<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Orchard Day and Respite Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000691</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Temple Road, Blackrock, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 207 3839</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:theorchard@alzheimer.ie">theorchard@alzheimer.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
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<td>Alzheimer Society of Ireland</td>
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<tr>
<td>Provider Nominee:</td>
<td>Donal Murphy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td></td>
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<tr>
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<tr>
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<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times
From: 01 June 2016 09:00  To: 01 June 2016 21:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to follow up on matters arising from a monitoring inspection carried out on 23 March 2016 and to monitor progress on the actions required. This inspection also considered information received in the form of notifications forwarded by the provider.

As part of the inspection, the inspectors met with residents and staff members observed practices and reviewed documentation such as policies and procedures care plans, medical records and risk management processes.

Overall a good standard of nursing care was being delivered to residents in an atmosphere of respect and cordiality. Staff were knowledgeable of residents and their abilities and responsive to their needs. Safe and appropriate levels of supervision were in place to maintain residents’ safety in a low key unobtrusive manner.

Overall, there was evidence of progress in many areas by the provider in implementing the required improvements identified by the previous inspection.
Evidence of improved governance processes was found. Improved staffing levels and skill mix was also found.
The Action Plan at the end of this report identifies a small number of areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
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:
Governance systems were found to have improved on this inspection. The senior management team which comprised the provider nominee, person in charge, head of operations and quality, safety and practice development manager had commenced implementing many of the actions contained in their response to the actions arising from the previous inspection.

Minutes of the monthly quality and risk management meetings were reviewed and issues discussed included; feedback on recent documentation audit; infection prevention and control; issues included on the risk register such as moving and handling risks and control measures and risk management of residents at risk of absconsion and restrictive practices.

Actions addressed included;
- Additional nursing and healthcare assistant resources were in place. An extra care assistant was rostered on all shifts including night shifts and an additional nurse was rostered five days per week since the last inspection. Improved levels of bank relief staff were also reported.
- Improvements to the clinical assessment and review of resident’s needs on admission had identified that the service was unable to meet the needs of some residents following admission.
- Improvements to the system in place to monitor quality and safety of care and the quality of life of residents. A comprehensive review of the standard of care delivered to residents focused on direct care practices. Issues which arose following the last inspection were used as learning to improve care practices. However, this process has only recently commenced and a complete cycle audit has yet to be established to ensure a strong and effective monitoring system.
- Communication within and between grades of staff and teams across all units in the centre had improved. Formal handovers still took place at the start and end of shift but
an additional handover session had commenced in the late morning to update staff on resident’s overall condition and health status. The inspector attended one of the handovers and noted that the information provided to staff during the session was relevant; person centred and included direction from the person in charge on how to manage responsive behaviours related to disorientation, anxiety, restlessness and potential for attempts by some residents to leave the centre unaccompanied.

- Roles and responsibilities of each staff person had been reviewed and although revised job descriptions were not yet fully rolled out, staff spoken to were much clearer on their own role and the role of others within the team.
- Supervision systems were much more defined. These included high visibility of the person in charge across the unit. Improvements to the provision of leadership, direction and guidance given to staff throughout the day were observed. The provider nominee was also directly involved on an operational level in the development of change processes within the unit. A keyworker system was in development whereby each nurse and healthcare assistant were responsible for a certain number of respite and day care residents. A daily allocation chart for both day and night shift set out the specific role and responsibility of each staff person on duty.
- During this inspection unqualified community employment scheme staff had considerably reduced. There were six community employment scheme staff on the roster. None were delivering direct care to any residents. Most were involved in administrative duties, some were involved in assisting with activities and some were involved in transport duties. The inspector was told that going forward the numbers of people availing of the scheme and working in the centre may increase and may involve inclusion in direct care delivery but that this would only occur where commitments to undertake a full FETAC Level 5 course was provided by the scheme participant.
- The involvement of all nursing staff in the development and review of care assessment and planning had commenced although it was noted that training and a high level of support by the nursing management team was still required.

Aspects of the actions required from the previous inspection which were not addressed included;
- Further improvements to governance and monitoring processes such as the inclusion of performance indicators for clinical care such as; nutrition and weight; pressure ulcers; trending of incident reports on slips trips and falls and medication management remain to be established. The inspector was told that this is scheduled to commence in September.
- Although a deputy manager had been recruited, there was a slight delay in the commencement of this post by a couple of weeks and the new manager was due to commence on the week following this inspection.
- Turnover had slowed and several nurses had been successfully recruited for vacant positions. A heavy reliance on the use of agency staff with one nurse and two care assistants from the agency on duty on a daily basis remained.
- Further improvements to preadmission processes such as transfer of information between the centre and community based health professionals and up dated assessments on potential residents were required. This would enable more informed decisions be made on the ability of the centre to meet comprehensively assessed needs. A review of the purpose and function of the service and an accurate and realistic determination on the level of need the service can safely meet particularly in relation to managing responsive behaviours associated with physical or verbal aggression and
absconsion is urgently required. This was discussed at length at the conclusion of the inspection.

**J**udgment:
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:**
Although it was found that most of the actions required under this outcome remain to be addressed it was noted that the provider and person in charge had appropriately prioritised their actions.

**Actions addressed included:**
- A risk register was being established.
- Records requested were available for review to facilitate the inspection process.

**Actions not addressed included:**
- All records required under Schedule 3 of the Regulations were maintained in the centre. But improvements to the documentation and recording of care continued to be required to ensure that a high standard of evidence based nursing care was being delivered to residents.
- A review of policies in place and all records as required under schedules 2 and 4 of the regulations had not commenced to update them in line with best practice. Opportunities for staff to become familiar with policies and practices has yet to be provided.
- Personnel records did not fully meet the requirements of the regulations in that: all records did not contain evidence of qualifications, employment history, written references or photographic identification were not included on all files reviewed.

**J**udgment:
Non Compliant - Moderate

### Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Evidence that a deputy manager had been recruited and appointed was available although the person had not yet commenced in post.

**Judgment:**
Compliant

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

**Findings:**
Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse.

It was noted that the centre policy on prevention of elder abuse was not updated to reflect the most recent HSE guidance on safeguarding vulnerable adults. An action in relation to this is located under Outcome 5.

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

Improved guidance and training was being provided to staff on the management of responsive behaviours although further improvements to positive behaviour support plans were required. This is referenced under Outcome 11 healthcare. Risks associated
with poor management of responsive behaviours were not found on this inspection.

**Judgment:**
Compliant

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**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:**
The actions required from the last inspection were partially addressed.

Actions addressed included:
- Fire training was delivered and all staff had been given an opportunity to attend. Staff spoken too were more confident in their knowledge of the fire procedures in place. All staff knew who the designated fire warden on duty was on the day of inspection. They also knew who would check the fire panel and who would call the fire brigade.
- Two unannounced fire drills were held since the previous inspection. One in the early afternoon and the other in late evening. Both were used to determine the response of staff to a fire alarm activation and knowledge of the fire procedure.
- The fire procedure was revised and now directed staff to follow the instructions of the person in charge or designated fire warden on duty to evacuate the building if required and not to return.
- Fire records showed that weekly fire alarm tests and quarterly fire drills were now in place.
- Emergency evacuation sheets were correctly fitted to all beds.
- Significant improvements were found in the standard of hygiene throughout the centre. The centre was odour free and premises equipment and furnishings were stain free and visibly clean. In conversation with the provider and cleaning staff the inspector found that all cleaning processes were completely revised. The cleaning staff showed the inspector the supply of new cleaning equipment and products in place since the last inspection. The staff had also been given training and information sheets on all of the products. A cleaning system was established that followed best practice guidance for prevention and control of healthcare associated infections. For example, all equipment was colour coded for use in specific areas. A single use and replace for each mop head was now in use. A washing machine was installed to wash all cleaning cloths and mop heads on a daily basis at 90 degrees. A range of cleaning products including, multipurpose and antibacterial were in place and a set dispensing system installed to ensure that products were used in accordance with recommended dosage and concentration.
- Supervision and support for the team was also in place. During the inspection the area
manager called to the centre to check on the standard of hygiene and address any problems or difficulties the staff may have. In conversation with the manager the inspector was told that he visited the centre on a weekly or bi-weekly basis. The manager said staff had received training in moving and handling and infection prevention and control specific to their role and evidence of this training was available. Further training in product and equipment use and also training on cleaning skills was planned. This was also confirmed in conversation with the staff on duty who told the inspector they were much more supported and felt that their role was more respected and valued. The staff were enjoying the training and were looking forward to being up-skilled and developed.

- All staff spoken to were aware of the responsibilities of each grade of staff to clean certain types or items of equipment.
- A risk register was being developed. It included some environmental risks related to use of chemicals and hazards and also included clinical risks such as: falls, responsive behaviours and abscondion. The register rated each risk and assigned it a colour code for ease of identification. The ratings ranged from trivial to medium, severe and emergency.
- Appropriate arrangements for investigating and learning from serious incidents/adverse events were also being established. This was previously referenced under outcome 2 where all such incidents were also discussed at the weekly Quality and Risk committee meetings. Incidents related to responsive behaviours that negatively impacted on others were addressed in a timely manner. Other incidents related to medication errors: bruising and falls were reported. Measures to prevent or reduce occurrence were identified such as: 1:1 supervision.

Actions not addressed included:
- Personal evacuation plans in place for each resident were not specific enough to guide staff on the level of assistance, supervision or expected level of compliance in an emergency situation. All residents had a formal or suspected diagnosis of dementia or cognitive impairment. Staff acknowledged that they were unclear what they should do in the event a resident refused to leave the building in an emergency situation. Staff responses varied, some said they would leave the resident and note their location others said they had previously been instructed that they should ensure the resident leaves the building. All staff said that this was an area that needed more clarity in the evacuation procedure especially where residents were mobile and prone to anxiety, agitation or wandering.
- Although unannounced fire drills had been held these did not include simulated practice using the evacuation aids such as evacuation sheets to improve staff familiarity with equipment, process and timing or identify and resolve any potential problems.
- A full cleaning schedule was not yet developed to ensure continuity and consistency of approach and guide new or replacement staff on the procedures in place.
- Although improvements to the processes for learning from adverse incidents were found some further improvements are required. The identification and implementation of measures to reduce or prevent the risks of abscondion was not complete. Two residents had managed to exit the building without staff knowledge in a 10 day period. One had climbed out the main sitting room window and the other had pushed the automatic release button for the emergency exit door on the bedroom corridor. In both instances the residents found themselves in an enclosed garden and were returned to the centre within minutes by staff. However, although a restrictor was immediately put
on the window to prevent recurrence it was found that the installation of an alarm on
the exit door to alert staff should this incident recur was not considered. It was further
noted that a second emergency exit door with an automatic button release in the
smaller sitting room is also not alarmed. Although on the day of inspection a senior fire
officer was reviewing the fire prevention arrangements in the centre with the person in
charge at their request. A medication error was reported to the person in charge two
days prior to the inspection. All of the medication for a resident admitted on that day
was reported as missing by the night staff. The person in charge had immediately
commenced an investigation into the circumstances surrounding the receipt and location
of the medication and had contacted nursing staff on duty to make statements on their
knowledge or involvement with the medications. However although the missing
medications had not been located despite it being established that they had been
received in the centre, the seriousness of the incident and the need to extend the
investigation had not been considered. In discussions with the provider and person in
charge and the head of national operations, the inspector advised that where the
preliminary investigation found there may be cause for concern that a serious incident
had occurred, they would need to consider the involvement of external agencies such as
professional bodies or the Garda Síochána.

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:
Actions addressed included:
- a photograph was in place for all residents to aid staff recognition
- the allergy section of the prescription sheets was completed for all residents
- a review of the medication audit process was underway but not fully completed. An
  audit was carried out two days prior to this inspection. This included a review of
  medication administration practices and competency assessments by the practice
development manager. The audit recorded a high level of compliance by nursing staff
with medication management policies and procedures in place in the centre.
- Medication errors continued to be appropriately recorded and discussed by the risk
  committee. Records reviewed showed that errors subsequent to the last inspection
  were now being used to drive improvements in practice. Staff were given feedback,
direction and identified training needs were being followed through.
Actions not addressed included:
- development of a medication reconciliation process.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
Improved identification, assessment and recording of risks were found on this inspection. Improved management and reporting was also found. The person in charge was complying with the requirement to notify the Chief Inspector within the appropriate timeframes of all notifiable incidents.

Judgment:
Compliant

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:
All aspects of this action were partially addressed but the need for considerable further improvements were found.
Some improvements to the standard of care being delivered to residents were found. The improvements although limited were sufficient to mitigate the risks found on the
- Evidence of access to medical and allied health professionals remained limited but there was evidence that most, though not all, recent admissions had an updated referral from the public health nurse (PHN) and/or a report from their general practitioner (GP). The GP report gave a brief overview of past medical history, medications and in some instances recent reviews by other consultants.

- The PHN referral included information on the reason for referral, usually for family support, an overview of current condition in relation to mobility, level of assistance required with activities of daily living and usual pre disposition or mood. But of the sample reviewed it was found that information was not available to indicate that a recent review of the present condition, health status or abilities for all residents prior to admission had been conducted by any member of the primary care team to update staff in the centre and assist them to meet the residents needs.

- A pre admission assessment was being established. This was called a care plan assessment and was conducted by the person in charge prior to admission to determine whether the centre could meet the prospective resident's needs. Key information to be collected included: demographic information; community supports availed of; emotional medical and physical status. But it was found that a lot of this information was not entered and few of the forms reviewed were completed with many having very few entries.

- There were an increased number of recognised evidence based risk assessment tools in use in the centre to determine residents' abilities and needs for activities of daily living. In addition to clinical risks for falls and pressure ulcer development, there were also continence, nutrition and moving and handling assessments in use. In addition residents were being assessed for risks of absconsion and responsive behaviours. Inspectors did note that a considerable improvement was made by staff in relation to ensuring baseline vital signs were recorded on admission and the overall condition of the residents' skin integrity was clearly recorded and any bruising marks or breaks mapped out on a body chart.

- Improvements to wound care charts and identification and implementation of treatments for wounds was clearly recorded and regularly reviewed.

- Care plans were also in place to manage the needs identified but again it was noted that the plans in place were not specific enough to guide staff or fully manage the needs identified. Examples included; positive behaviour support plans; mobility; weight monitoring and risks of absconsion.

Overall it was found that there were some improvements to the quality of clinical documentation. This together with practices observed had mitigated the risks found on the last inspection. It was also noted that staff were now being provided with better support and supervision by the senior management team specifically the person in charge to deliver better care.

However, ongoing support and training was still required to embed improvements to practices and further improve the standard of care delivery. Some aspects of documentation and recording were not improved including, the daily nursing progress notes which were primarily summation and did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians. Care plans, nursing progress notes and other supporting documentation were not appropriately linked to ensure that a high standard of evidence based nursing care was being provided or give a clear and accurate picture of residents' overall health management.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Suitable and sufficient staffing and skill mix were found to be in place to deliver a good standard of care to the current resident profile. Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. However, it was noted that there continued to be a heavy reliance on agency staff on this inspection.

Improvements to supervision of practice had improved and it was noted that an additional communication handover session at midday introduced following to the last inspection was in place to ensure consistency of approach and maintain effective communication across grades. The information provided during the handover was found to be relevant and updates on residents' mood behaviour and level of participation in activities were shared across the team of staff.

Records reviewed showed that staff had been provided with opportunities to receive updated training in areas such as: safeguarding; and fire safety. Dates were set for further training on areas including: assessment and care planning and management of responsive behaviours.

Judgment:
Compliant

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

Acknowledgements

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

Report Compiled by:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Health Information and Quality Authority**

**Regulation Directorate**

**Action Plan**

**Provider’s response to inspection report**

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<tr>
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<td>01/06/2016</td>
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<tr>
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**Requirements**

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

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

**Outcome 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 in place require to be further strengthened and improved to ensure a safe consistent and high standard of care is delivered to all residents. Issues of concern remain in relation to; continued reliance on agency staffing; ongoing review of staffing resources and skill mix; inclusion of clinical key performance indicators into the audit processes and embedding a complete cycle audit system.

A review of the purpose and function of the service and an accurate and realistic

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
determination on the level of need the service can safely meet particularly in relation to managing responsive behaviours associated with physical or verbal aggression and abscondion is urgently required

1. 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 monitored.

Please state the actions you have taken or are planning to take:
• Deputy Manager is in post since the 6th June.
• Staff have been issued with updated job descriptions.
• We have advertised for staff nurse and care staff positions to reduce our reliance on agency staff.
• We are continuing to improve our management systems to ensure safe, appropriate, consistent care is in place and monitored effectively through supervision and ongoing audits.
• Performance indicators for clinical care such as; nutrition and weight; pressure ulcers; trending of incident reports on slips trips and falls and medication management to be established.
• A complete audit cycle spreadsheet has been devised to ensure a strong and effective monitoring system will be in place.
• The statement of purpose will be updated to reflect changes to the admission of clients to the Centre.
• Preadmission processes to include the transfer of information between the centre and community based health professionals and up dated assessments on potential residents.
• Documentation to be devised to guide the nursing staff in care planning and the appropriate steps to take to ensure that all care plans are reviewed appropriately.
• Care Plan Training to be organised
• A review of the service to be completed to determine if resident’s requirements can be fulfilled within the present structure.

Proposed Timescale: 30/09/2016

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:
All policies were not revised within a three year timeframe, gave sufficient guidance to staff or reflected current best practice and the regulations.

2. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any
event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
- PIC will review all Schedule 5 policies to ensure that they are in line with best practice, are centre specific and up to date.
- Safeguarding the Vulnerable Person at risk of Abuse policy has been completed in line with the HSE policy.
- Policies in draft currently are End of Life, Behaviours that Challenge (Responsive Behaviours), and Medication Management. Training will be provided when the policies are complete.

**Proposed Timescale:** 30/09/2016  
**Theme:** Governance, Leadership and Management  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Opportunities for staff to become familiar with policies and practices has yet to be provided.

3. **Action Required:**  
Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

**Please state the actions you have taken or are planning to take:**
- The Policies and procedures are available to all staff.
- A new system has been introduced to ensure that staff read the policies and sign that they have read them.

**Proposed Timescale:** 31/07/2016  
**Theme:** Governance, Leadership and Management  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Personnel records in place did not fully meet the requirements of the legislation under schedule 2

4. **Action Required:**  
Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less then 7 years after the staff member has ceased to be employed in the designated centre.
Please state the actions you have taken or are planning to take:
- Review of present staff records commenced in May to ensure they fully comply with Regulation 21(6) of the Health Act. (Schedule 2). Any outstanding items are being collected. Audit spreadsheet, which is reviewed weekly, is in place to monitor progress during the new weekly Orchard Management meeting.
- Plan for review of previous staff files to ensure compliance completed.

Further actions taken from Monitoring Report with regard to Outcome 05 included:
- Review of all resident records commenced in May to ensure they fully comply with Regulation 21(6) of the Health Act. (Schedule 3). Audit spreadsheet, reviewed weekly, is in place to monitor progress and identify any outstanding items to the Orchard PIC/Deputy Manager. Spreadsheet set up in nurses’ station to ensure outstanding items are completed and signed off.
- Review of all other records planned to ensure they fully comply with Regulation 21(6) of the Health Act. (Schedule 4)
- Review of Statement of Purpose planned to ensure it complies with Regulation 21(6) of the Health Act. (Schedule 1)
- Review of Polices and Procedures planned to ensure they are maintained to comply with Regulation 21(6) of the Health Act. (Schedule 5)
- Review of Premises, Kitchen and Sanitary Facilities planned to ensure they are maintained to comply with Regulation 21(6) of the Health Act. (Schedule 6)

Proposed Timescale: 30/09/2016

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:
Systems in place to identify assess manage and review risks throughout the centre were not established or sufficiently robust or were not implemented to safeguard all residents.

5. 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:
- We continue to review our systems in place to identify record, investigate and learn from serious incidents or adverse events involving residents. This will be achieved through the terms of reference and learnings from our Risk Management Committee.
- A system is now in place to review incidents with staff on an ongoing basis and at handover reports which take place three times each day or sooner if required.
- Reflective practice sessions will commence with staff and investigation and learning from serious incidents or adverse events involving residents will be discussed at these
sessions.
  • A review of these systems will be conducted through our audit schedules.
  • Further training in product and equipment use and training on cleaning skills is being
    arranged for external cleaning staff.
  • Evacuation procedure for all residents to be clarified with staff to guide everyone on
    the level of assistance in an emergency situation.
  • Simulated fire drills to be completed.
  • To further reduce the risk of absconson an alarm on relevant exit doors will be
    installed to alert staff immediately if an incident should occur.

Proposed Timescale: 31/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Audit processes in place did not include a robust medication reconciliation process to
minimise risks associated with medication errors or discepencies.

6. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy
set out in Schedule 5 includes the measures and actions in place to control the risks
identified.

Please state the actions you have taken or are planning to take:
  • Medication reconciliation system is now in place and will be included in the medication
    audit.

Proposed Timescale: 31/07/2016

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:
Assessment and care planning were not specific enough to direct the care to be
delivered or guide staff on the appropriate use of interventions to consistently manage
the identified need.
Complete comprehensive nursing assessments were not carried out for each resident.

7. 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
Please state the actions you have taken or are planning to take:
• Pre-admission assessments are completed following receipt of a referral and a medical report from the PHN/GP. We continue to seek comprehensive up to date information from the allied health professionals.
• The PIC will review the ASI referral form, to ensure that we receive a more detailed assessment in relation to the diagnosis of dementia.

Proposed Timescale: 31/08/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

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

Please state the actions you have taken or are planning to take:
• A system is in place for the review of care plans and is monitored through the audit cycle spreadsheet to ensure a strong and effective monitoring system will be in place
• Training will be provided to nursing staff, to ensure that the care plans, nursing progress notes and other supporting documents are inter linked.
• The care plan assessment will be reviewed by the PIC.

Proposed Timescale: 31/08/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of care was not sufficiently accurate or appropriately linked to ensure that a high standard of evidence based nursing care was being provided or give a clear and accurate picture of residents’ overall health management.

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:
- PIC will continue to review and audit the documentation to ensure a high standard of evidence based nursing care is provided.
- Training will be provided to nursing staff, to ensure that the care plans, nursing progress notes and other supporting documents are inter linked.

**Proposed Timescale:** 31/08/2016