

**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:	Nuala Rafferty
Support inspector(s):	Jim Kee
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

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: 23 March 2016 10:00 To: 23 March 2016 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This was an unannounced inspection conducted by two inspectors over one day. The original purpose of the inspection was to determine what life was like for residents with dementia living in the centre, as part of a dementia thematic inspection. But due to the level of non compliance and risks found, the purpose changed to a risk based inspection.

As part of the inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors found that there were a significant number of areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Inspectors found that there was a lack of adequate clinical governance in the centre which resulted in poor outcomes for residents. The management systems in place did not ensure that services provided are safe, appropriate to residents' needs, consistent and effectively monitored. Risks were identified in risk management specifically related to fire safety and staffing levels and skill mix were not adequate

to meet residents' needs during the inspection. Immediate action plans were issued to the deputising person in charge at the end of the inspection. The provider nominee was informed of the immediate action plans in a phone call at the conclusion of the inspection.

Appropriate and timely responses to the immediate action plans were received from the provider subsequent to the inspection.

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

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:

Management systems or sufficient resources to ensure an effective, appropriate and safe level of care was being delivered, in accordance with the statement of purpose was not found. This is a recurrent finding from previous inspections.

A system in place to monitor quality and safety of care and the quality of life of residents on aspects of care such as risk management; care planning; safeguarding or staff supervision and training was not effective in that it did not identify improvements required to raise standards of care as part of overall quality and safety improvements.

-Monitoring of clinical risks such as management of responsive behaviours, falls, infection prevention and control and wound care was not in place. Data on these or other key performance indicators was not being collated or critically analysed to identify trends and implement measures to prevent or reduce recurrence.

- Adequate staffing resources and appropriate skill mix to ensure the delivery of safe, suitable and sufficient care to residents' was not in place. A senior nurse appointed in October 2015 and identified as the deputy person in charge resigned the post seven weeks prior to the inspection. Contingency cover for planned or unplanned absences was not in place. Agency cover was regularly used, particularly for nursing staff on night shifts. Other than the person in charge, only one other full time and experienced nurse was identified on the roster. The remaining nursing staff were part time relief or had recently started and were on induction. Healthcare staff cover was also compromised. Regular use of agency staff was noted and all shifts were not identified as being filled on the planned roster for the week in which the inspection took place.

Governance and management systems to provide a safe appropriate consistent standard of care were not established.

Evidence of negative impacts on the safety of care delivered included;

- A high number of significant and serious incidents occurred during the 1st quarter of

2016, none were notified to the authority as required by the regulations.

Evidence that a comprehensive review of these serious incidents with measures to prevent or reduce recurrence was not available.

- Effective systems to supervise the standard of professional nursing care to residents were not in place. Evidence was not found of the delivery of an adequate standard of nursing care including; appropriate assessment of need; development and implementation of care plans and treatment regimes; underlying causes of responsive behaviours not investigated or determined; appropriate and timely referral and follow up not evidenced.
- Staff allocation systems were not in place and clear roles and responsibilities of each grade staff were not evident.
- Supervision or monitoring of staff on community employment schemes was not in place particularly for new and inexperienced staff.
- Supervision or monitoring of cleaning staff was not in place and inspectors identified risks related to poor infection prevention and control practices.
- Annual refresher training for staff on fire safety and evacuation and safeguarding and safety was not provided. Instructions or direction was not given to new staff on policies or guidance in place.
- Communication within and between staff was not supportive of consistent practice. A formal staff handover to update each other on resident's condition took place at the beginning and end of shift but there was no formal method of exchanging information on changes which occurred during the day.

An annual review of safety and quality of care was not in place. With the exception of audits carried out by the contracted pharmacist there was limited evidence of other audit processes in place to monitor clinical or non clinical practices

Findings relating to poor management of responsive behaviours, care planning and assessment, fire safety and risk management which are detailed under the relevant outcomes further in this report did not assure the inspection team that the service provided was safe, appropriate to residents' needs, consistent or effectively monitored.

Judgment:

Non Compliant - Major

***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:

There was some evidence that all records required under Schedule 3 of the Regulations were maintained in the centre. But significant improvements were required in respect of maintaining clinical records in accordance with professional standards. This included linking clinical assessments and risks with care plans to aid evaluation. Documentation and recording of care was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered to evidence that residents' healthcare needs were fully met.

Inspectors requested to view a number of specific records including; minutes of staff meetings samples of personnel records, rosters, risk register and service level agreements with external companies. Some of these were made available. However, although the management team tried to locate all the records requested, it was found that some records were locked away and as the person in charge was on leave they could not be accessed.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

Although it is acknowledged that the person in charge was not absent for a period of 28 days or more, it was found that suitable arrangements were not in place in the event of absence of the person in charge

A clinical nurse manager (CNM) had been appointed to deputise in the absence of the person in charge, but this person had subsequently left and had not yet been replaced.

Although the person deputising for the person in charge on the day of inspection was an experienced manager with a nursing qualification, they were not familiar with the centre's policies procedures staff or residents.

Judgment:

Substantially 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):

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

Findings:

Evidence that measures were in place to protect residents from being harmed or suffering abuse was not found.

There were a high number of serious incidents that took place during the first three months of 2016 related to responsive behaviours of residents.

These incidences included; shouting; threatening and abusive language; grabbing; slapping; pushing and punching.

These physical assaults included staff and other clients being kicked, punched pushed and slapped. One resulted in loss of consciousness requiring transfer to hospital. Others related to inappropriate kissing and touching.

Incidents reviewed highlighted that both day care clients and respite residents were fearful and crying during and after these incidents.

Inspectors viewed records of nine such incidents in January, seven in February and three in March 2016

As all of these incidences had a negative impact on other residents such that residents were fearful, it could be determined that they fall within the definition of abuse.

Evidence that these incidents were appropriately assessed, reported, recorded, responded to or managed was not found. Measures to ensure appropriate and timely responses and management of risks associated with negative peer interactions were not found. The management team did not initiate any investigations into the underlying causes of the behaviour and appropriate referrals or follow up to relevant public health nurses, general practitioner's consultants or allied health professionals were not found. These incidents were not brought to the Authority's attention through the notification process by the person in charge throughout the first quarter of 2016. It was found that the provider or person in charge had not conducted preliminary investigations into the more significant incidents. Evidence to support the outcome of a thorough investigation process was not available. Evidence that any of these were reported to the health service executive's social care officers for older persons was not found.

There were reporting mechanisms in place to direct what staff should do in the event of a disclosure about actual, alleged or suspected abuse. In conversation with them, some staff were knowledgeable on the policy and procedures in place for recognising the possible signs and symptoms of abuse, responding to, managing and reporting them.

But although staff told the inspector they had received training on prevention of elder abuse, training records viewed showed that updates had not been provided since 2014 on Safeguarding Vulnerable Adults. New staff had not been provided with this training at the time of inspection.

Positive behaviour support plans to appropriately and consistently manage responsive behaviours were not in place, this is further referenced under Outcomes 11 and 18.

Judgment:
Non Compliant - Major

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:

Emergency lighting and fire fighting equipment, directional signage and fire procedures were available throughout the building.

The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors and a register of visitors was available. Inspectors reviewed some available documentation relating to fire safety including: daily and weekly check lists completed by staff, certificates confirming servicing of fire equipment including fire extinguishers, emergency lighting, and service reports for the fire alarm system.

However, although, staff spoken to knew some of the procedures to be followed in the event of fire, overall staff knowledge was inconsistent. Inspectors found that staff were not fully clear on who would check the fire panel, check the location of the fire or who would call the fire brigade. New staff had not received training in the fire procedures and had not been inducted in the procedure to follow. The majority of staff had not been provided with updated training since 2014 and some last had refresher training in 2013.

Some emergency evacuation sheets were available to aid the safe evacuation of less mobile or immobile residents. Inspectors viewed two of these in place on residents' beds. But these aids were not applied correctly which left them ineffective as they were caught under the bed frame. Fire records viewed showed that three simulated fire drills were held during 2015 and one in 2016. All were during the day. Simulated drills to reflect night staffing or fire evacuation procedures using the emergency sheets had not occurred.

Personal evacuation plans in place were not detailed enough to guide staff on the specific measures to be used to safely evacuate each resident.

A procedure on responding to a fire emergency and evacuating the centre, called the fire marshall action plan was pinned to the notice board in the nurses' station and person in charge office. Inspectors were told this was the procedure being followed by staff.

This procedure advised staff that in the event of a person being missing during a fire they should 're enter the building if it is safe to do so'.

Practices to support good infection prevention and control were not found.

Cleaning in the centre was outsourced to an external company. Cleaning equipment provided such as mops buckets and cloths were colour coded. This system distinguished the equipment to be used in different areas in the centre. For example, red coloured equipment was for use in toilet areas, blue in bedrooms and corridors and yellow in kitchen areas. Inspectors found that the system was not being implemented. The blue mops, buckets and cloths were used in both toilet and bedroom areas on the day of inspection. The cloths and pads used earlier were subsequently observed rolled up together in the mop bucket after the cleaning staff had left. They were damp and one was stained with faecal matter. They had not been washed, dried or sterilized as part of an overall cleaning process to reduce and prevent re contamination.

Inspectors found that the cleaning products used by the cleaning staff were limited to a perfumed cleanser spray and air freshener. The cleanser spray did not contain any disinfectant, antibacterial or antimicrobial properties. The instructions on the bottle identified it as suitable for showers baths and sinks only. But this product had been observed in use throughout the premises and staff identified it as the one used to clean all equipment and furnishings.

Inspectors found that the centre was not visually clean, with a build up of grime and stains viewed in some areas, particularly in toilets, sluice and laundry room. There was a strong odour of urine in some of the toilets. These had already been cleaned by the cleaning staff.

This was of concern when inspectors noted that a current resident had an infected cut to the leg and a recently discharged resident had a fungal nail bed infection. Fungal infections are transmissible in warm damp environments such as showers or baths. The provider or person in charge were not monitoring the standard of cleaning or infection control provided by the company. Inspectors were told that the cleaning staff were supervised by the company supervisor who had last visited several weeks ago.

Inspectors were told that the healthcare staff were responsible for cleaning equipment and fixtures or fittings such as beds, mattresses, pressure relieving mattresses or cushions, crash mats, lockers and wardrobes. Staff spoken too were aware of their responsibilities to do this and told inspectors all relevant equipment and furniture were cleaned on discharge of a resident in preparation for the next admission. But a system that ensured this took place was not effective. There were four discharges and new admissions during the inspection. At approximately 11 am inspectors were shown around the building by one of the management team. Inspectors noted that much of the equipment was inappropriately stored on the floor in the sluice room. Marks and stains were observed on pressure relieving mattresses and cushions and crash mats. Two stained crash mats were also viewed in one bedroom.

At 2pm the inspector asked if the equipment and furniture for the newly admitted residents had been cleaned. Staff said they were sure it had. When checked, it was found equipment had not been moved and the stains were still evident. But new residents had already been admitted to the bedrooms, one bed had been remade with a pressure relieving mattresses system which the inspector had observed was previously used by a resident discharged earlier.

Appropriate arrangements for investigating and learning from serious incidents/adverse events such as those detailed under Outcome 7 relating to responsive behaviours were not effective. Measures to ensure appropriate and timely responses and management of all risks were not in place.

A risk register was not maintained to ensure the identification and management of environmental, clinical and non clinical risks in the centre.

Judgment:

Non Compliant - Major

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:

Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of blister packed medication. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. Fridges were available for medicines that required same. Although it was noted that nutritional supplements were not appropriately stored and were located in a small kitchenette identified as for use by more independent residents.

Medication administration was observed and appropriate practice in line with professional guidance was observed. Prescription practices were also in line with current professional guidance. But it was noted that not all residents had a photograph attached to their medication sheets to aid staff recognition. The allergy section of the prescription sheet was not completed for all residents to clarify whether residents had any known allergies to medicines or had no known drug allergies (NKDA).

Medication audits were conducted in the centre and inspectors reviewed a sample.

These audits only covered some aspects of good medication management practices.

Competency assessments related to medication management had been completed for a small number of nursing staff, but there was no clear process in place to ensure these assessments were completed for all nursing staff. The audit process did not include a review of the reconciliation procedures on admission and discharge to ensure residents prescribed medicines were checked against the prescription provided by the residents' general practitioner, the prescription sheet in place in the centre and the medicines dispensed.

The audits were conducted by the external pharmacist who supplied medicines to the

centre. The audits looked at aspects such as; storage, labelling, administration records controlled medicines and temperature controls on medicine refrigeration.

Medication errors were appropriately recorded and discussed at the drug and therapeutics committee. But inspectors learned that action plans associated with follow up on these medication errors that included appropriate feedback to staff, identified and implemented any learning needs was not in place.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the designated centre was maintained. But all relevant incidents were not notified to the Chief Inspector as required under Regulation 31.

Judgment:

Non Compliant - Major

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:

A safe and suitable standard of care was not being delivered to all residents. Evidence of appropriate access to medical and allied health professionals was limited. Inspectors noted that nursing staff contacted the area doctor on call service where residents required to be seen. But evidence of access to other allied health professionals or referral to specialist consultants was not found.

Samples of clinical documentation including nursing and medical records were reviewed these showed that all recent admissions to the centre were not assessed prior to admission. A referral form was forwarded to the centre usually by the public health nurse or liaison nurse. But there was no evidence that a comprehensive pre admission assessment was conducted by the person in charge to determine the health and social needs of the potential resident and whether the centre could meet those needs.

Inspectors reviewed a sample of residents' files and found that the system in place to meet residents' assessed needs required significant improvement.

A resident profile called 'This is me' was completed by the resident's family or next of kin. This included personal preferences past interests and information to help staff become familiar with the resident's personality.

A small number of clinical risk assessments were completed including; risk of falls, pressure ulcers and dependency level. But inspectors noted that residents' vital signs were not recorded on each admission to establish a baseline for monitoring signs of clinical deterioration or acute illness. Also residents were not routinely weighed on admission and a nutritional MUST assessment was not completed.

A healthcare plan for each identified health or social care problem is required to be put in place by the nursing team to maintain residents' health and well being and monitor improvements or deterioration. These were not in place for all identified needs. Inspectors found only one care plan was in place. This was to manage emotional well being. But the plans were not updated or reviewed on each respite admission.

One resident had a wound which may have developed in the centre. This was unclear due to the poor standard of clinical documentation. The resident's skin integrity was stated as healthy on the pressure ulcer risk assessment on admission, but, following assessment later that night a small infected wound was noted on the right shin. This was treated with a small dressing and oral antibiotics. A wound care and treatment regime was not established. There were no care plans to guide care, such as the frequency of the change of dressing or the type of dressing required.

A new resident was admitted on the day prior to the inspection. Staff were not familiar with her needs. The falls risk assessment identified the resident as a high risk. Night Nursing progress notes entry stated that the resident required the assistance of three staff to transfer from chair to bed and queried the use of the full body hoist. A moving and handling assessment or care plan was not completed.

As previously referenced under outcome 7 residents with responsive behaviours did not have positive behaviour support plans to guide care and management. Inspectors found that residents with underlying diagnosis of dementia and identified responsive behaviours such as resistance to personal care and increasing agitation were not being referred for review. Assessments such as blood screening or urine testing to identify underlying causes such as delirium due to acute infection was not in place. Behaviour monitoring charts to assist in identifying trends for the behaviour to enable appropriate

and effective treatment were not in place. Care plans were not in place to identify or guide staff on possible triggers, measures to alleviate or manage the behaviour such as distraction techniques and other strategies to prevent escalation.

Nurses' daily progress records were found to be relatively detailed. On a sample of those reviewed they contained some specific details regarding residents' mood and behaviours and the interactions and responses by both staff and residents when dealing with responsive behaviours. But the notes did not identify the possible causes of the behaviours, which interventions were most effective or what if any referrals or follow up was required.

Judgment:
Non Compliant - Major

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:

It was found at the time of this inspection, that the levels and skill mix of staff were not sufficient to meet the needs of residents.

The person in charge was on leave and was replaced by a day service manager. Although this manager was experienced with a nursing qualification, they were not familiar with the centre. There were two nurses on duty. But one nurse had commenced in post just three days earlier and was on induction. This meant that there was only one senior nurse on duty who was familiar with residents and the systems in place to deliver care. This nurse was trying to mentor their new colleague whilst also coping with all admissions and discharges. This meant that there was little time for review of assessments and care planning. Inspectors also noted that there was little time available for nurses to provide supervision and support to staff. This was of concern as there were several new and very inexperienced staff working in the centre who did not have any formal training in the care of older persons.

Inspectors noted that there was little supervision or direction given to staff throughout the day. A key worker system or other work allocation system was not in place.

There were five staff on community employment schemes all were part time. Two were involved in delivering the activity programme only. Otherwise the roles and responsibilities of each group of staff was unclear.

Work and communication systems that supported staff to deliver better care were not in place. Although there was a handover at the start and end of each shift a structure to update all staff on the progress of residents or other key work challenges throughout the day was not in place.

Inspectors found that nurses were not sure whether personal care had been delivered to all residents. Healthcare staff did not know whether all equipment and furniture was cleaned prior to the admission of new residents.

Inexperienced and untrained staff were told to supervise residents with responsive behaviours, on a one to one basis, without any direction or information on how to identify triggers, respond or manage the behaviours. This was brought to the provider's attention as a risk to both residents and staff, during the morning but inspectors found that the same staff was again providing this supervision on a number of occasions throughout the day.

Inspectors were told planned staffing levels were;

Two nurses on day duty from Monday- Wednesday and one nurse for remainder of week. One nurse on all night shifts.

Four healthcare assistants on day shifts Thursday and Friday and three on all other days. Two on night shifts.

But on review of the roster it was noted that there were gaps with staff not identified to fill some shifts throughout the week. A small relief staff panel to provide cover for planned and unplanned leave was in place but there was also a heavy reliance on agency staff. Agency staff were used on a weekly basis to cover nursing shifts.

A high turnover of staff during 2015 was noted with a significant number of senior and experienced staff leaving the centre. This had impacted negatively on the continuity of and standard of care delivered to residents. There was a lack of experienced staff to provide clear direction and leadership to other grades of staff.

Turnover of staff resulted in lack of familiarity with policies and processes in place to ensure care practices reflect policies and meet residents assessed needs.

Inspectors learned that staff did not know until the bus returned how many day clients would arrive to the centre each day. The maximum places available were 20 in addition to the 11 respite residents. On the day of inspection there were 11 respite and 9 day service clients attending the centre. There were four respite residents discharged and a further four admitted. This gave a total of 24 people for whom staff were responsible.

The nursing staff were fully occupied with medication administration and these admissions and discharges. This meant that three healthcare staff were providing and managing all resident's care needs, whilst also preparing bedrooms and equipment for new admissions. Two of these three healthcare staff were experienced and familiar with the centre and residents. The third person was relatively new. They were also overseeing the provision of meals and snacks and trying to provide guidance to the part time community employment scheme staff most of whom did not have any formal healthcare training and some were very inexperienced. Additionally the staff also had to manage the challenges presented through resident's responsive behaviours.

On review of a sample of personnel files, all did not contain Garda vetting

documentation as required by Schedule 2 of the regulations. The roles and responsibilities of all grades of staff particularly volunteers and those on community employment schemes were not identified.

Confirmation that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2015 was found but was not available for 2016 for all nursing staff.

A training matrix was utilised by the person in charge to identify gaps and requirements in staff training. Inspectors were told a central training plan by the Human Resources Department was used to ensure staff training needs were met. But all staff had not received refresher training in mandatory areas including prevention of elder abuse or fire safety. All new staff had not received formal initial training in these areas.

Updated training to improve staff knowledge relevant to the resident profile was found to be required. As identified under Outcome 7 inspectors were not assured all staff were clear on the signs, symptoms or reporting responsibilities of potential abuse. It was also found that they would benefit from updated training on areas inclusive of but not limited to; risk management; infection prevention and control; dementia; positive behavioural supports; identifying and managing delirium; communication; care assessment planning and review and person centred care.

A training plan for 2016 was not in place to ensure these training needs were met.

Judgment:

Non Compliant - Major

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 report¹

Centre name:	The Orchard Day and Respite Centre
Centre ID:	OSV-0000691
Date of inspection:	23/03/2016
Date of response:	11/05/2016

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:

Management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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

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:

- Management systems are in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
- Person in Charge will be full time in the centre until the new Deputy Manager is in situ thus ensuring there will be a high standard and continuity of care and safe management control in place within Orchard at all times. The Deputy Manager will cover for the Person in Charge when they are absence from the centre.
- Register Provider will be full time available to oversee the provision of care and management of the centre. This will be completed in conjunction with the Person in Charge and Quality Safety and Practice Development Manager.
- Monthly report on progress of actions from this inspection to be circulated to Head of Operations and discussed at monthly meeting with Registered Provider.
- The Quality Safety and Practise Development Team will be visiting at least once a week to complete inspections. The Manager of this team will act as an advisor to the Registered Provider and Person in Charge.
- Usage and training of salesforce as a management control system will be conducted with all nurses and care staff.
- Risk Management committee meetings will return to a weekly basis and will revise its present Terms of Reference. It will discuss all incidents, complaints and follow up actions needed to ensure learning and best practices are instilled across staff.
- External Health and Safety Audit on Orchard will be commissioned to track progress on previous year's audit and action follows up.
- Quarterly audits of the quality / safety of care delivered will be responsibility of the Register Provider to ensure the centre is in line with Authority standards. Residents, their carers and families will form an integral part of this review.
- Responsive Behaviour, Falls, Inflection Control and Wound Care to be key performance indicators of the quarterly audit of care delivered. These are presently being tracked on our IT risk management and monitoring system.
- Standard of nursing care will form part of this quarterly audit based around needs assessments, care plans and management of behaviours.

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

Evidence that there were sufficient resources in terms of staffing levels and skill mix to provide safe sufficient and appropriate care to residents was not available.

2. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

- A contingent plan for unexpected absence of Person in Charge has been agreed with existing day care manager coverage until Deputy Manager is in situ.
- To ensure that one extra Alzheimer Society of Ireland carer is on the roster at all times we have added 4 full time carer staff hours to our weekly roster. This has been in place since 24th March 2016.
- One extra nurse on roster Monday/Friday (8am/4pm) since 11th April 2016.
- External cleaning person added to double cleaning resource since 19th April 2016.
- Relief panel of nurses to be increased to 5 / Carers to be increased to 8
- New Deputy Manager Role to support Person in Charge due to start 23rd May subject to Garda Clearance.
- Existing Community Employment/TUS staffs to be assigned to an experienced staff member.
- Any future Community Employment staff will be placed on a FETAC Level 5 development programme and supervised with experienced staff member.
- Staff to complete/commence the following training:
 - FETAC Level 5
 - Statutory Training
 - Responsive Behaviour
 - Dementia Awareness
- Policies to be made user friendly with a flow chart process to guide staff practice, to ensure staff have sufficient knowledge on these policies. These flow charts will be displayed at Nurses station. We will commence will 5 policies by end of June.

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

The role, responsibilities and level of accountability and authority within the centre in relation to management and all grades of staff both full time and part time were not clearly defined.

3. 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:

- The centre has a clear and well-defined structure of management to promote robust reporting, assessment, implementation / action planning, learning outcomes and evaluation/audit. Outstanding vacancies due for completion early June.
- Organisational chart of managerial structure to be displayed within centre at nurses' station, reception and in staff kitchen area.
- Staff to be given job description of main role and direct line management organisational chart for themselves i.e. carer, night nurse, cook etc.
- Level of authorisation and accountability in relation to responsibilities to be circulated to staff.
- Person in Charge will discuss with staff their roles, responsibilities, management structure and reporting mechanisms.
- Sign off that staff understands these roles and responsibilities to be completed.

Proposed Timescale: 31/05/2016

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 records requested for review were not accessible and could not be made available to the inspection team.

4. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

- Accessibility of records has been reviewed with an additional 2 extra IT risk

management and monitoring system licenses purchased. This will ensure that nurses that work within respite can always accessed records.

- PIC to implement an agreed procedure regarding 24/7 access to all records care plans, incident reports, investigations, notifications, risk register, SLAs, complaints, complements and communicate same to all staff.

- Resident Records

Review of resident records to ensure they comply with Regulation 21(6) of the Health Act.

- Staff Records

Review of staff records to ensure they comply with Regulation 21(6) of the Health Act.

- Other Records

Review of other records to ensure they fully comply with Regulation 21(6) of the Health Act.

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

Documentation and recording of care was not sufficiently accurate or complete to evidence that residents' healthcare needs were fully met.

5. 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:

- Person in Charge will do a weekly audit of selected care plans to ensure that all documentation relating to the client is in place and that all care plans are reviewed with the relevant referrals made to appropriate healthcare professionals are completed.

- Quality Safety & Practise Development team to conduct monthly audits examining care plans of selected clients.

- Audit findings to be used to run weekly reflective practice sessions with staff.

- Resident Records

Review of resident records to ensure they comply with Schedule 3 of the Health Act.

- Staff Records

Review of staff records to ensure they comply with Schedule 2 of the Health Act.

- Other Records

Review of other records to ensure they comply with Schedule 4 of the Health Act.

Proposed Timescale: 30/06/2016

Outcome 06: Absence of the Person in charge

Theme:

Governance, Leadership and Management

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

Suitable arrangements required to be put in place in the event of absence of the person in charge

6. Action Required:

Under Regulation 33(1) you are required to: Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 33(2).

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

- Person in Charge on holidays for 14 days and Regulations state that notification is required prior to a 28 days absence. New Deputy Manager being recruited who will cover for Person in Charge when they are absence.

- Agreement that both Person in Charge and Deputy Manager can't take annual leave at the same time. Registered provider will be co-ordinating their leave to ensure no clashes.

- A contingent plan for unexpected absence of Person in Charge has been agreed with existing day care manager coverage until Deputy Manager is in situ.

Proposed Timescale: 21/04/2016

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:

All staff had not been provided with training or direction on how to respond to or manage responsive behaviours and were not familiar with policies or procedures in place.

7. 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:

- Responsive behaviour training will have commenced for staff.

- 3 role models for Responsive Behaviour (1 nurse / 2 carers) have been identified within the centre to coach other staff.

- Refresher sessions to be completed for staff with regard to responsive behaviours policies and procedures.

- Supervision, Incident Reports, Complaints and Audits will be used ensure that responsive behaviour polices are being reflected in practise by staff. If issues are identified these will be discussed either through team meetings or if required individually with staff members. These will be documented and will form part of each staff member's development plan / appraisal.

- Further Responsive Behaviour refresher sessions to be completed with staff until they successfully demonstrate understanding.

- All safe guarding incidents are investigated and process is documented on our internal IT risk management and monitoring system.

- All safe guarding incidents to be discussed between the Registered Provider and Head of Operations on a monthly basis to check progress and learning. These learnings will form the basis from further staff training.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

All staff were not knowlegable or consistent in recognising the possible signs and symptoms of abuse, responding to, managing and reporting them.

8. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect

residents from abuse.

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

- Safeguarding training for Vulnerable Adults conducted on April 28th for staff reflecting the newly signed off ASI Safeguarding policy (aligned to HSE policy). This training was conducted by HSE trained ASI personnel.
- Person in Charge has recently been trained on the incident reporting process on March 30th. Refresher sessions due to take place in June to train and reinforce learning of incident reporting process with staff.
- 3 role models for Safeguarding for Vulnerable Adults (2 nurses / 1 carer) have been identified within the centre to coach other staff.
- Supervision, Incident Reports, Complaints and Audits will be used ensure that Safeguarding for Vulnerable Adults polices are being reflected in practise by staff. If issues are identified these will be discussed either through team meetings or if required individually with staff members. These will be documented and will form part of each staff member's development plan / appraisal.
- Further Safeguarding for Vulnerable Adults refresher sessions to be completed with staff until they successfully demonstrate understanding.
- All safe guarding incidents are investigated and process is documented on our internal IT risk management and monitoring system.
- All safe guarding incidents to be discussed between the Registered Provider and Head of Operations on a monthly basis to check progress and learning. These learnings will form the basis from further staff training.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Training records viewed showed that updates had not been provided to staff since 2014 on Safeguarding Vulnerable Adults. New staff had not been provided with this training at the time of inspection.

9. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

- Training for Safeguarding of Vulnerable Adults completed on April 28th for staff reflecting the newly signed off ASI Safe Guarding policy (aligned to HSE policy). This

training was conducted by HSE trained ASI personnel.

- Further session to be organised for staff unable to attend on April 28th.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Evidence that serious incidents were appropriately assessed, reported, recorded, responded to or managed was not found. Measures to ensure appropriate and timely responses and management of risks associated with negative peer interactions were not found.

10. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

- Person in Charge has responsibility for ensuring all incidents are investigated and documented on our internal IT risk management and monitoring system. The Registered Provider, Person in Charge and administration staff have 24/7 access to the system. 2 further licenses have been purchased and allocated to nurses.
- Training to be provided to all staff on our process of investigation of all incidents through this system.
- The Person in Charge will continue to assess, record and report all incidents in line with the policy for the service.
- The Person in Charge will continue to report incidents to the HSE Manager for Older persons.
- Nurses have access to the internal IT incident reporting system and will be able to enter incidents or review incidents in the absence of the Person in Charge.
- Where it is deemed that the client is not suitable to be admitted or remain in the centre due to risks from behaviours that challenge, a decision to refuse or discharge the client will be made. These occurrences will be logged.
- All incidents pertaining to respite clients will be notified to the Chief Inspector in line with the current regulations.

Proposed Timescale: 31/05/2016

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:

A risk register was not maintained to ensure the identification and management of environmental, clinical and non clinical risks in the centre.

11. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

- Person in Charge has developed a comprehensive Risk register for the centre. Daily on-going maintenance will be required and a weekly review completed during the Risk Management Committee meeting.
- A report on progress to be issued to Head of Operations on a monthly basis and to Sub Board Quality and Safety committee by Registered Provider on a quarterly basis.

Proposed Timescale: 31/05/2016

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 sufficiently robust or were not implemented to safeguard all residents.

12. 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:

- Review existing risk management policy and ensure that a customised version is implemented for the centre. This will enhance the present risk management process.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Practices to support good infection prevention and control were not found. Appropriate infection and prevention control was not being implemented or monitored. Appropriate products were not being used and systems to ensure all equipment was adequately and appropriately cleaned when residents were discharged were not in place. Cleaning equipment such as cloths were not being washed, dried or sterilized as part of an overall cleaning process to reduce and prevent re contamination.

13. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

- External cleaning staff hours have been doubled since 19th April.

- New cleaning equipment procured from cleaning company to comply with infection control standards implemented on 7th April.

- Current company contractor for cleaning to be replaced with more experienced contractor with regards to the healthcare sector. New cleaning company to replace existing company on 30th May 2016

- Regular supervision of cleaning staff by Person in Charge and company representative. Cleaning schedules to be put in place and signed off each day by the cleaning staff and audited by the Person in Charge weekly.

- Cleaning checklist to be introduced when cleaning rooms between discharge and admissions. This will be reviewed by Nurse on duty prior to new admission.

- Overall centre cleaning audit to be completed each night by nurse on duty and signed off by Person in Charge.

- External audit on infection control to be conducted in the coming month.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

All staff had not received training in the fire procedures and had not been inducted in the procedure to follow. The majority of staff had not been provided with updated training to ensure familiarity and knowledge of procedures since 2014 and some last had refresher training in 2013. Inconsistency and lack of knowledge was found on inspection.

14. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

- Fire training completed for 30 staff on the 24th March and the 29th March 2016.
- New staff who have commenced or relief staff who missed the training will be provided with fire training.
- Monitor ongoing fire training requirements through the Training Plan on a weekly basis as an agenda item on the Registered Provider/PIC meeting.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Simulated fire drills and practices that reflect night time staffing were not conducted and drills during day time were not conducted with sufficient regularity to ensure staff were competent in the procedures and use of equipment such as evacuation sheets.

15. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

- Documentation showing quarterly fire drills are being conducted; including simulated night time evacuation fire drills, by the Person in Charge in compliance with Schedule 4 of The Health Act.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Personal evacuation plans in place were not detailed enough to guide staff on the

specific measures to be used to safely evacuate each resident. The fire procedure advised staff that in the event of a person being missing during a fire they should 're enter the building if it is safe to do so'.

16. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

- Current personal evacuation plans have been reviewed and amended to provide more detail on how to evacuate the client in the event of a fire. This will be based on their assessment of mobility and dependency. This system has been implemented since 20th April.

Proposed Timescale: 20/04/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Systems in place did not ensure appropriate administration in that prescription and administration sheets were not fully completed and audit processes and competency assessments were not all in place.

17. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

- Photographs of new clients are taken on admission for the medication administration and recording sheet (MAR). New printer purchased and in place since 15th April to allow photographs to be printed immediately
- Procedure for alerting the pharmacy of allergies on admission to be devised in consultation with the pharmacist, to ensure that any allergy is entered onto the MAR sheet by the pharmacist. Meeting to be arranged by end of May.
- A schedule to be developed to ensure that the competency assessments are completed for all nurses annually by the Quality Safety and Practice Development team.
- Medication reconciliation document to be developed in consultation with the pharmacist and recorded in the centre. Present system to be maintained until this is

completed.

- Audits that cover all aspects of medication management and safety will be completed monthly. These will be tracked and actions identified to lead to further training requirements.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Medication management practices required improvement to ensure that systems in place supported professionals to meet their relevant legislative requirements and professional guidance.

18. Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

- All nurses to continue to update their HSE land medication management training annually.
- 1 day symposium for staff nurses on medication safety organised for all nurses employed in the service has been arranged for 22nd June 2016 run by the HSE.
- A schedule to be developed to ensure that the competency assessments are completed for all nurses annually by the Quality Safety and Practise Development.

Proposed Timescale: 30/06/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

All relevant incidents were not notified to the Chief Inspector

19. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

- The PIC will ensure that all incidents pertaining to respite clients will be notified to the Chief Inspector including any formal investigations.

Proposed Timescale: 31/05/2016

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:

Care plans were not in place for all identified needs.

20. 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:

- Care plans based on the clients care plan assessment will be devised no later than 48 hours after the client's admission.
- 5 extra full time staff hours have been allocated to the roster to provide nursing staff the appropriate time to spend on assessing the client's needs and devising care plans based on the client's assessment. This will complement our existing admission process.
- Training session on documentation in line with the Nursing & Midwifery Board of Ireland guidelines will be provided for all staff nurses
- PIC will do a weekly audit of selected care plans to ensure that all documentation relating to the client is in place and that all care plans are reviewed with the relevant referrals made to appropriate healthcare professionals are completed.
- Quality Safety & Practise Development team to conduct monthly inspections examining care plans of selected clients.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

Where care plans were in place they were not updated or reviewed on each respite admission.

21. 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:

- There is an allocation form solely dedicated to the admissions process in place since 18th April. This is to ensure that all aspects of the client's admission are completed by the nurse responsible. This will act as an audit tool for the PIC for each respite admission.
- Schedule for care plan review developed and implemented from the 19th April 2016 to ensure that care plans are reviewed regularly by the nurse responsible throughout the clients' respite stay.
- 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

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

All the care needs of all residents were not being met and suitable safe and sufficient care was not being provided. Residents were not assessed prior to admission or re-assessed on subsequent admissions to determine the health and social needs of the potential resident and whether the centre could meet those needs.

22. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

- Additional staffing resources have been allocated which will ensure that there is a pre-assessment or re-assessment completed with all potential clients; this will be the basis for the decision as to whether the client is suitable for the centre.
- Quality of present care plans to be reviewed on a weekly basis for new admissions.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

Residents were not comprehensively assessed to identify their personal, health and social care needs as detailed in the report.

23. 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:

- The client's Public Health Nurse will be required to complete a common summary assessment report (CSAR) or equivalent prior to the admission of the client.

- If the client is unsuitable for the centre, a decision will be made not to proceed with the admission. This will be logged in the centre. The client's PHN, GP and family will be informed of the decision, and the reason for the decision to not proceed with the admission.

- For any issues that arise during the client's respite stay we will continue to communicate this to the appropriate healthcare professional and the family at the earliest opportunity.

- Weekly checks by Person in Charge or Deputy Manager on admission forms to be conducted to ensure highest standards maintained. A record of this examination to be recorded.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

Evidence that all care plans were fully reviewed for effectiveness as residents' needs changed was not found.

24. 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:

- We will continue to update care plans on a needs basis.

•Person in Charge will do a weekly audit of selected care plans to ensure that all documentation relating to the client is in place and that all care plans are reviewed with the relevant referrals made to appropriate healthcare professionals are completed.

•The Quality Safety & Practise Development team will do a monthly audit of care plans to ensure that all documentation relating to the client is in place and that all care plans are reviewed with the relevant referrals made to appropriate healthcare professionals are completed.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

Where changes to residents' condition indicated clinical deterioration evidence of appropriate or timely referral to medical and allied health professionals was not found.

25. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

•A flow chart will be devised to ensure that staff have full awareness of all processes to be followed in the event that a clients' condition indicates clinical deterioration.

•A list of contactable professionals relating to clients to be produced and made accessible to all staff.

•The flow chart will indicate which relevant medical or allied healthcare professional is required to review the client.

•24 hour 'out of hours' support available.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

A high standard of evidence based nursing care was not being delivered to all residents to fully meet their personal social and healthcare care needs as evidenced by lack of appropriate assessment pre or post admission for moving and handling or skin integrity; poor management of responsive behaviours; recording or assessment of residents vital

signs, weight or nutrition status to establish a baseline for monitoring signs of clinical deterioration or acute illness was not found.

26. 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:

- All assessments to complete the following: Barthel assessment, MUST assessment, FRASE assessment, Bristol Stool Chart, Manual Handling and WATERLOW assessment and signed of by revelant nurse.
- Vital signs taken as standard as part of admission unless the client refuses.
- Residents will be routinely weighed on admission unless they refuse or mobility issues prevents it.
- Person in Charge and nurses will conduct weekly audits on both pre assessment and admission forms and information to ensure higher level of compliance to baseline monitoring signs. A record of these ad hoc audits to be maintained and followed up at team meetings.

Proposed Timescale: 31/05/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The number and skill mix of staff was not appropriate to manage the needs of resident's with responsive behaviours.

There was a lack of experienced and qualified staff on duty to ensure safe supervision of and protection to all residents.

The number of nursing staff on duty providing direct care to residents were not sufficient to ensure a safe standard of suitable care was delivered

27. 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:

- A contingency plan for unexpected absence of Person in Charge has been agreed with existing day care manager coverage until Deputy Manager is in situ.

- To ensure that one extra Alzheimer Society of Ireland carer is on the roster at all times we have added 4 full time carer staff hours to our weekly roster. This has been in place since 24th March 2016.
- One extra nurse on roster Monday/Friday (8am/4pm) since 11th April 2016.
- External cleaning person added to double cleaning resource since 19th April 2016.
- Relief panel of nurses to be increased to 5 / Carers to be increased to 8
- New Deputy Manager Role to support Person in Charge due to start 23rd May subject to Garda Clearance.
- Existing Community Employment/TUS staffs to be assigned to an experienced staff member.
- Any future Community Employment staff will be placed on a FETAC Level 5 development programme and supervised with experienced staff member.
- Staff to complete/commence the following training:
 - FETAC Level 5
 - Statutory Training
 - Responsive Behaviour
 - Dementia Awareness
- Policies to be made user friendly with a flow chart process to guide staff practice, to ensure staff have sufficient knowledge on these policies. These flow charts will be displayed at Nurses station. We will commence will 5 policies by end of June.

Proposed Timescale: 30/06/2016

Theme:
Workforce

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

Staff were not appropriately supervised to ensure that a good standard of care was delivered, which fully met residents needs and was safe.

28. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

- Additional staffing resources have been put in place to allow the nurse leading the shift have more available time to oversee the supervision of staff on duty and standard of care delivered.

- There is an allocation system in place and staffs are allocated responsibilities in line with their qualifications/training.

Proposed Timescale: 20/04/2016

Theme:
Workforce

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

A training plan was not in place to ensure a high standard of care would be delivered to residents. Refresher training in key areas such as prevention of elder abuse or fire safety had not been provided.

29. 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:

- 2016 Training Plan is in place to ensure all statutory training is up to date for all staff
- 2016 Training Plan will be used to ensure Dementia Awareness, Responsive Behaviour training are completed by all staff
- Fire training completed for 30 staff on the 24th March and the 29th March 2016. New staff who have commenced or relief staff who missed the training will be provided with fire training.
- Safe guarding training for Vulnerable adults has been conducted in May for all staff reflecting the newly signed off ASI Safe Guarding policy (aligned to HSE policy). This training was conducted by HSE trained ASI personnel.
- Regular team refresher sessions will continue with regard to policies, procedures and updates.
- The training plan will continued to be updated as training is undertaken.
- Person in Charge met with the training manager on the 4th April to discuss training needs for the centre.

Proposed Timescale: 31/12/2016

Theme:
Workforce

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

The roles and responsibilities of all grades of staff particularly volunteers and those on

community employment schemes were not identified.

30. Action Required:

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

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

- CE staff have job descriptions in place for their relevant roles.

- Weekly staff roster and daily task allocation form to remain in Nurse's station and now also be displayed in staff kitchen area.

- Volunteers will be added onto the allocation sheet and they are currently allocated on the day service schedule. They will be given role descriptions.

Proposed Timescale: 30/06/2016