

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cherry Orchard Hospital
Centre ID:	OSV-0000508
Centre address:	Ballyfermot, Dublin 10.
Telephone number:	01 620 6000
Email address:	kevint.brady@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Kevin Brady
Lead inspector:	Linda Moore
Support inspector(s):	Deirdre Byrne;Liam Strahan;
Type of inspection	Announced
Number of residents on the date of inspection:	150
Number of vacancies on the date of inspection:	11

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
13 February 2015 10:00	13 February 2015 11:30
16 February 2015 09:30	16 February 2015 18:30
17 February 2015 07:00	17 February 2015 15:30

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

Overall, inspectors found that the provider met the requirements of 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. However there were significant deficits in the premises.

There was a very committed management and staff team who continually worked hard to provide a high standard of care. Several of the staff worked in the centre for many years.

Inspectors found that the health needs of residents were met to a high standard.

Residents had access to medical care seven days per week and were available on call. A range of other health services were also provided.

Residents were consulted about the operation of the centre and there was open communication in the centre. Residents and relatives knew the management on a first name basis. The collective feedback from residents was one of satisfaction with the service and care provided.

The provider and person in charge promoted the safety of residents. Staff had received training and were knowledgeable about the prevention of elder abuse and other relevant areas. Staff had an in-depth knowledge of residents and their needs. Recruitment practices met the requirements of the Regulations. There were improvements required in risk management policy.

Significant improvement was noted from the previous inspections, improvements in care planning was noted. Seven actions identified at the previous inspection in July 2014 were addressed, one action was partly completed and one action had not been addressed.

Areas for improvement included:

Policies in line with the regulations

Premises issues

Dining experience

These areas for improvement are discussed further in the report and are included in the Action Plan at the end of this report

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors found that the statement of purpose contained all of the information as required by the Regulations. The provider had made a copy available to residents. This clearly described the range of needs that the designated centre intended to meet.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

Inspectors found that systems were in place to ensure that the quality of care given to residents was monitored, developed and improved on an ongoing basis. Audits were completed on several areas such as care planning, falls, medication management and restraint. The speech and language therapy department had developed communication cards and other new initiatives to enhance the communication. There was evidence of quality improvement plans being identified. These included other areas such as end of

life care.

There are plans in place to collect data each month on the number of key quality indicators to monitor trends and identify areas for improvement.

There is a clearly defined management structure that identifies the lines of authority and accountability as outlined in the statement of purpose.

The provider is available on a daily basis and begun to meet the person in charge each month. The minutes of two of these meetings were reviewed. He provided support to the person in charge, appropriate resources were allocated to meet residents needs.

There was evidence of consultation with residents and representatives formally and informally and their feedback was used to improve the service.

Judgment:

Compliant

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors read a sample of completed contracts and saw that they did not fully meet the requirements of the Regulations. They included adequate details of the services to be provided but did not include the fees to be charged, this also did not include the cost for the additional services not included in the fee.

A resident's guide is available to each resident which describes the services.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was a registered nurse and she worked full-time in the centre. She was on duty for the duration of the inspection and was supported by two assistant directors of nursing, clinical nurse managers and staff nurses.

She had good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the Authority's Standards.

The person in charge has many years of experience working within older person services and she demonstrated strong leadership and good communication with her team. She had adequate systems in place to ensure good supervision to all staff. She was an organised manager and all documentation requested by inspectors was readily available. The person in charge had deputising and on call arrangements in place.

Inspectors observed that she were well known to staff, residents and relatives with many referring to her by her first name. She had both maintained her continuous professional development. She had completed a BSc in Health Services Management, a leadership programme in 2013/2014, clinical risk and complaints management training.

Judgment:

Compliant

***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):

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the records listed in schedules 2, 3 and 4 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and

ease of retrieval.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. However some of these policies were in draft format and were in the process of being rolled out. This included the restraint, behaviours that challenge and medication management policies. There was no policy on epilepsy which would have guided staff as many of the residents had epilepsy.

Records were stored securely.

An up to date insurance policy was in place for the centre which included cover for resident's personal property and accident and injury to residents in compliance with all the requirements of the Regulations.

Judgment:

Substantially Compliant

***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:

The provider was aware of his responsibility to notify the Chief Inspector of the absence of the person in charge.

The person in charge is supported in her role by two assistant directors of nursing (ADON) who deputise for her in her absence. Inspectors met with one ADON and found that she was aware of the responsibilities of the person in charge and had up to date knowledge of the Regulations and Standards.

Judgment:

Compliant

***Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to allegations of elder abuse. A centre-specific policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. Aspects of the management of behaviours that challenge and the use of all restraint required improvement.

The provider, person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. A review of incidents since the previous inspection showed that there were no allegations of abuse in the centre.

Residents spoken to and those who had completed the Authority's questionnaire commented that they felt safe and secure in the centre. They attributed this to the fact that staff are very caring and always reassuring residents if they have concerns. They also said that there was twenty four hour security in place and there was staff on duty at all times. This was confirmed by inspectors.

There were systems in place to safe guard resident's money. The policy was in the process of being reviewed. Comprehensive and complete records of resident's financial transactions were maintained.

There was a policy on and procedures for managing behaviours that challenge. This was in the process of being reviewed. During the inspection staff approached residents with behaviour that challenged in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. Inspectors noted that greater than 70 percent of residents presented with behaviour that was challenging. Inspectors met the clinical nurse specialist in this area and discussed the plans for the service. Training had been provided to all staff and daily support was provided as required.

There was evidence that the medical director or officers, and Psychiatric services were involved in the care as required. Inspectors reviewed the records of residents and found that there were risk assessments completed and residents had care plans, possible triggers had been identified and staff spoken with were very familiar with appropriate interventions to use. However, the residents care plan in this regard would not fully guide care. Inspectors also noted that each episode of behaviour was not fully documented, including the antecedent, behaviour and consequence in line with the policy. Inspectors noted that additional staff resources were provided to respond to a need in this area.

Overall, the use of restraint was in line with the national policy on restraint. The rationale for use was documented which was a multidisciplinary decision. However this was not detailed for all restraint in use. There was a restraint register in place. There was a system in place to monitor all residents using restraint.

A staff nurse had been assigned to lead on restraint and a considerable number of alternatives were available to reduce the use of bedrails. Inspectors noted that appropriate risk assessments had been undertaken. Consent forms were signed by the resident and care plans were in place. Frequent checks were completed when bedrails were in use overnight. There was no documented evidence that alternatives had been tried prior to the use of restraint as required by the centre's policy. Staff spoken with confirmed the various strategies that had been tried but these were not documented.

Judgment:

Substantially Compliant

***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):

No actions were required from the previous inspection.

Findings:

Inspectors found that there were robust systems in place in relation to promoting the health and safety of residents, staff and visitors. However, there were areas for improvement. The risk management policy did not guide the actual practice in place for the hazard identification, recording, investigation and learning from risk. Some aspects of fire safety required improvement.

A safety statement for each unit was in place and it related to the health and safety of residents, staff and visitors. There was a corporate and local risk register in place and there were plans in place to develop a register for documenting risk associated with residents who present with behaviours that challenge.

There were systems in place for hazard identification, recording, investigation and learning from risk. There was a health and safety committee in the centre. There were good systems in place to respond to incidents through the incident review group. This group reviewed incidents associated with falls, medication errors, and behaviours that challenge and plans were implemented to minimise the risk of future reoccurrences. However these processes were not set out in the risk management policy.

All staff had attended the mandatory training in moving and handling which was held on a monthly basis. This training had included the use of hoists and slings and inspectors

saw staff using this equipment appropriately. In addition, inspectors saw that individual comprehensive risk assessments were carried out for residents who required the use of the hoist.

Overall fire safety was well managed but there were two areas for improvement. Inspectors reviewed the fire procedures and found they did not guide the actual practice in place. However, inspectors viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as defined by the Regulations. This could be further developed if the learning from drills were documented. Inspectors viewed the fire records which showed that fire equipment had been regularly serviced. The fire alarm had been serviced quarterly. Inspectors found that all internal fire exits were clear and unobstructed during the inspection.

Written confirmation from a competent person that of all requirements of the statutory fire authority, was submitted to the Authority prior to the inspection.

There was no emergency plan in place. Inspectors reviewed the evacuation plan which was in draft and was being reviewed to guide practice. Inspectors noted that some of the fire exits were not clearly displayed, this was being addressed.

Inspectors found that there were measures in place to control and prevent infection. Staff were knowledgeable in infection control. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre. There was a clinical nurse specialist in infection control in the centre who completed regular audits and provided advice and support to staff.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that each resident was protected by the designated centre's policies and procedures for medication management. These policies were being reviewed. Having reviewed prescription and administration records, procedures for the storage of medication including those requiring refrigeration and procedures for the

management of medications that required strict controls, the inspectors were satisfied that appropriate medication management practices were in place.

Staff had received training. Written evidence was available that three-monthly reviews were carried out. There was evidence of pharmacy input. Medication errors were reviewed and systems were in place to minimise the risk of future incidents.

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of inspectors, all relevant incidents had been notified to the Chief Inspector by the person in charge.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Inspectors were satisfied that each resident's wellbeing and welfare was maintained by appropriate evidence-based nursing, medical and allied healthcare.

Inspectors found that the residents had diverse needs; some were highly dependent and required full assistance while other residents were quite mobile and independent. There were 150 residents in the centre on the day of the inspection. The dependencies were as follows. There were 99 residents with maximum dependency, 24 were high dependency, 23 were medium dependency, three were low and one was independent.

Inspectors found that there was good access to medical care in that the Medical superintendant and medical team were on duty seven days per week and were available on call. A full range of other services was available on referral including speech and language therapy (SALT), occupational therapy (OT), physiotherapy. Chiropody, dental, audiology and optical services were also provided. Inspectors reviewed residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes. Dietetic services are currently not provided but this was being addressed.

A multidisciplinary review of residents took place every three months. The records of these meetings were reviewed in the units. These meetings consisted of the medical team, unit nursing representatives, occupational therapist (OT), speech and language therapist (SALT) and physiotherapist and any other professional deemed appropriate to attend the meeting. While residents were reviewed regularly by the multidisciplinary team, this could be further enhanced if there was follow through to ensure the action agreed were implemented.

Inspectors read care plans of residents who had a wound and noted that there was an assessment and treatment plan in place to manage the wound. Inspectors were satisfied that the correct management strategy was in place and staff spoken with confirmed this. Staff had access to a specialist in wound care who reviews all residents with wounds.

Inspectors read the care plans of residents who had fallen and saw that risk assessments were undertaken and an action plan was devised. This included review of medications, additional equipment and review by the physiotherapist. Neurological observations were completed when residents sustained an unwitnessed fall. A multi disciplinary team closely monitored the incidence of falls which were analysed and trends identified.

There were policies on nutrition and hydration which were being adhered to and supported good practices. See outcome 15 for further information on meals and nutrition.

Inspectors reviewed a sample of residents' files and noted that a nursing assessment and additional clinical risk assessments were carried out for residents. Daily notes were being recorded in line with professional guidelines.

Overall care plans contained the required information to guide the care for residents. Residents and/or relatives were involved in the development of their care plans and they discussed this with inspectors.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

Residents' accommodation is provided as follows:

Sycamore Unit

This unit is divided into two separate areas known as Sycamore East and Sycamore West. The main entrance is wheelchair accessible and there is a key pad locking system in place. It caters for 47 residents with high to maximum dependency needs. The majority of residents had a dementia related condition.

Sycamore East provides accommodation for 23 residents. There are 16 single bedrooms, two twin bedrooms and one three - bedded. All bedrooms have en suite shower, toilet and wash hand basin.

Sycamore West consists of 17 single bedrooms, two twin bedrooms and one room with three beds. Each bedroom has a wash hand basin for staff use.

Residents in the Sycamore unit share a sitting room, dining room, occupational therapy, physiotherapy, activities room and beauty therapy room, multisensory stimulation room, quiet room and an oratory. Other shared facilities include the kitchen and treatment room. Each unit has a nurses' - station, sluice room and utility room. The clinical nurse specialist's offices are located on this unit. The dining areas on Willow and Sycamore did not provide adequate dining space. The inspector noted that there were 30 spaces available, while these units can accommodate up to 47 residents. The day room was being used during the inspection to address this.

There are four additional assisted toilets within close proximity to communal areas. Staff facilities includes a dining room, separate male and female changing / shower facilities.

Both units share a secure courtyard which is accessible from the sitting room.

Aspen Unit.

This unit caters for 18 residents. It is under the management of St James's Hospital.

The main entrance is wheelchair accessible and there is a key pad locking system in place. The nursing office is located next to the main entrance. Accommodation for residents is provided on one corridor to the left and right of the nurse's office and there are two four- bedded rooms with wash hand basin, three three bedded rooms and one single bedrooms with wash hand basin.

Facilities for residents include a sitting room which has an interconnecting door leading into the dining room, a kitchenette and six toilets of which four are assisted. There is two assisted shower rooms, one bathroom, a store room, linen room, treatment room, sluice room with bed pan washer and a cleaning room. Staff facilities include a coffee room, changing facilities with toilet and wash hand basin.

Beech Unit.

Beech unit caters for 16 male residents with dementia in four four- bedded bedrooms and one single room which is only used to move a resident into at their end of life if required. There are four toilets, none are assisted. There are two showers, one of these is assisted.

The main entrance is wheelchair accessible and there is a key pad locking system in place at the entrance. The nursing office is located next to the main entrance. Accommodation for residents is provided on one corridor to the left and right hand side of the nurse's office.

Facilities for residents include a sitting room which has an interconnecting door that leads into the dining room. There is also a kitchenette which staff can use. A small visitors' quiet room is available. Other facilities consist of a store room, treatment room, sluice room with bed pan washer, a utility room and a cleaning room. There is a secure garden which can be accessed from each of the bedrooms. Staff facilities include a locker room.

Poplar Unit.

Poplar unit caters for 16 female residents with dementia in four 4 bedded bedrooms. The main entrance is wheelchair accessible and there is a key pad locking system in place. The nursing office is located next to the main entrance. Accommodation for residents is provided on one long corridor. Facilities for residents include a sitting room which has an interconnecting door leading into the dining room. There is also a kitchenette, a small visitors' quiet room is available. There are four toilets of which one is assisted, two showers which are assisted, as well as a store room, linen room, treatment room, sluice room and cleaning room.

The secure garden may be accessed from each of the bedrooms. Staff facilities include a locker room, toilet and wash hand basin.

Willow Unit.

Willow unit is a new purpose built unit for 47 residents with high to maximum dependency needs, including 12 residents with dementia.

The main entrance is wheelchair accessible and there is a key pad locking system in

place at the entrance. The unit is divided into two separate areas known as Willow East and Willow West.

Willow East has 16 single bedrooms, two twin bedrooms and one bedroom with three beds. All bedrooms have en suite assisted shower, toilet and wash hand basin.

Willow West has 17 single bedrooms, two twin bedrooms and one bedroom with three beds. All bedrooms have en suite assisted shower, toilet and wash hand basin. Each bedroom has a wash hand basin for staff use.

Residents share a spacious sitting room, dining room, occupational therapy, physiotherapy, activities room and beauty therapy room. There is also a therapy room, quiet room and an oratory. Other shared facilities include a kitchen, treatment room. Each unit has a nurses' station, sluice room and utility room. There is a secure garden accessible from the day room which has a lawn and a paved seating area.

There are four assisted toilets and four assisted shower rooms within close proximity to communal areas. Staff facilities include a dining room, separate male and female changing / shower facilities.

Hazel Unit

Hazel unit is one of the older units. It has 17 places for long term care.

Residents have high to maximum dependency needs, and the majority of residents have dementia or have had a cerebrovascular accident (stroke).

The main entrance is wheelchair accessible and there is a key pad locking system in place at the entrance. The nursing office is located to the right hand side of the main entrance. Residents' bedrooms and facilities are located on one long corridor. All of these bedrooms are multi occupancy.

There are five toilets of which three are assisted, and two assisted showers. Other facilities include a dining/sitting room and a visitors' room. There is a kitchen, treatment room, equipment and general storage room, a cleaning room and sluice room.

The physical environment in the centre does not meet the requirements of the Regulations as stated above.

The centre was clean, comfortable, welcoming and well maintained both internally and externally.

The provider informed inspectors that he was aware of the requirements in the Standards which needed to be put in place in relation to many of the multi occupancy bedrooms and the environmental issues. This was currently at planning stage and planning is to be lodged later this year. Residents, relatives and staff have been involved in this new development.

There were many bedrooms with occupancy of more than two residents. Inspectors

noted that the noise level and the fact that some of the residents used a commode in a shared bedroom did not maintain resident's dignity. The three and four bedded rooms did not provide adequate space for the use of assistive equipment without moving the residents bed.

There was an inadequate number of assisted showers/ baths and toilets on Beech and Poplar units which limited residents' choice.

There was inadequate storage space. Inspectors observed residents equipment stored in the bathrooms used by residents.

Inspectors observed that the units for use by residents with dementia were not designed in accordance with best practice for residents with dementia. The layout did not include any landmarks, cueing or highly distinctive visually unique elements to help to orientate residents with dementia. These areas did not include appropriate signage, and did not use colour and lighting in line with best practice dementia care principles.

The kitchen and kitchenettes were found to be well equipped. Inspectors observed a plentiful supply of fresh food and snacks available for residents.

There is twenty four hour security of the premises maintained.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were systems to respond to complaints and the complaints management process was effective. However, the policy was not developed in line with the Regulations to guide practice.

The complaints procedure was available in the centre as required by the Regulations. This procedure did not meet the requirements of the Regulations and did not guide the practice. The complaints officer was identified on the policy.

All verbal complaints were recorded and dealt with at local level by the nurses and managers in the unit or by the social work department. The policy did not contain

information on the person separate to the complaints officer who was responsible for reviewing complaints to ensure they were responded to appropriately and that records were being maintained as required by the Regulations.

Inspectors reviewed the complaints folder and found that there were a small number of complaints on each unit and numerous "thank you cards" on file to staff for the care delivered.

Inspectors found that there were two complaints escalated to the person in charge and provider in 2014 and these were being appropriately managed. The complaints log contained all relevant information about the complaint and the investigation and outcome to the satisfaction of the complainant.

Residents said they knew who to speak to if they wished to make a complaint. They also said that if they any issues raised were addressed. Staff members were knowledgeable about their role in responding to issues raised by residents so that they did not escalate and become the subject for a complaint. Complaints and feedback from residents were viewed positively by the provider and the person in charge. The person in charge told inspectors that she encouraged staff to view complaints as a way to improve the service and to ensure that no resident was adversely affected by reason of the complaint having been made.

There was now a system in place to audit complaints and the data collected by the person in charge on the numbers of complaints in the centre on a monthly basis. This included the type and action taken.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

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

Findings:

Residents received a high standard of end-of-life care which was person centred and respected the values and preferences of the individual and resulted in positive outcomes for residents.

This centre had a thematic inspection in 2014 and was found to be minor non complaint in this area. Inspectors found that the areas of good practice had been maintained since

the thematic inspection and further development in the post death review had taken place.

There was a policy on end-of-life care which had been rolled out to staff since the previous inspection.

Inspectors reviewed documentation for a number of residents in relation to end-of-life care planning. Inspectors found that all of residents had an assessment in place which dealt with future healthcare needs in the event that the resident became seriously ill and was unable to speak for themselves. There was evidence of resident and family involvement in the development of these assessments. The decisions concerning future health care needs had been discussed with the GP and were documented. There was a system being developed to ensure the decision would be consistently reviewed. Care plans were of good quality and referenced the religious needs of the resident; they addressed the social and spiritual needs as well as preferences.

There was one resident receiving active end-of-life care at the time of inspection. Inspectors read records of a resident, who had died recently and found evidence of good practice, including regular review by the medical team. Regular family meetings were held and were attended by the medical team and nursing staff as appropriate. The majority of residents resided in multi occupancy rooms in parts of the centre. However a single room was facilitated for end-of-life care.

The managers stated that they based staffing levels on the assessed needs of the residents and always allocated a staff member to sit with a resident who was very sick or dying.

Relatives were made feel welcome and were facilitated to stay overnight and be with the resident when they were dying. Overnight facilities were provided for visiting family members who wished to stay with their loved one, and refreshments were also provided.

Staff were trained to administer pain relief to residents as their condition deteriorated, and they had support from the local palliative care team when required. Two of the nurse managers had completed a MSc in palliative care and a staff nurse had completed a post graduate diploma in end of life care. They provided support and training to staff. Staff members were knowledgeable about how to initiate contact with the service. This was documented in resident's files.

Records showed that staff had received training in end-of-life care. Residents, spoken to by inspectors, stated that their religious and spiritual needs were respected and supported and that their wishes regarding their preferences and choices at their end of life had been discussed with them or their family.

Mass services took place daily in different units in the centre and this was available to all residents. Access to other religious representatives from other faiths was available if requested. Residents also stated that staff members were caring and respectful and they were comfortable confiding in them.

Residents and visitors were informed sensitively when there was a death in the centre. The staff members informed the residents and it was announced at mass. A mass would be held specifically for a resident whose condition was deteriorating and again a month after the death. While the staff said they would provide information to families following the death of a loved one including details of how to register a death. This was in the process of being documented.

The post death review of the end of life practices was being piloted.

There were appropriate bags available to handover personal possessions

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

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

Findings:

Residents received a varied and nutritious diet that was tailored to meet individual preferences and requirements. This centre had a thematic inspection in 2014, inspectors noted that there were improvements in this area since the inspection. However the assistance at breakfast time still required improvement. This was identified at the thematic inspection and was not fully addressed.

There was a food and nutrition policy in place which was centre specific and provided detailed guidance to staff. Staff members spoken to by inspectors were knowledgeable regarding this policy.

Inspectors observed the service of breakfast and the main meal to residents. Inspectors observed that all residents did not have a choice of being served breakfast in the dining rooms as all breakfast were served in bed.

Residents who required assistance at this meal received this in a sensitive manner. However, improvements were still required in this area. Inspectors noted and staff confirmed that not all residents could choose the time they had breakfast as the times were set. Inspectors observed staff standing at the resident's beds in one unit assisting them with a meal at breakfast. This may not be an enjoyable experience for residents.

This conflicted with the speech and language recommendations for one resident.

Inspectors spent time in the dining rooms at the main meal and visited residents who also chose to eat in their bedrooms during lunch time and found that the dining experience was dignified, pleasant and relaxed with a strong emphasis on providing a high quality dining experience for residents.

Inspectors noted that meals were well presented and all residents expressed satisfaction with their meals. Staff were seen assisting residents discreetly and respectfully as required. Inspectors were satisfied that residents received a nutritious and varied diet.

Residents were offered a choice of food at each meal time and individual preferences were readily accommodated. The nursing staff monitored the meal times closely.

Residents, who required their food to be modified, for example pureed, were served this food in individual portions and had the same choice of food at the main meal. Regular fluids were provided during the day. Portion sizes were appropriate and second helpings were offered.

Inspectors found that weight records showed that residents' weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk and were also repeated on a regular basis. Records also showed that some residents had been referred for and received a SALT speech and language review. The medical team reviewed the nutritional needs and provided treatment plans. The treatment plans for residents was recorded in the residents' files. Medication records showed that supplements were prescribed by a doctor and administered appropriately. Staff provided fortified meals as a first choice as required.

Many of the chairs used for residents in one of the dining areas were not appropriate and some residents were seen to be having difficulty reaching these tables at times. Residents discussed this with inspectors. This did not make for a comfortable dining experience for residents. The person in charge informed inspectors that seating assessments had been completed and were awaiting funding to address this issue.

There was a clear, documented system of communication between nursing and catering staff regarding residents' nutritional needs and preferences. Inspectors spoke to catering staff who were knowledgeable about modified consistency diets. Overall responsibility with regards to resident's dietary needs rested with the nurse manager. There was a three weekly menu plan in place, which was varied, this would be enhanced if the menu had been audited by the dietician in order to ensure that it was nutritionally balanced.

Inspectors spoke to many residents regarding food and nutrition. Overall the response was uniformly positive with residents and relatives expressing a high level of satisfaction with the choice of food and the meal times. The new times of evening meal at 16.30 appeared to suit more residents. This was addressed following the previous inspection. Catering staff completed a satisfaction survey with residents in 2014, the responses were mainly positive.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that staff treated residents with privacy and dignity and that strong emphasis was placed on these values by the provider, person in charge and all staff. Issues regarding dignity in the multi occupancy bedrooms was discussed under outcome 12.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. Inspectors observed staff interacting with residents in a friendly and courteous manner. There was an open visiting policy and contact with family members was encouraged. Families said they can visit any time.

A residents' committee continued to meet, this meeting was chaired by the social work department, and the person in charge attended twice yearly. This was provided for residents and relatives to give them the opportunity to express any concerns they may have and for it to be discussed with the person in charge if they wished. There was access to independent advocacy as required. The minutes showed that issues identified were responded to by the provider and person in charge. These included staffing and access issues. Residents also said they had opportunities to discuss issues as they arose with the nurse manager in charge of their unit or any staff members.

Relatives said if they had any query it is addressed immediately. Relatives said they were kept up to date on their family status and any changes.

Inspectors observed staff working from a person centered approach, for example, there were examples of appropriate positive engagement from staff, for example, non verbal residents were spoken to in an age appropriate respectful manner.

Residents were seen enjoying various activities during the inspection. The activity team provided a service to all units on the hospital site including day and residential services. Social care assessments had been completed in respect of all residents and there were care plans to guide the social care services delivered. A programme of activities was

widely displayed and residents and relatives spoken to commented on the various activities available to them. Activities included day trips, relaxation, music and Sonas (a therapeutic technique for residents with communication difficulties), karaoke, head and face massage and knitting groups. However residents, staff and relatives said that there is little to do at the weekend in the absence of this activity group.

Inspectors noted that while televisions had been provided in residents' bedrooms. Residents did not have access to a private telephone.

Staff were aware of the different communication needs of residents and they had developed systems to meet the needs, such as the communication forum.

Judgment:

Substantially Compliant

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents could have their laundry attended to within the centre. The laundry was situated in a separate building and was well equipped. Inspectors spoke to the staff member working there and found that they were knowledgeable about the different processes for different categories of laundry. Residents expressed satisfaction with the laundry service provided.

Adequate storage space was provided for residents' possessions.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act

2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

Inspectors found that there was a very committed and caring staff team. This was confirmed by residents and relatives when they described the staff as caring, professional and understanding. Others described the staff as dedicated, with a commitment for the care of all residents.

The person in charge and provider placed strong emphasis on training and continuous professional development for staff. All staff told inspectors that they felt well supported by person in charge and provider and described the workforce as like a family.

There was evidence of safe staff recruitment practices in line with policy and inspectors were satisfied that there was appropriate staff numbers and skill mix to meet the assessed needs of residents. Additional staff had been recruited since the previous inspection and there was less reliance on agency staff which was improving the outcomes for residents. Inspectors reviewed the roster which reflected the staff on duty. Resident dependency was assessed using a recognised dependency scale and the staffing rotas were adjusted accordingly. One to one staffing was provided to some residents who required additional care.

Inspectors confirmed that up-to-date registration numbers were in place for nursing staff.

Staff files of newly recruited staff were available and inspectors saw that these met the requirements of the Regulations.

The provider and person in charge promoted professional development for staff and were committed to providing ongoing training to staff. An educational needs analysis survey was completed yearly and the results were used to inform the training plan. For example several staff had requested additional training on dementia care and inspectors saw where this was now included in the training plan. Other planned training included communication and dysphagia. A training matrix was maintained which identified which staff had attended training, which were due to attend and the dates of courses planned. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included behaviours that challenge, infection control, dysphagia training and falls prevention and management.

The induction programme for new staff was reviewed, it included training in intimate care, wound care, dysphagia and CPR.

The provider had ensured that volunteers were vetted appropriate to their role.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Cherry Orchard Hospital
Centre ID:	OSV-0000508
Date of inspection:	13/02/2015, 16/02/2015 and 17/02/2015
Date of response:	13/04/2015

Requirements

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

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

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The contract of care did not meet the requirements of the Regulations.

Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

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

The contract of care will be amended to reflect the requirements of the Regulations

Proposed Timescale: 13/02/2015

Outcome 05: Documentation to be kept at a designated centre**Theme:**

Governance, Leadership and Management

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

Many of the policies as required by the regulations were in the process of being reviewed.

Action Required:

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

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

All policies as set out in Schedule 5 will be reviewed and amended as necessary

Proposed Timescale: 31/07/2015

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

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

There were aspects of the management of behaviour that challenge and the use of all restraint which was not in line with best practice.

Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

The MDT restraint group have developed a prn psychotropic medication document to monitor the prn use of chemical restraints which will be initially trialled for a month. The response will guide the group around recommendations for completion of incident forms. The use of chemical restraints will also be addressed within the restraint and behaviour that challenges policies.

A responsive behaviours risk register has been developed for the hospital

Proposed Timescale: 31/08/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk management policy did not guide practice.

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:

A document will be developed that will allow for management and/or the MDT to demonstrate what measures have been taken to address/manage serious incidents/events

Proposed Timescale: 31/05/2015

Theme:

Safe care and support

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

Some of the fire exits were not clearly displayed, there was no emergency plan and the fire procedures did not guide practice .

Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

The fire officer has been contacted and has included the markings of the fire exits in his capital plan for 2015.

An emergency plan will be developed to guide practice

Proposed Timescale: 31/08/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

There was inappropriate seating provided to meet some residents needs in the dining areas.

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:

An OT assessment has been carried out in relation to the seating areas in the dining rooms and quotes have been sought per the financial regulations which will be submitted to the Provider.

Proposed Timescale: 31/05/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The premises does not meet the needs of residents.

Action Required:

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

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

A tender for a design team for a new 100 bed unit is in process. It is anticipated that the design team will be appointed in May 2015 with a view to construction being completed in Q4 2018

Once the new unit is built the residents from either Sycamore or Willow will move and the residents on Aspen will relocate to that vacated unit. All three-bedded rooms will then reduce to 2-beds at that time.

The bathrooms on Poplar and Beech unit are being renovated to comply with the Regulations.

Proposed Timescale: Immediate for the bathrooms

Construction of new 100 bed unit to be completed in Q4 2018.

Proposed Timescale: 31/12/2018

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy did not meet the regulations.

Action Required:

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

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

The local complaints procedure will be revised to comply with the Regulations.

Proposed Timescale: 30/04/2015

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Appropriate assistance was not provided to all residents at breakfast time.

Action Required:

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

All residents will be offered the choice of where they would like to dine for all meals.

The SLT will carry out visual inspections in the mornings to ensure that all residents who require assistance with their meals while in bed are positioned correctly for swallowing purposes.

The OT will carry out seating assessments for staff who are required to assist residents with their meals while in bed to ensure the staff are not standing at the bedside.

Proposed Timescale: 31/05/2015