separate companies that specialise in access control - and after examining both systems neither were seen as being totally suitable. One was wholly unsuitable while the other was cost prohibitive. Most systems on the market are for healthy elderly homes.

(B) We accept the feedback received from HIQA as to the closure of the outer door and its impact especially in inclement weather. The outer door is open daily from 7am to 12 midnight. From 12 Midnight to 7am it is locked for security reasons and any family members that wish to visit will normally call to let the staff know they are coming.

Note: At all other times the outer door is open and all main carers / family members / visitors enter directly into the reception area. This area can accommodate up to ten people. This avoids people being exposed to the elements at any time of the year.

We have discussed building a canopy / port area outside the outer door to protect all residents / main carers / visitors ensuring that nobody is exposed to the elements.

Note: As of today, 3 August 2010, we have a contractor on-site assessing the layout (in cooperation with our engineers) to agree the best and safest 'set-down' area for our residents admissions and departures. The agreed solution will also address the issue of inclement weather at all times of the year.

<table>
<thead>
<tr>
<th>Ongoing</th>
<th></th>
</tr>
</thead>
</table>
Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Best practice recommendations</th>
</tr>
</thead>
</table>
| Standard 25 Physical Environment | Provide a more suitable surround to the home instead of the high fence to reflect person-centred care.  
Provider’s response:  
The existing fence is a requirement of our insurance company. We have explored other options but when dealing with maximum dependency Alzheimer patients our focus is safety and quality of life at all times. The fence is the best option we found to allow a visual experience and also ensuring that our residents could not go missing via the boundary fence.  
Complete September 2010 |
| Standard 24 Training and Supervision. | Implement an appropriate review of competencies to provide for the ongoing assessment of staff suitability and competence to deliver appropriate care to residents.  
Provider’s response:  
We will design an appropriate appraisal process to highlight deficits in knowledge and skills development.  
Completion November 2010. |
| Standard 10: Assessment | There was no evidence of comprehensive assessment prior to admission to determine each resident's needs and whether the centre was able to meet their needs  
Provider’s response:  
We have always received a letter from the resident's GP or Doctor for Mental Health Services however the letter did not always provide sufficient detail. We have now designed a new pre-admission form and have contacted all GP’s in the counties of Galway, Mayo and Roscommon and urged them to fill this form in detail to allow us design a comprehensive care plan. The information we receive from their GP |
and the main carer is the most important information for us. If there are emergency (not normal) admissions we will carry out the assessment within 72 hours.

Completion September 2010.

<table>
<thead>
<tr>
<th>Standard 25 Physical Environment</th>
<th>Make the enclosed garden a pleasant and therapeutic area with adequate seating in line with evidence based dementia care practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's response:</td>
<td>We have procured an all weather table and chairs plus seating next to our newly renovated bedding plant garden. Our water feature has been upgraded and numerous plants have been planted. We are considering raising the level of the garden (cost permitting) for a more sensory experience for our residents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 19 Meals and Mealtimes</th>
<th>Consult with staff and residents on how they can enhance mealtimes to reflect a more social occasion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's response:</td>
<td>Opportunities are limited when dealing short-term respite Alzheimer high dependency residents however we make the experience of eating meals as social as possible by chatting and singing with the patients as we sit at the tables with them.</td>
</tr>
<tr>
<td>Completed and ongoing.</td>
<td></td>
</tr>
</tbody>
</table>
Provider’s response:

Thank you for your detailed and comprehensive report. We are very pleased that you have highlighted most of the key areas that have been central to our ethos of quality care. This is very important to us - as this is central to us being seen as having a ‘unique model of care’ in our area of expertise i.e. respite care of maximum dependency Alzheimer sufferers.

As a registered charity CHY 11416 operating on a very low level of state funding we have built our reputation from the early 1990’s on a culture of person centred care. We have never refused care to anyone and we especially respond to the most needy cases. The recent TV coverage was vital in explaining to people the desperate plight families find themselves in when a loved one has Alzheimer’s disease.

It was against this background we set up our respite home in Ballindine - which is Ireland’s first purpose built Alzheimer Home. The only Alzheimer home dedicated to respite care. This is unique in the Irish healthcare sector and especially as it is run mainly from the organisations own fundraising activities.

Our charges for respite are 25% of the accepted rates in other homes throughout the country.

The Action Plan:

We have already addressed most of the areas highlighted in the Action Plan with training interventions and the remainder are outlined in the Action Plan details.

We would like to stress that our home cares only for respite residents and the longest duration any resident would be in our home at any one time would be two weeks. We feel quite a number of the areas mentioned in the Action Plan are more suited to long stay rather than respite care and don’t fit with the shorter care cycle of respite. We also care for our residents at a maximum dependency level of care.

Areas mentioned that we would like to point out as key areas of concern for us:

(A) **Quality of Care**

We have an acknowledged excellent level of care. We have contributed to numerous Government reports most notably ‘Action Plan for Dementia’.

(B) **Staffing Levels**

Our staffing Levels are higher than any other similar care centre.
(C) **Procedures**
   We have designed a comprehensive list of procedures (Health Act, 2007).

(D) **Use of CCTV in the Home**
   We and all the families / carers want the CCTV as evidenced by letters.

(E) **Activity led programmes**
   We have trained / invested in two full time activity coordinators.

(F) **Risk Assessments**
   We are sourcing a suitable course for us to improve on risk assessments.

(G) **Facilities within the home**
   We provide the very best facilities with our limited resources.

(H) **Challenging Behaviour**
   We have invested in very good training in this area.

(I) **Maximum level of Care of all of our residents**
   All of our residents care planning is delivered at maximum levels of care.

(J) **Assumption on level of engagement of residents**
   Without exception, none of our residents could engage in their care plan.

(K) **Funding of our organisation (Charitable Status)**
   As a Registered Charity, we provide the very best within our limited resources. A total of 75% of our residents are referred to us by the HSE.

Overall, I fear for people with dementia if the new HIQA guidelines divert caring staff to more paperwork as I feel this will take the heart out of caring.

**Provider's name:** John Grant

**Date:** 5 August 2010