

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Orchard Day and Respite Centre
Centre ID:	OSV-0000691
Centre address:	Temple Road, Blackrock, Co. Dublin.
Telephone number:	01 207 3839
Email address:	theorchard@alzheimer.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Alzheimer Society of Ireland
Provider Nominee:	Donal Murphy
Lead inspector:	Linda Moore
Support inspector(s):	Liam Strahan
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	2

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 30 March 2015 08:25 To: 30 March 2015 17:30

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

Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

At this inspection, inspectors followed up on the 25 actions for improvement which were identified at the registration inspection of 09 and 10 December 2014. These actions included aspects of fire safety, assessment and care planning, medication management practices, risk management, staffing levels, premises issues and healthcare.

The Orchard day and Respite service is a purpose built single storey building which has 11 places. The service provides short term respite service for residents with a diagnosis of dementia with an average length of stay of two weeks. There also provide up to 18 day attendees places on a daily basis in the centre.

Because of the significant number of non compliances identified at the inspection in December 2014, the provider was required to attend a meeting with the Authority on 15 December 2014 to discuss the findings. Following the meeting, the provider gave a commitment to the Authority to address the issues identified at the inspection.

At this inspection, inspectors met the provider, interim person in charge and operations manager. They also met with residents and relatives. Nine actions were completed, eleven actions were partly addressed and five actions were not addressed. The time frame for most of the actions had expired.

The provider had strengthened the governance with the establishment of a risk management committee and weekly management meetings to progress the action plan. A quality, safety and practice development manager was appointed who worked two days per week with the centre.

The provider was still required to invest significant resources into the care practices and the premises to address the actions required. Overall, inspectors found some improvements across most areas during the inspection. However further improvement was required. The changes in management team since the previous inspection had not supported the implementation of the action plans. The dining experience for residents had significantly improved as were aspects of fire safety and residents finances.

Areas identified for improvement included:

- care planning
- medication management
- risk management
- staffing
- premises issues

These items are discussed in the body of the report and are included in the Action Plan at the end of this report.

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

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

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

Findings:

While there was some improvements noted in this outcome since the previous inspection, inspectors found that there was still a lack of adequate clinical governance in the centre which could have resulted in poor outcomes for residents. Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 11, healthcare, risk management and inadequate supervision and allocation of staff as outlined in Outcome 18.

The provider and a number of staff had completed training to support them to understand and meet the requirements of the Regulations. A quality, safety and practice development manager was appointed. The provider visited the centre on a weekly basis. A risk management and clinical governance committee was established and were working through the action plan from the previous inspection. This committee consisted of the person in charge and the provider.

The provider told inspectors that an external audit of the centre was completed but the report was not available for review.

The systems in place to review the safety and quality of care provided had improved, these included audits of medication management and care plans, however, there was limited evidence that all of the recommendations identified were implemented.

Inspectors found that the provider still did not ensure the current governance arrangements provided sufficient oversight of key areas such as medication management, risk management and healthcare issues as discussed throughout this report.

The lines of accountability for decision making and responsibility for the delivery of services to residents were still not clarified.

The person in charge had chosen to move from the post since the previous inspection and a new person in charge was appointed on an interim basis. The supports for the person in charge in the delivery and supervision of care were not adequate. The provider said he was in the process of addressing this.

Staff nurses explained that since the previous inspection, the number of admissions and discharges were now staggered. They identified the benefits from the change in this practice. A review of complaints showed that there were less complaints from residents who were discharged. The nurses said they had more time to spend with residents, however the admission assessments and care plans were still of a poor quality and the supervision of residents required improvement. See outcome 18.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

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

Findings:

Inspectors observed that there were still a significant number of signs on display throughout the centre. This did not facilitate residents to retain choice and control in their daily life. See outcome 16.

Inspectors observed that many of the corridors and rooms within the centre were still not identified and many of the residents asked staff and inspectors for direction. Residents also wandered into other residents bedroom. Inspectors noted that this could be enhanced with the use of pictures for residents with dementia.

Inspectors observed that there were two clocks on the corridor, one of these was incorrectly set and the date was incorrect on the clock in the main day area. This would be more confusing for residents with dementia.

There was also a notice board communicating information about the daily social activities within the centre. While this was generally positive, it again appeared to have an over-reliance on words. It was only changed from Friday to Monday during the inspection when a resident was heard saying "so it is Friday". The list of activities identified that there was an exercise programme on during the day, when the staff said

that this was not the activity that was planned.

Judgment:

Non Compliant - Moderate

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

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

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

Findings:

While this action was partly addressed in that policies were available additional work was required to ensure implementation of all policies into practice.

The designated centre had all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). However, they were still not adapted to guide practice in the centre. This included the policy on the protection of vulnerable adults, medication management and falls management. Staff were not fully aware of the content of the policies available as they had not all received training in these areas.

The directory of residents now included all aspects of the Regulations. This now included the name of the referring organisation.

Inspectors found that resident's records were still not completed in line with Schedule 3 of the Regulations. Records were not maintained of a nursing record of the person's health and condition, completed on a daily basis in accordance with relevant professional guidelines. Residents assessments were not signed and dated and all residents were not weighed on admission as per the centres policy.

Judgment:

Non Compliant - Moderate

***Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or***

suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

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

Findings:

This action was partly addressed.

Inspectors found that measures were now in place to protect residents from being harmed or abused. However they still required improvement. All staff had received training on identifying and responding to allegations of elder abuse. There was a policy available to give guidance to staff, however this would still not guide staff on the reporting and investigation of any allegation of abuse.

A review of incidents showed that there were no allegations of abuse in the centre.

There were no restrictive practices in the centre during the centre. Staff had received some training on restrictive practices and was more knowledgeable in this area. However, they told inspectors that they required training on the management of behaviour that is challenging. The service was often provided to residents who displayed responsive behaviours. However, inspectors noted sufficient policies were available but were not being followed for residents who presented with this behaviour. Many of the residents were observed to require a lot of reassurance from staff and their behaviour often impacted on other residents. Staff were not fully familiar with residents needs and the care plans did not guide practice.

There were appropriate systems now in place to manage residents' finances in line with the centres policy.

Judgment:

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.***

Theme:

Safe care and support

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

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

Findings:

Inspectors generally still found that while the provider had put some risk management measures in place, they needed to be improved. There were however some improvements since the previous inspection.

The risks associated with medication management, healthcare as per Outcome 11, manual handling practices and the allocation of staff and supervision of residents as per Outcome 18 also required improvement.

The systems for the identification, assessment, management, recording and investigation of risk required improvement.

Records showed that staff had received manual handling training since the last inspection, Manual handling assessments were in place, but they were insufficiently detailed and were not being used to guide staff. However, Inspectors were informed that poor manual handling practices took place in the absence of a standing hoist and the location and design of the showers. Staff said they had to lift a resident who could not easily access the shower, which may cause injury to the resident and staff. This procedure was not in line with the resident's manual handling plan.

Again inspectors found items such as a liquid and a scissors in a press in one of the day rooms, which may be a risk to residents with dementia.

The person in charge had developed a number of risk assessments for the centre since the last inspection in an attempt to reduce the risks. The staff members were still not aware of the content of the safety statement or the risk assessments. While there were risk assessments for smoking in place, they were not comprehensive and the care plan would not guide care in relation to the supervision of the resident.

The staff told inspectors they were not sufficiently trained in risk assessment. This was concurred from a review of training records.

While the risk management policy now included many of the requirements of the Regulations. It did not include the actual practice for the identification and management of risk and the measures to control the risks. The policy had not been adhered to when a resident was at risk of self harm.

A number of accident and incidents for 2015 were being recorded but all incident reports were not available for review. While a risk management committee was established to review incidents on a weekly basis, preventative measures were not consistently recorded or implemented to reduce the risk of future incidents.

Aspects of fire safety were reviewed and inspectors found that the actions identified at the previous inspection were completed. All staff on duty had been provided with fire training and fire drills were carried out at suitable intervals as required by the Regulations. Records showed that all fire equipment was maintained since the last inspection.

Inspectors found that there were measures in place to control and prevent infection.

Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre. Inspectors observed however that disposable gloves were left on the radiators throughout the centre, which may have been a choking risk to residents. There was no risk assessment to deem if this practice was safe.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

There were some improvements noted in this outcome.

Inspectors observed that the administration of medication had improved, prescribing practices now reduced the risk of error, however, there were still areas for improvement.

Prescribing practices had improved and this had reduced the time nurses spent clarifying prescriptions. Photographic identification was in place for all residents since the inspection.

A policy on the management of medication was reviewed by inspectors. This policy had been revised, but it still did not guide practice. For example, the policy on the use of PRN (as required medication) was not being followed in that the maximum dose in a 24 hour period was still not recorded.

The temperature of the fridge which was used to store medication was checked daily. This did not contain medication for residents on the day of the inspection. The temperature on the day of the inspection was recorded as 14 degrees Celsius but there was no plan to address this.

Medication error reports were completed in 2015, errors included the administration of the incorrect dosage of medication to the resident. However, these reports were only partly completed and while they included some of the learning required, there was no evidence that this had taken place.

Many of the nurses had completed training in medication management since the previous inspection. Competency assessments had taken place for two of the staff, the

person in charge said they planned to roll this out to all staff nurses.

Medication audits had taken place since the inspection, however, the learning and actions taken were not documents or implemented.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

This action was partly addressed, however improvements were still required in assessment and care planning and the associated policies to guide practice.

While residents' healthcare needs appeared to be met in some areas, this was not consistent. Residents had clinical risk assessments such as falls, and pressure sore assessments completed, which were updated for residents from their previous admission. While preadmission assessments were now being completed on occasion, this was not updated on admission. A new comprehensive assessment was implemented since the previous inspection, however this did not inform the care plans and the care plans still did not guide practice.

There was no evidence of residents or relatives involvement in the development of the care plans. The provider said in the previous action plan that the care plans would be addressed by 30 June 2015.

Inspectors noted that residents were still not routinely weighed on admission and the malnutrition risk assessment was not always completed. Staff had received training in these assessments but there were no care plans to guide the care for these residents.

Falls prevention and management

While there was a system in place to assess falls, the management of falls still required improvement. Records showed that some residents had unwitnessed falls in 2015. There was insufficient evidence that neurological observations were fully completed following these falls. The falls policy did not guide staff on the procedure to follow when a

resident falls. Post falls assessments were not routinely completed. There were falls diary in place since the inspection. While the residents care plans identified that they had fallen, the preventative measures were not included to guide care. Staff did not have access to equipment for residents such as sensor alarms etc, to minimise the risk of future falls.

Wound care

There were no residents with wounds in the centre. Inspectors read the records of previous residents and noted that wound charts had been completed for residents with wounds. There was a care plan to guide care, such as the frequency of the change of dressing and the type of dressing required. This was not consistent for all residents. Staff had not been provided with any training in wound care and were not knowledgeable on the classification of pressure sores and the use of the pressure relieving equipment and this was not available for all residents at risk.

Restraint Management

Inspector found that there were no residents using bedrails. However, there were no alternatives available if required. Training had been provided to staff on the use of restraint. Inspectors read the records of previous residents and found that risk assessments were completed but the alternatives to restraint were not documented. Residents care plans would not guide care.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

Overall, the physical environment in the centre met the requirements of the Regulations. However there was no action taken to address the deficits identified at the previous inspection. The time frame in the report to address this action had expired.

All bedrooms were single and included a toilet and sink, eight of the bedrooms had ensuite bathrooms with showers and toilets. However seven of the showers had steps into them and could not be accessed by all residents. See outcome eight which impacted

on the safe transfer of residents into the showers.

While there were two additional baths in the centre, staff said that residents still used the shower in other resident's bedrooms if they did not want to have a bath or could not access the shower in their room. This would impact on the dignity of residents.

There was a sluice room but there was no mechanical sluicing facilities in the centre to ensure that best practice in infection control could be adhered to if there was an outbreak of infectious disease. Staff did not have a policy on cleaning commodes to guide their practice.

Overall the centre was clean, comfortable, welcoming and well maintained both internally and externally, however the kitchenette used by visitors was not maintained in a clean manner.

There was no smoking shelter for residents; staff said that residents stood outside if they wish to smoke.

Inspectors found that there were only 11 duvets in the centre, while each resident had a duvet on their bed, there were no additional blankets available should a resident get cold. Inspectors were informed that this was due to the lack of funding available.

While there was a full time maintenance staff employed, the maintenance records did not include a broken couch that was in need of repair. Inspectors noted that some of the lights over the beds had been taped together as they required to be repaired.

Inspectors also observed that residents had difficulty getting up from a couch which was too low for residents, this would impact on the independence of residents.

There was still a lack of pressure relieving devices such as mattresses and cushions, there were an insufficient number of slings available to be used in the transfer of residents using a hoist. There was no standing hoist available.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

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

Findings:

There were some improvements noted in this outcome since the previous inspection. Complaints were well managed informally but there were still areas for improvement. While there was a complaints procedures on display, the complaint's policy did not fully meet the requirements of the Regulations. Managers described the procedure which was conflicting with the procedure on display, for example, the nominated person as per Regulation 34. There was no space to document the satisfaction of the complainant.

Relatives and residents who spoke with inspectors knew the procedure if they wished to make a complaint.

A complaints log was maintained and inspectors found that it contained details of a small number of complaints. The number of complaints had reduced since the previous inspection. However, inspectors found that there were still complaints regarding residents clothing going missing. See outcome 17.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

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

Findings:

There was no improvement in this action since the previous inspection. The person in charge informed inspectors that they do not routinely provide care for residents at their end of life. However the need may arise. There were no residents at this stage of life during the inspection.

There was a policy on end-of-life care which still did not provide detailed guidance to staff and staff were not familiar with it.

Due to the deficits in care plans, there was still no system in place to capture resident's wishes.

Inspectors noted that residents would receive support from the local palliative care team when required. Staff had not received training in end-of-life care.

Judgment:

Non Compliant - Minor

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

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

Findings:

This action was addressed.

Residents received a varied and nutritious diet that overall was tailored to meet individual preferences and requirements. Meal times were supervised by staff and the person in charge.

Inspectors met with the chef who demonstrated knowledge of residents dietary needs, likes and dislikes and this was documented. The records in the kitchen were updated after each admission to the centre. All residents received the prescribed meal as required. Picture menus were in place and staff used these to offer choice to residents.

Inspectors observed that none of the residents required assistance with eating and they all sat in appropriate and safe positions to eat their meal.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

While there were no actions identified in this area at the previous inspection, inspectors noted that that each resident did not have opportunities to participate in meaningful

activities, appropriate to his or her interests and preferences.

Inspectors observed staff interacting with residents in a friendly and courteous manner.

Inspectors noted that while there were some activities for residents in the afternoon, there was limited access to any activation for all residents who did not want to partake in the group activity. Staff said they did not have the time to carry out meaningful activation. For example, access to the sensory room.

All of the residents had a diagnosis of dementia, inspectors noted that residents who required more attention than others sat with staff as they provided the activity and other residents wandered around asking to go home. Inspectors observed that many of the residents became agitated as the all day attendees put on their coats to go home in front of the respite residents. Apart from the television on in the open day room, there was no other distraction offered to residents at that time.

While some of the staff had training in SONAS programme (a therapeutic communication activity primarily for older people, which focuses on sensory stimulation) ,this was not provided, It was evident that all staff did not have training in activation provision. Inspectors observed that staff did not have the resources available to provide activation to residents. The jigsaws had missing pieces and were not age appropriate for the residents.

Social care assessments had being completed in respect of the residents, but they did not inform care plans. The provider said that additional funding was being provided to address this area.

Judgment:

Non Compliant - Moderate

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

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

Findings:

This action was partly addressed.

The centre had adequate washing and drying facilities for residents' laundry, however as this was a respite service, residents clothing was not routinely washed in the centre.

A revised property list was implemented, which included all items of clothing, this was signed by the relative on admission and discharge. The provider was encouraging family to label residents clothing on admission.

Inspectors noted that there were still complaints regarding resident's clothes going missing. Staff told inspectors that residents walked into other resident's bedrooms and would take other residents clothing. While one resident's records stated that the staff had "difficulty trying to persuade the resident to stay out of other residents bedrooms", there was no care plan to address this.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

This action was partly addressed in the provision of training to staff since the previous inspection.

Staff told inspectors they felt well supported by the person in charge but the morale in the centre was low, inspectors found that this may impact on the care delivered to residents. Staff knew some of the residents well from their frequent visits to the centre for respite and the day services. However, this was not always the case. Staff said they received day and respite admissions and apart from a hand over on the day after the arrival of the resident, they do not get the information required to meet the resident's needs. Staff did not routinely receive any information pertinent to the needs of the day attendees.

Inspectors found that there appeared to be an adequate number of staff on duty on the day of the inspection, however, a review of the rosters showed this was not consistent. The provider said in the previous action plan that this would be addressed by the 30 April 2015.

While the staffing levels are based on the 11 respite places, there could be up to 18 day attendees.

The allocation and supervision of residents required improvement. Staff were responsible for providing care to residents and day attendees who had varying abilities and needs, mainly in the one day room. Managers relied on the use of the volunteer "befriender programme" to supervise residents. There were periods during the inspection where residents were unsupervised due to the layout of the premises and the needs of other residents. Inspectors observed residents wander into other residents bedrooms.

Inspectors found that performance reviews of staff were being implemented to identify good practice, but they did not identify any training needs of staff.

Training records outlined the training for all staff. There was still no system to identify those who had received any training and any deficit. Training certificates were also not maintained on file for each staff member.

Staff had received training in falls management, Dysphagia, care planning and dementia awareness, however the training had not been applied in practice. See outcome 11. There was still no training plan developed to ensure evidenced based care could be delivered to residents.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	The Orchard Day and Respite Centre
Centre ID:	OSV-0000691
Date of inspection:	30/03/2015
Date of response:	10/05/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The management systems did not ensure that services are safe, appropriate to the needs of residents and effectively monitored.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

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

monitored.

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

The Registered provider has undertaken training to understand his role and the responsibility as required by the regulation. The provider now spends at least 1 day a week at the centre and is available on call. He is supported by the Operations Coordinator of the Eastern region of the organisation, who works in the centre at least 3 days a week. The new Quality Safety and Practise Development Manager also dedicates up to 2 days a week working on centre requirements.

Weekly management meetings are now held to progress the following items:

- HIQA action plan
- Centre Management
- Finance and Administration
- Quality, Safety and Risk Management

The management structure at present is being supported by the Operations Coordinator. This governance structure does not fully support the acting Person in Charge. We have completed the process of recruiting for the Person in Charge role in the centre and while this has taken longer than we would have liked we feel this was appropriate to ensure we get the candidate that will be right to lead the centre. The new Person in Charge will commence their role on May 25th. The acting Person in Charge will return to their role of Deputy Person in Charge. A Nurse Manager from another Alzheimer Day Care centre will also join the nurse's team in the Orchard on May 19th to strengthen this team.

The organisational structure will now be agreed with the Head of Operations and will lead to new role/job specifications for staff in the centre. This will ensure that staff know the management structure and the reporting arrangements.

Following the previous HIQA inspection staff have undertaken training/briefings in:

- Elder Abuse/Safe Guarding
- Health & Safety
- Nutrition
- Medication Management
- Risk Management
- Health Act
- Fire Training
- Care Planning
- Restraint / Falls

Not all staff have attended these sessions and this will have will be addressed by reviewing the training matrix and ensuring that staff attend the required programmes.

The terms of reference for a Quality and Safety Committee was developed and now form a vital part in striving to achieve the highest standards of care quality, health, safety and welfare management.

An audit has been completed by an external Health and Safety consultancy and this

report is now completed and these actions will be progressed through the Quality and Safety Committee.

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

There was still a lack of adequate clinical governance in the centre.

Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

Regular audits are now taking place in the following areas:

- Food & Nutrition
- Care Plans
- Medication Management
- Competency assessment of Nursing staff

A process of further audits in the areas of Restraint Management, Activities, Falls are to be introduced.

The learning from these audits are still not being applied to the level they should be and further supervision will be required to ensure the importance of these findings from the audits are understood by staff and embedded in our practises. This will form part of each staff member's performance management process.

Further training is to be completed for care planning. The results of the care plan audits will need to be implemented and will be a key focus for us now.

Proposed Timescale: 31/05/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

the centres policies were generic and did not guide practice

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Polices to be made generic in a summary format. These will be used through briefings with staff to ensure that they have been given sufficient knowledge on the centre polices. Supervision and audits will be used ensure that polices are being reflected in practise by staff. If issues are still identified through the audits/supervision these will be discussed either through briefings or if required individually with staff members. This will form part of each staff member's performance management process.

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

Inspectors found that resident's records were not completed in line with schedule 3 of the Regulations.

Action Required:

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

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

Process for Care Plans to be produced in a summary format. These will be used in a workshop with the Nurses. Further Care Plan training to be completed also. Supervision and audits will be used to ensure that records completed by nursing staff do outline the full range of care and treatment provided to residents. If issues are still identified through the audits and supervision these will be discussed either through briefings or if required individually with staff members. This will form part of staff member's performance management process.

Proposed Timescale: 31/05/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The management of behaviour that challenges was not in line with a high standard of nursing care.

Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Elder abuse training completed. Responsive behaviour training provided to 18 staff in February and further training to be provided to staff who did not attend this training. Dementia Awareness training was made available to staff.

Relevant policies to be made generic in a summary format to ensure staff have sufficient knowledge on these policies. Supervision, Incident Reports / Audits will be used ensure that policies are being reflected in practice by staff. If issues are still identified these will be discussed either through briefings or if required individually with staff members. This will form part of each staff member's performance management process.

Proposed Timescale: 31/05/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The systems for the identification, assessment, management, recording and investigation of risk required improvement.

Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The terms of reference for a Quality and Safety Committee was developed. They now form a vital part in striving to achieve the highest standards of care quality, health, safety and welfare management. This committee has begun meeting on a weekly basis to review incidents within the centre with an aim to use this forum to introduce preventative measures to reduce risk of future incidents. This committee will initially ensure that there is an efficient recording and notification of incidents, its aim would also be to ensure that there is an effective system for learning from incidents.

We will review our Risk Management Policy to include arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

A costed plan for the centre has been completed to improve facilities and address the lack of equipment. A number of the items on this plan are already in the centre or have been purchased and we are awaiting delivery. For the remainder of the costed plan a business case proposal is being produced for a board meeting on May 25th.

Fire drills to be carried out on a frequent basis over the coming weeks.

Proposed Timescale: 31/05/2015

Theme:

Safe care and support

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

The risk management policy had not been adhered to when a resident was at risk of self harm.

Action Required:

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

A review of the centre specific policy will include measures and actions to control self harm. Policy to be made generic in a summary format to ensure staff have sufficient knowledge of the policy. Statements/Incident Reports to be reviewed by the Quality and Safety Committee will be used to ensure, along with supervision, the policy is being reflected in practise by staff. If issues are still identified these will be discussed either through briefings or if required individually with staff members. This will form part of each staff member's performance management process.

Further training/workshops for staff on Risk Management/Safety Statement to be completed by Health & Safety Officer.

Proposed Timescale: 31/05/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The preadmission assessments were not updated on admission and did not inform the care plan.

Action Required:

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

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

Admission process has been changed from all residents on Mondays to the process been spread out on Monday, Tuesday and Wednesday. This new process was reviewed

one month after it was introduced and was agreed to be successful. Pre-admission assessments have begun.

The pre-admission assessment to be updated on admission and a comprehensive assessment put in place for each resident.

Proposed Timescale: 31/05/2015

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Care plans did not guide practice.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Process for Care Plans to be produced in a summary format. These will be used in a workshop with the Nurses. Further training to be completed also. Supervision and audits will be used to ensure that records completed by nursing staff do outline the full range of care and treatment provided to residents. If issues are still identified through the audits and supervision these will be discussed either through briefings or if required individually with staff members. This will form part of staff member's performance management process.

Process for the involvement of residents or relatives in the development of care plans to be developed.

All residents to be weighed on admission and the malnutrition risk assessment always completed.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

A high standard of evidenced based nursing care was not consistently delivered to all residents in falls, nutrition and wound care.

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with

professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Falls and Nutrition training completed with Wound care training being arranged. Regular audits being completed on Nutrition with audits on Falls to commence. Supervision and audits will be used to ensure the required care is consistently delivered to all residents in falls, nutrition and wound care. If issues are still identified through the audits/supervision these will be discussed either through briefings or if required individually with staff members. This will form part of each staff member's performance management process.

Proposed Timescale: 31/05/2015

Theme:

Effective care and support

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

Some manual handling practices placed residents at risk.

Action Required:

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

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

Moving and handling training has been provided to staff. Supervision will be used to ensure the required care is consistently delivered to all residents. If issues are still identified through supervision these will be discussed either through briefings or if required individually with staff members. This will form part of each staff member's performance management process.

Proposed Timescale: 31/05/2015

Theme:

Effective care and support

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

Medication management required improvement as outlined in outcome 9.

Action Required:

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

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

Guidance to Nurses and Midwives on Medication Management read and understood by all Nurses. Process for medication developed. Medication error reports communicated to resident's GPs with actions and responses recorded to aid learning. The updated medication kardex has been sent out to GPs which includes information on administration of PRNs as per our policy. All nursing staff have read the centre specific medication management policy.

Regular medication audits now in place. If issues are still identified through the audits these will be discussed either through briefings or if required individually with staff members. This will form part of staff member's performance management process.

Proposed Timescale: 30/06/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

There was an insufficient number of showers available in the centre.

Action Required:

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

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

Costings to improve shower facilities have been completed and are part of an overall costed plan for the centre has been completed to improve facilities and address the lack of equipment. A number of the items on this plan are already in the centre or have been purchased and we are awaiting delivery. For the remainder of the costed plan a business case proposal is being produced for a board meeting on May 25th.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

There were no additional blankets available should a resident get cold.

There was still a lack of pressure relieving devices such as mattresses and cushions, there were an insufficient number of slings available to be used in the transfer of residents using a hoist. There was no standing hoist available.

Some of the furniture was in need of repair.

Action Required:

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

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

Additional blankets are now in place.

Inappropriate furniture will be removed from the centre.

Costings to improve facilities have been completed and are dependent on the availability of funds.

Proposed Timescale: 30/06/2015

Outcome 13: Complaints procedures**Theme:**

Person-centred care and support

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

The complaints policy still did not meet the regulations.

Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

Review complaints policy to ensure it fully meets the requirements of the regulations. The person we have nominated in January will now be included in the complaints policy.

Proposed Timescale: 31/05/2015

Theme:

Person-centred care and support

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

The records of complaints did not include the satisfaction of the complainant.

Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

Satisfaction of complainant to be included in the process.

Proposed Timescale: 31/05/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Resident did not have opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Action Required:

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

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

A 7 day (Mon - Sun) Activity Therapy Program has been drawn up for both Day Care and Respite clients. Activities take place in the centre both in the morning and afternoon on all days. The introduction of this Activity Therapy Program has provided a more structured / guided day for staff with regards coordinating / delivering same activities.

All activities on the new program have been selected to meet the therapeutic meaningful needs of our dementia clients while maintaining and promoting the clients self-help skills and independence.

New activities equipment have been purchased and inappropriate or incomplete activity equipment will be removed from the centre. Staff will receive support / further training to deliver these dementia specific activities. As part of this programme we will ensure that a distinction is made for respite residents when day residents are leaving the centre.

Residents will be consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. They will be facilitated to communicate and enabled to exercise choice and control over their life and to maximise their independence. Each resident will have opportunities to participate in meaningful activities, appropriate to their needs, interests, preferences and abilities.

Day care clients and Respite clients have now been successfully parted at mealtimes. This has helped to greatly improve the dining room experience for all clients.

It is planned SONAS training will be offered to 12 staff – 2 weekend staff, 2 night duty staff and 8 day care staff. When training has been completed SONAS will then take

place daily within the centre.

Proposed Timescale: 31/05/2015

Theme:

Person-centred care and support

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

Residents information was not in an accessible format in line with their assessed needs.

Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

Residents will be consulted and allowed the choice to participate in activities of their choice. Pictures will be used as a form of communication and Dementia awareness training is provided to staff to ensure information will be provided to residents in line with their assessed needs.

Proposed Timescale: 31/05/2015

Theme:

Person-centred care and support

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

Information on display did not support residents with communication difficulties.

Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

We have begun using pictures as a form of communication. The staff are being trained in Dementia Awareness which will support and empower them to improve communications with residents.

Proposed Timescale: 31/05/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents clothes continued to go missing.

Action Required:

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

A system has been introduced where staff are allocated responsibility for specific residents to ensure their belongings are not misplaced and if clothes are laundered they are returned to the resident.

Audits for belongings will be commenced.

Proposed Timescale: 30/04/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The staff number and skill mix was not sufficient at times to meet the needs of residents.

The allocation of staff and supervision of residents was not satisfactory.

Action Required:

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

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

The new Person in Charge will commence their role on May 25th. They will take full ownership of the centre roster to ensure that there is a consistency of staff to ensure proper allocation for the centre's requirements.

New role specifications for staff will be completed by 30th June. The definition of roles will lead to the allocation of tasks for staff on a daily basis while the new management structure will have responsibility for the supervision of these roles. This will form part of the management role specifications. If issues are still identified these will be discussed either through briefings or if required individually with staff members. This will form part of each staff member's performance management process.

All staff will have completed a full performance management review by 31st July.

These performance reviews and role definitions will identify if the skill mix is sufficient

to meet the needs of residents.

Proposed Timescale: 31/07/2015

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was no training plan developed to ensure evidenced based care could be delivered to residents.

Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Training requirements are identified through the centre's Training Matrix which includes all the mandatory and dementia specific requirements. It identifies each staff's outstanding training requirements and when refresher training is required. A monthly plan is produced from this Matrix. If further specific training is required it will be identified through a staff member's performance management review.

On a quarterly basis a review of the effectiveness of training will be completed. These will be completed at the end of July and October.

Proposed Timescale: 31/07/2015