Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Ballyfermot, Dublin 10
Type of inspection:	Unannounced
Date of inspection:	13 February 2020
Centre ID:	OSV-0000508
Fieldwork ID:	MON-0028691

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This centre comprises of 161 continuing elderly care beds including up to 21 respite care residents. The centre is registered to provide 24 hour care to male and female residents aged over 65 years. Full nursing care is available based on individualised care planning. Education is provided for nursing staff so that residents with all levels of medical needs can be cared for in the units. Health care assistants work with the registered nursing staff to provide a high standard of care to all clients. The nursing staff work under the guidance of the ward manager supported by clinical nurse specialists and nursing administration. Included in the staff is a Clinical Nurse Specialist (CNS) in behavioural therapy and dementia. Other services are available from allied health professionals; which include physiotherapy, occupational therapy, and social work and there is a chaplaincy programme. Accommodation is different across the units. It is composed of single, twin, triple or four bedded bedrooms. In two units the bedrooms are ensuite, in the other units there is access to shared toilets and bathrooms, many of which are adapted for use by people with physical disabilities. Hazel unit has 17 beds, Beech unit has 16 beds, Poplar unit has 16 beds, Sycamore and Willow have 47 beds each, and the Aspen unit has 18 beds. Both the Willow and Sycamore Units have a large sitting room, dining room, physiotherapy room, occupational therapy room, snoozelan room, activity room, and a quiet room/communal room. There is also access to a large secure garden and smaller gardens. Hazel unit consists of one single room/visitors room (for palliative care or isolation), two 2-bedded rooms, three 3-bedded rooms, one 4-bedded room. None are en-suite. Aspen unit has one single room, two 4-bedded rooms, three 3-bedded rooms, none of which are en-suite. Beech unit consists of one single room used for specific purposes such as end of life or isolation due to infection, four 4-bedded rooms, none en-suite. Poplar unit has four 4-bedded bedrooms and none are ensuite.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	132

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 13 February 2020	10:00hrs to 17:45hrs	Sarah Carter	Lead
Friday 14 February 2020	09:30hrs to 17:30hrs	Sarah Carter	Lead
Thursday 13 February 2020	10:00hrs to 17:45hrs	Michael Dunne	Support
Friday 14 February 2020	09:30hrs to 17:30hrs	Michael Dunne	Support

What residents told us and what inspectors observed

The centre had 132 residents on the day of inspection and inspectors spoke with several residents across the five separate buildings in the centre, in their bedrooms and in the communal areas.

Residents told inspectors that they liked where they lived and thought the premises and staff were nice. Residents said they found that staff were warm towards them and knew their preferences well. Several residents said they liked the activities and their access to the outdoor areas when the weather was better.

Residents felt safe in the centre, and felt their needs were well taken care off and they were respected by staff.

Some residents, who did not have dementia, said they thought that the centre treated people with dementia well and cared for them well.

They liked participating in the activities, especially attending mass and bingo and also reported that they liked the food they had. Residents also said they thought the choices on the menu were suitable to their tastes, and if they wanted to change their choice of meal they could. They also said they had enough snacks and drinks available to them.

Inspectors observed several residents engaging in different activities and walking around their units. In some units in the centre residents were gathered on seats near the door, away from TVs and radios.

Inspectors observed that most bedroom doors were left open throughout both days of inspection, regardless of whether a resident was in the room or not. All units were observed to be extremely warm.

Visitors were noted to be entering and exiting the units without restrictions, and there appeared to be sufficient space for visitors to meet residents in private if they wished.

Capacity and capability

Good quality care was being provided to residents by an appropriate number of care staff and nurses in this large centre. In this centre, residents currently live in five

separate buildings spread across a large HSE campus in Dublin.

The person in charge (PIC) is supported in her role by a large number of managers; some of whom are in assistant directors of nursing and clinical manager's roles. The PIC is further supported by clinical specialists in a variety of areas. Not all of these personnel work full time, however there are managers with delegated levels of responsibilities present all days of the week. The provider, the HSE; is represented by a senior manager, who is not based on the campus, but meets the person in charge and various managers at several management meetings and forums on a week-to-week basis.

The large governance structure had led to a devolved and delegated approach. There had been a significant movement of personnel in and out of management and clinical specialist roles since the last inspection. Inspectors acknowledged that professional progression is important for staff however continuity of service and succession planning are a requirement of good governance structures, to ensure residents care is of a continuous and good standard. Over the last year several positions had been vacated and remained vacant on the days of inspection.

As managers and other specialists left their positions, gaps in completing their work arose. This was evidenced by:

- Gaps in the timely risk assessment by clinical specialists.
- Gaps in measuring the different elements of service provision in a timely way.
- Poor levels of interpretation of clinical data and metrics by remaining staff.

Despite the number of managers involved in the governance structure, several issues were identified which indicated that the governance systems required review. The governance systems were not effectively ensuring:

- The completion of timely audits and reviews.
- The translation of data collected into tangible quality improvement plans and improvements for residents in a timely manner.
- Identifying, and then addressing, the deficits in resident's environments, and in the external grounds of the centre, and ensuring all residents rights to privacy and dignity were upheld.
- Identifying and addressing risks. On the inspection days the inspectors identified health and safety risks, risks relating to fire and risks of poor privacy and dignity in care practices and in the care environment which had not been actioned by the governance team.
- Improving the levels and impact of resident consultation forums. There was a fragmented approach to resident consultation and where residents were consulted the impact and outcome of this consultation was not always clear.
- Compiling complete staff records and ensuring they were accessible at all times.

The governance system and structures were working well in the following areas:

- The complaints process in the centre was well managed, and records maintained indicated the complaints were dealt with in a timely fashion.

- Staff training was completed to a good level, and training was supported in the centre.
- A tracker system had been implemented to ensure policies were reviewed and amended as required.

Despite feedback received from managers indicating there were insufficient staff numbers, the rosters reviewed during this unannounced inspection indicated residents care was provided by sufficient numbers of care staff number to meet resident's needs, and was cognisant of resident's dependencies. Care staff and nursing staff were supported in their role by a sufficient number of activity staff. However activity staff were available only on a Monday to Friday basis. Catering and household staff were available across all days of the week. In addition there were allocations of allied health professions to the centre; which included occupational therapists and physiotherapists.

There were long term vacancies for staff in some care and operational areas, which were impacting on residents care needs. For example the centre had experienced a long term vacancy in its speech and language therapy resource, which had been filled by an agency staff in the weeks before the inspection. A further significant and long term vacancy was recorded in the dietician resources, with letters seen in care files indicating that all residents referred were being wait-listed for review by the community services that provided the dietician resource. In the interim; the specialist dietician input was being replaced by medical and nursing assessments.

The provider had also failed to provide sufficient maintenance resources and sufficient facilities staff to ensure the residents environments were maintained to a high standard. The provider had committed to developing a new building on the campus to address the long term premises deficits identified in all recent reports. On inspection no update was available on this projects progress, and on walking the grounds, no evidence was seen of any site works and a planning application was not observed. The deficits in the centres premises will be described in full in the next section of the report.

Inspectors were aware on inspection that the provider was preparing an application to register a new footprint of the centre to reflect the correct footprint of the centre, to include all existing buildings associated with residents care and the storage of records.

Regulation 15: Staffing

There was sufficient staff on duty and on the planned roster to attend to resident care needs. Staff were allocated to specific units, and in the larger units were allocated to specific corridors / wings of the unit.

The gaps identified - where position had been vacant for excessive periods of time - will be addressed in regulation 23 below.

Judgment: Compliant

Regulation 16: Training and staff development

Staff spoken with during the inspection confirmed that they had attended a range of training while working in the centre. A review of training records indicated that staff had attended mandatory training which focused on safeguarding, fire safety and manual handling. Staff were able to access additional training in areas such as wound care management, medication management, infection control and CPR. Training records were well maintained and included a training needs analysis of staff working across the designated centre.

Staff informed the inspector that they had a planned induction prior to working on the units. The inspectors were informed that a newly developed supervision tool was ready for implementation in March 2020 which would further enhance staff supervision in the centre.

There was evidence on the units that staff were well supported and supervised in their work, there were systems in place to promote effective communication within the team through regular handovers and staff meetings.

Judgment: Compliant

Regulation 19: Directory of residents

There was a directory of residents available in the centre for inspectors to review. Information reviewed was well maintained with all records meeting the requirements as expressed in schedule three of the Health Act 2007(Care and Welfare Regulations in Designated Centres for Older People) regulations 2013.

Judgment: Compliant

Regulation 21: Records

A review of schedule two records which requires the provider to maintain records pertaining to staff working in the centre, revealed that not all records were located on site. Employment records including references relating to the most recent member of the team were not available however the management team had requested that this information be remitted from the relevant human resource dept.

There was evidence to indicate that records relating to residents and the

management of the centre were secure and well organized however the maintenance of staff records required improvement as the retrieval of staff documents was found to be problematic on the days of the inspection.

Records pertaining to residents care such as risk assessments and care plans were not always updated in a timely fashion. Residents who were identified as having behaviours that challenge did not always have risk assessments in place that were current with many classified as being under review for a significant length of time.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to provide sufficient resources to deliver the care described in the centres statement of purpose (SOP).

This was evidenced by a failure to recruit allied health professionals in a timely fashion; resulting in excessive delays in referral and access to specialist treatment.

A large team of activity staff were rostered across 5 days, and there was limited information made available to inspectors that any activity was provided over weekend.

The provider had failed to provide sufficient physical resources to meet the care needs of residents - in Beech, Poplar, Hazel and Aspen Unit. These units had multi-occupancy rooms (up to four residents living in one bedroom), limited circulation space and inadequate and poorly maintained decor. The environment impacted on resident's privacy and dignity while in receipt of care. There were a very small number of single rooms available which also impacted on residents rights to privacy and dignity during their end-of-life care or if they carried an infection.

The management structure was large and the provider had delegated management responsibilities throughout the structure. However due to the lack of succession planning and vacant posts specific roles and responsibilities were not always maintained when a person left their post or was unavailable. The impact of this on residents care included gaps in service provision and oversight over the care provided to residents.

The management systems required improvement. There was an over-reliance on incident data to inform improvements in practices in the centre. The processes around gathering and responding to clinical audit data required strengthening. Several data sets were being gathered by specified personnel however the management team were not able to explain the impact of this data on residents care and service provision, and the data did not appear to link in any way with identified quality improvement plans. In addition there some audits were completed at long intervals, and the data compiled was not current and did not feed into relevant and current quality improvement plans. This meant that a long period of time could

elapse before service deficits were improved. The health and safety of residents was overseen by a committee and incidents involving residents were reviewed regularly however day-to-day risks were not identified by managers and there was a gap in oversight environmental risks and the role of maintenance to address the issues.

An annual review was available, however it was an undated document, and there was no evidence that this annual review had been completed in consultation with residents. In addition it contained quality improvement plans that did not link with incident and clinical audit data.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were well handled in the centre, and the policy and process followed was in line with regulatory requirements. An accessible and effective complaints procedure was in place. Residents' complaints and concerns were listen to and acted upon in a timely, supported and effective manner. There was evidence that residents and other complainants were satisfied with measures put in place in response to their complaint.

A record of complaints was maintained and there was robust oversight of the complaints process and response by the provider.

Judgment: Compliant

Regulation 4: Written policies and procedures

Inspectors found that there was a well-organized system in place to ensure that policies and procedures were maintained and updated as and when required. Policies were updated according to the centre's schedule with all policies reviewed within a three year cycle. There were a range of policies in place to support both the clinical and operational governance of the designated centre with key operational staff involved in policy development. There was evidence that staff could access policy documents throughout the designated centre.

Judgment: Compliant

Quality and safety

Resident's health and social needs were being met through quality care provided by a caring staff group. However the safety of residents was being compromised by poor levels of upkeep in the premises, deficits in fire safety precautions and the risk management of items in day-to-day use.

Residents who experienced behaviours that challenge, were cared for by staff who were knowledgeable about the best approach to take. Some residents who experienced behaviour that challenge did not have up to date risk assessment. Residents healthcare needs were met, however not always by the specialist staff. As stated earlier there were some staff vacancies in specialist roles – for example there was a vacancy in dietician services – that had not been filled, resulting in lengthy delays to see a dietician. In lieu of this intervention the medical staff were providing support.

Residents rights were safeguarded, and there was systems in place that protected residents. Where allegations of mistreatment or abuse had been made, staff responded in an appropriate and timely way to protect residents involved. Investigations were taking place following the centre's policy, and safeguarding plans had been made. It was the centres policy to refer allegations relating to staff to an external team, while this was within the centres policies, it often resulted in lengthy delays to concluding allegations received. This meant residents who may have raised the allegations were waiting long periods of time to hear the outcome of the investigations.

Residents currently live in five separate buildings spread throughout the "campus" of Cherry Orchard Hospital. Hazel, Poplar and Beech are smaller older units, and Willow and Sycamore are newer and larger units. The sixth unit; Aspen; was undergoing some maintenance on inspection and residents were not living there.

Despite the variation in age; all units were found to require maintenance; displaying signs of wear and tear on walls and floors. Any courtyards or outdoor garden areas related to the units, were found to also require maintenance. These areas were found not to be clean and littered with rubbish, both loose and in uncollected bags, plant debris and cigarette butts. Roof windows were in place in some units and some were noted to require cleaning.

In the three smaller, older units, the large multi-occupancy rooms were deficient in providing privacy and dignity to residents. There were privacy curtains around beds, however all bedrooms doors had clear glass panes. There were opaque glass sections in adjoining walls, meaning light and noise could travel from adjoining bedrooms. Following the last inspection the provider had changed one opaque glass wall for a solid structure, but had done this in just one bedroom. All multi-occupancy bedrooms on these units had patio doors and windows directly out to an enclosed garden. However these windows and door were aging and of poor quality, and were observed to be drafty and unable to seal properly. There was insufficient seating and break out areas for residents. Despite the presence of a day room, residents tended to gather on the corridor by the front door, and areas of limited space and light. The "quiet rooms" in units were underutilized for residents comfort. Not all bed areas had access to a TV, as the connection points were on one side of the

rooms. All units were also observed to be extremely warm.

In the two newer units bedroom doors were observed to be left open more often than not, and in some case residents were in a state of undress within. All bedrooms doors had clear glass panes, and attempts had been made to obscure this in only some rooms. In these units, bedrooms windows faced out onto nearby pathways, and there was clear and uninterrupted views of residents in their bedrooms.

Accessible, directional signage was not in place to assist residents move throughout the units.

Inspectors observed some health and safety risks that had not been addressed. For example there were unsecured oxygen tanks in storage close to nurse's stations in some of the units. This position had not been highlighted on the fire and evacuation maps. In addition some residents smoked, and the area in which they smoked had overflowing ashtrays in addition to large full refuse sacks which posed a risk of fire.

Resident's safety was further compromised by deficits in fire safety precautions. In the older units some fire exits were in rooms that were locked. And the access to these fire exit doors were blocked and impeded by equipment. The access from the fire exits which were bedroom patio doors were into a secure garden, however the key was not available beside the locked exit gate and was attached to a set of keys carried by the manager. No bedroom doors in any units had self-closers, and throughout the two day inspection both inspectors observed that bedroom doors were left open. Closing doors in the event of a fire was part of the fire policy however no staff reported this step when asked about safe evacuation techniques.

In the older units, it was not possible to determine if bedroom doors were fire doors. Due to their age, they had a different design to modern fire doors, and had been heavily repainted.

In the newer units, almost all bedroom doors had the features of a fire doors, however none had tags indicating the level of protection they provided.

A thorough activity programme was being offered, but only on a Monday – Friday basis. Records kept captured attendances only, and did not detail the level of engagement or impact the activity had on the residents. Some additional effort was required to ensure that all residents had the opportunity to participate regardless of their cultural background. Care plans indicated resident's preferences and detailed their communication requirements, for example if an interpreter was required. However no evidence was seen that an interpreter had been provided.

The level of consultation with residents had improved since the last inspection, and residents meetings were taking place on most units. The frequency of meetings on some units had been impacted by staff changes. Records of the meetings did not consistently record the actions taken or the persons responsible for addressing feedback raised. The minutes of the meetings were not always displayed. Some feedback raised by residents had resulted in tangible changes – for example altering the layouts of dining rooms and providing air conditioning. There was a resident's

booklet available and it contained the requirements of the regulation.

Regulation 10: Communication difficulties

Residents communication needs had been detailed in their care plans as required by the regulations. An additional resource was required to ensure that all residents could communicate freely through the provision of independent interpreter services.

Judgment: Substantially compliant

Regulation 17: Premises

The premises required cleaning and updating throughout as evidence was seen throughout the inspection and on all units of:

- Wear and tear on paintwork on walls
- Wear and tear on floor coverings in Willow and Sycamore Units
- Poorly maintained outdoor areas and evidence of litter in outdoor areas
- Occluded roof lights / windows that had not been cleaned
- Inadequate private accommodation in the units with multi-occupancy bedrooms.
- Inadequate seating and rest areas in the units with multi-occupancy bedrooms
- Excessive heating in all units, and poor levels of ventilation
- Poor levels of directional resident-friendly signage in all units.

Judgment: Not compliant

Regulation 20: Information for residents

There was a resident's guide available which described the facilities and services available in the centre. The guide also made reference to the terms and conditions of the contract between the residents and the provider. Guidance on visiting arrangements and on how a resident may register a complaint was also included in this brochure.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy set out clear information on the management of specified risks. There was a clear process in place to record and review risks and incidents. There was an emergency response plan in place. However some improvement was required in the identification of day-to-day risks relating to the environment. This is reflected in regulation 23 above.

Judgment: Compliant

Regulation 28: Fire precautions

Staff were fully trained in fire response. However as bedroom doors did not feature self closers, the policy and procedure stated staff were required to check and close bedrooms doors as part of their response to a fire alarm. Staff did not verbalise this on the days of inspection and bedroom doors were left open on all units throughout both days of inspection.

Some emergency exits on the units with the most multi-occupancy rooms were behind locked doors. While they may not be in regular use, these exits were defined as fire exits on the site map.

Where exits led to secure gardens and courtyards, arrangements to exit the secure garden areas were inadequate.

The fire-rating of designated fire doors on bedrooms and corridors was unclear.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

All resident care records seen confirmed that they had a comprehensive assessment of their needs in place prior to being admitted to the centre. This assessment assisted the centre to determine whether they would be able to meet the health and social care needs of the resident being referred.

The care records reviewed also indicated that the nursing team developed care plans to meet the residents identified needs whilst incorporating the views and preferences of the resident into these plans. In instances where the resident was

unable to contribute to these plans, the resident's family were engaged to be involved in developing care interventions.

Care plans were well written and easy to follow which assisted in the review process. Care plans were reviewed every four months or as and when a significant change occurred. End of life care plans were sensitively written in a manner that captured resident's last wishes with regard to their spiritual needs, funeral arrangements and arrangements for pain relief. Residents who had a do not attempt resuscitation in place (DNAR) these records were found to be signed by the appropriate medical personnel. However care plans created for a resident who was self-isolating had not been updated to take account of recommendations made in a multi-disciplinary team meeting (MDT). This resulted in the resident not having updated interventions in place to meet their needs.

A review of resident activity care plans showed that while residents had attended organised activities in the centre their effectiveness in meeting residents identified needs was often based on an over reliance quantitative data. Records were seen that only captured residents attendance at activities as opposed to data which captured residents participation and enjoyment of the activity they attended. Measuring this information would enhance and improve the overall activity experience for the residents in the designated centre and ensure that activity care plans better reflected residents experiences.

Judgment: Substantially compliant

Regulation 6: Health care

There were arrangements in place for residents to access medical and allied health professionals. A medical officer was available from Monday to Friday while there was access to out-of-hours medical support outside of these days and at weekends. There was access to an occupational therapist and physiotherapist which was shared across the five units that made up the designated centre.

Access to allied healthcare services such as speech and language therapy (SALT) and tissue viability nursing (TVN) was provided on site. Staff had recently been appointed to both of these disciplines. There was arrangements in place for residents to avail of support with their chiropody and optical care needs with professionals in these areas visiting the centre on a regular basis.

Support for residents with mental health needs was provided through psychiatry of later life based at Tallaght hospital.

There were sufficient numbers of nursing staff available to ensure resident healthcare needs were monitored and met in a timely manner, with clinical nurse specialists leading on infection control, wound care, challenging behaviour, restrictive practices and falls management. Access to input from safeguarding and

social work was also available on site.

Regular multidisciplinary team meetings gave clinical oversight regarding resident health and social care interventions while the management team utilized nursing metrics and audits to inform them of trends and areas that required improvement.

Inspectors noted however that there were delays in accessing input from community dieticians which resulted in residents not having access to this specialist intervention in a timely manner. This is reflected in regulation 23 above.

Judgment: Compliant

Regulation 8: Protection

Staff were trained in safeguarding and there had been additional safeguarding officers trained and appointed from the staff group. The centre had an up-to-date safeguarding policy. As noted in the report above, allegation relating to staff were taking significant lengths of time to conclude due to the providers policy of referring the allegations to a third party.

Judgment: Compliant

Regulation 9: Residents' rights

Residents spoken with during the inspection said that they felt their rights were respected by the staff team. Residents told the inspector that they had attended a residents meetings and discussed key topics such as activities and quality of meals. However these meetings were not being held regularly on some units and there was a lack of recorded actions taken in response to issues residents raised.

There was access to a social worker on site to advocate on behalf of the resident group, and access to independent advocacy was also available. Residents spoken with also confirmed that they were supported to vote in the recent general election.

Residents also mentioned that they felt they had a degree of control over their lives in that they were able to choose what to wear, what time they wanted to arise and on where they wanted to dine.

Activities were provided by a team of activity workers from a unit on the campus called Silver Birch. They organized group and individual activities for residents on a Monday to Friday basis with the weekends kept free for family visits and religious observance. Residents were observed attending a music session which was well attended. Residents were encouraged by staff present to participate in the activity

and appeared to be enjoying themselves.

Resident's rooms were spacious enough for residents to be able to store their personal belongings and to store their mobility equipment where appropriate. Residents levels of privacy and dignity were being impeded by deficits in the care environment which were further detailed in regulation 17 above. While this finding is relevant to multi-occupancy rooms, it also relates to the levels of privacy afforded to residents in single rooms. Inspectors noted that clear glass windows in bedroom doors did not afford residents sufficient privacy when they were in their bedrooms, and some bedrooms were overlooked easily from pathways around the buildings.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspector observed staff interacting with residents who were displaying responsive behaviours. Staff were seen to diffuse potential conflicts in a sympathetic manner whilst been able to respect the rights of the individual resident concerned. It was clear that staff were aware of the residents care needs regarding their challenging behaviours and on how they could they could de-escalate the situation.

There was a good understanding among staff about the effects of restrictive practices on resident's autonomy, choice and rights. Staff were able to describe how their day-to-day working practices could impinge on a residents right to choose and on how this could affect their well-being. Staff spoken with confirmed that they had training in managing situations where challenging behaviours were displayed.

A clinical nurse specialist developed a care pack to assist staff in managing a range of resident challenging behaviours through individualized support and social interventions. This had resulted in positive outcomes for residents with a notable reduction in instances where medication was used to manage these behaviours. Due to staff changes this model of care had not been fully introduced to all of the five units in the designated centre.

Care records reviewed indicated that residents care plans gave clear detail on managing challenging behaviours with a focus on the least restrictive practice being used to manage these behaviours. Inspectors noticed however that risk assessments relating to responsive or challenging behaviours were not always reviewed in a timely manner for residents accommodated on willow unit. In addition the responsive behaviours register was not current and had not been updated on a monthly basis in accordance with the centre's policy.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant

Compliance Plan for Cherry Orchard Hospital OSV-0000508

Inspection ID: MON-0028691

Date of inspection: 14/02/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A complete review of all staff records will be undertaken where all personnel files updated in a format that complies with the standards required.

Risk assessments were reviewed across campus with high and moderate risk being priority and subsequently untaken in the first instance by the Advanced Nurse Practitioner (ANP) older person's integrated care in the absence of a CNM 2 in Behavioural Therapy.

There was a risk assessment out of date on Willow unit observed by the inspector however, the risk register guided staff when advised that all risk assessments were under review and continue with current plan of care, staff were also informed to contact the ANP directly should there be a change in the residents status and also at the time should an incident occur. The responsive behaviours on Willow unit were also being observed on a daily basis from the incident / accidents reporting in place i.e. NIMS through NIRF 01 along with the local and National safeguarding policy and procedure. An error of date by year on one of the responsive behaviour risk register templates was incorrect; the template was immediately corrected and inputted prior to the ANP meeting with the inspector. The ANP was and is available to staff should the need arise regarding any of their residents presenting with responsive behaviors'.

An explanation was given to the inspector re the current vacant CNM 2 in Behavioural Therapy position and further advised that the ANP was undertaking to review and update all responsive behaviour risk assessments across the facility. Willow unit at this point had not been completed as minimal amount of risk behaviors' occurred here and these were also infrequent along with presenting as low impact in nature.

The CNM 2 in Behavioural Therapy has been advertised and prior to this inspection the responsive behaviors register had been reviewed monthly for 2/12 and indicated on the register the residents who were known to exhibit infrequent low impact risk behavior.
A process of daily communication with units and availability of the ANP is in place.

Responsive behaviors were also identified up through NIRF 01 and safeguarding.

Plan: To complete further training with staff and support the assessment and development of risk assessments for each resident requiring same.
The ANP will continue to provide education across campus relating to behaviour, risk, PRN Psychotropic and specific areas determined on educational needs analysis

The responsive behavior care pack will be rolled out to the remaining units across campus for residents presenting with responsive behaviours and new admissions to the centre. A plan to liaise with unit staff and set criteria for roll out with support of the ANP will be undertaken following the current pandemic and appointment of the
CNM 2 in Behavioural Therapy, a post which has been advertised.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There has been the appointment of a Consultant Geriatrician to Cherry Orchard hospital and St James's hospital who commenced on 18th May 2020, this senior clinician is providing services to Cherry Orchard hospital one day per week to help support and strengthen the governance and management structures for the delivery of effective care services to residents at the designated centre.

A resident's survey will be repeated and the annual review will be updated in line with the regulations.

All vacant positions have been approved for replacing by the Chief Officer and are with the National Recruitment Service. A vacant CNM 2 post has been filled since the inspection and the CNM 2 in Behavioural Therapy has been advertised.

There is a 0.5 WTE Dietician on site which is the current approved compliment. The potential to increase this to 1 WTE is being explored.

Once the current crisis with the Covid-19 pandemic is under control interviews for the vacant CNM 3 in in nursing administration will commence.

Residents in both Dementia units are mobile and it is their preference to 'gather on the corridor by the front door'. These units are of an older build and without substantial construction works cannot be widened. Residents are encouraged to utilize more open spaces using diversional techniques but it is their preference to congregate near the door.

The CHO Quality and Risk advisor position to support the unit with the Quality and Risk

programme has been approved has been advertised with interview dates agreed.

An Assistant Director of Nursing has been identified to lead on the clinical audit process across campus. They will be responsible for reviewing the schedule of audits, ensuring their timely completion,
Communicating across services and monitoring quality improvement plans to preserve robust standards. All information and actions will be communicated to the quality and safety committee, the monthly nursing admin and the monthly CNM meetings.

Standards

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
A Senior Speech and Language therapist is now in situ. Once the current Covid-19 outbreak has been lifted the post holder will carry out a full review of all resident's communication needs which will include interpretation requirements and an appropriate plan for each individual will be put in place.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of all multi-occupancy bedrooms in the older units will be undertaken and a schedule of works will be developed to include sound proofing partitions between the rooms as well as painting and repairs.

Additional cleaning resources are being engaged to ensure the external areas of the centre are maintained.

Air conditioning has been installed in the dining rooms of Sycamore and Willow.

Funding has been secured to repair the floors on Sycamore and Willow however this is on hold until the current Covid-19 crisis is lifted when a schedule of works will be agreed with HSE Estates.

The plan to develop 100 replacement beds on the campus still remains a priority for the HSE. The timing of this development is linked to the National Capital Plan and availability

of Capital funding in the context of other demanding priorities. The recent appointment of a Consultant Geriatrician (Cherry Orchard Hospital and St James's) is very welcome and will assist in influencing future developments on the Campus including the usage of the current bed stock particularly in light of the current Covid 19 pandemic and any replacement beds that will come on stream as part of the capital development plan.

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A complete review of the fire doors in all units will be carried out with the Fire Officer to ensure each door has the appropriate rating displayed on it. There are some rooms such as store rooms that have fire exit signs as guidance should the fire alarm be activated however these areas are not fire evacuation routes for residents. A schedule of works will be developed to upgrade the exits from the secure garden area. The doors in the multi-occupancy rooms are on a keypad lock that is connected to the fire system, these doors automatically release when the fire alarm is activated. 24-hour security personnel on site have keys for the gates exiting the gardens from all the older units, as part of the evacuation procedures security attend to any unit where the fire alarm is activated and can unlock these gates in the event of an evacuation. An upgraded bleep system is being introduced that will link to the fire alarm system on campus. The Emergency evacuation policy is currently under review.	

Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: A new document has been developed since the inspection to capture the resident's engagement and satisfaction with the various activity programmes offered using a numeric rating descriptor. This will be completed to capture the resident's participation/satisfaction in recreational activity. Each month the activity recording scores will be evaluated and a plan developed in consultation with the residents to endeavour to achieve a person centered social interaction scheduled activity plan for them.	

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A schedule of works will be developed to sound proof and modify the partitions between the bedrooms on the older units.

Monthly focus group meetings were taking place on all units however the residents requested that these meetings take place less often. The CNM's meet with their line manager in nursing administration every month and discuss any issues that arise at the focus groups. The PIC meets with nursing administration and the CNM's at scheduled monthly meetings where these issues are also discussed.

A review of nursing metrics will be undertaken to include documentation on the outcome of the activity programme for all residents. Metrics will be discussed at monthly Nursing Administration and monthly Clinical Nurse Managers meetings as a standing agenda item.

A new document has been developed since the inspection to capture the residents engagement and satisfaction with the various activity programmes offered using a numeric rating descriptor. This will be completed to capture the residents participation/satisfaction in recreational activity. Each month the activity recording scores will be evaluated and a plan developed in consultation with the residents to endeavour to achieve a person centered social interaction scheduled activity plan for them.

A capital funding application will be submitted to improve the paths around both the Sycamore and Willow units.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Risk assessments were reviewed across campus with high and moderate risk being priority and subsequently untaken in the first instance by the ANP older person's integrated care in the absence of a CNM 2 in Behavioural Therapy.
There was a risk assessment out of date on Willow unit observed by the inspector however, the risk register guided staff when advised that all risk assessments were under review and continue with current plan of care, staff were also informed to contact the ANP directly should there be a change in the residents status and also at the time should an incident occur. The responsive behaviours on Willow unit were also being observed on a daily basis from the incident / accidents reporting in place i.e. NIMS through NIRF 01 along with the local and National safeguarding policy and procedure. An error of date by year on one of the responsive behaviour risk register templates was incorrect; the template was immediately corrected and inputted prior to the ANP meeting with the

inspector. The ANP was and is available to staff should the need arise regarding any of their residents presenting with responsive behaviours.

An explanation was given to the inspector re the current vacant CNM 2 in Behavioural Therapy position and further advised that the ANP was undertaking to review and update all responsive behaviour risk assessments across the facility. Willow unit at this point had not been completed as minimal amount of risk behaviors' occurred here and these were also infrequent along with presenting as low impact in nature.

Prior to the inspection the behavioural therapy register had been reviewed monthly for 2/12 and indicated on the register the residents who were known to exhibit infrequent low impact risk behavior.
The daily communication with units and availability of the ANP is in place should support be required. Responsive behaviours were also identified through NIRF 01 and safeguarding.

Plan: to complete further training with staff and support the assessment and development of risk assessments for each resident requiring same.
The ANP will continue to provide education across campus relating to behaviour, risk, PRN Psychotropic and specific areas determined on educational needs analysis

The Responsive Behavior care pack will be rolled out to the remaining units across campus for residents presenting with responsive behaviors' and new admissions to the facility. A plan to liaise with unit staff and set criteria for roll out with support of the ANP will be undertaken following the current pandemic and the filling of the advertised CNM 2 position in behavioural therapy.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Substantially Compliant	Yellow	31/10/2020
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/12/2023
Regulation 17(2)	The registered	Not Compliant	Orange	31/10/2020

	provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall 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.	Not Compliant		31/08/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2020
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	30/09/2020
Regulation 23(c)	The registered provider shall	Not Compliant	Orange	30/09/2020

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	30/09/2020
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2020
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/10/2020
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after	Substantially Compliant	Yellow	31/08/2020

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/09/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	25/05/2020
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/12/2020
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/12/2020
Regulation 9(3)(c)(ii)	A registered provider shall, in	Substantially Compliant	Yellow	31/10/2020

	so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/09/2020