

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	The Orchard Day and Respite Centre
<b>Centre ID:</b>	OSV-0000691
<b>Centre address:</b>	Temple Road, Blackrock, Co. Dublin.
<b>Telephone number:</b>	01 207 3839
<b>Email address:</b>	theorchard@alzheimer.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Alzheimer Society of Ireland
<b>Provider Nominee:</b>	Donal Murphy
<b>Lead inspector:</b>	Linda Moore
<b>Support inspector(s):</b>	Liam Strahan
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	11
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

### **The inspection took place over the following dates and times**

From:	To:
09 December 2014 09:00	09 December 2014 17:50
10 December 2014 07:20	10 December 2014 16:30

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**

The provider had applied for registration for 11 places. This report sets out the findings of the inspection.

As part of the inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors received questionnaires from residents and relatives which were complimentary of the service being provided at the centre.

Inspectors noted that residents were treated with dignity by staff during the

inspection.

Inspectors found that there were a significant number of areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The Orchard day and Respite service is a purpose built single storey building which has 11 places. The service provides short term respite service for residents with a diagnosis of dementia with an average length of stay of two weeks. There were also 20 day attendees in the centre.

A monitoring inspection was carried out in September 2010 to determine the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. Subsequent to the inspection, and following a submission to the Health Information and Quality Authority (the Authority) Regulation Directorate, it was determined that this centre was not a designated centre due to its exclusive provision of respite care. However, following further clarification on the definition of a designated centre, The Orchard Day and Respite Centre applied to register with the Authority in November 2014.

The Alzheimer Society of Ireland is the provider for this voluntary centre, its Operations Manager Donal Murphy is the person nominated to act on behalf of the company. He was appointed in April 2014. The centre is run by a board of directors. The nominated provider reports to the head of operations.

The person in charge has been in the post since April 2014 and has responsibility for the overall daily operation of the centre. He had an excellent knowledge of each resident and had a very hands on approach to care.

Inspectors met with the person in charge, provider, CEO and operations coordinator during the inspection and found that they were willing and committed to meeting with the requirements in the Regulations and Standards. However, inspectors found that there was a lack of adequate clinical governance in the centre which resulted in poor outcomes for residents. The management systems in place did not ensure that services provided are safe, appropriate to residents' needs, consistent and effectively monitored.

Inspectors found that the provider and the person in charge had addressed five of the nine actions that had been identified on the previous inspection. Areas for improvement included:

- Assessment and care planning
- medication management
- risk management and fire safety measures
- staff training in fire safety, protection and manual handling
- updating policies and procedures
- developing a system for reviewing the quality and safety of care

- complaints management

These actions are detailed in the report and included in the Action Plan at the end of the report.

**Section 41(1)(c) of the Health Act 2007. 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.**

**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):**

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

**Findings:**

Inspectors found that the Statement of Purpose met the requirements of the regulations.

The Statement of Purpose reflected the centre's aims, ethos and facilities. It described the care needs that the centre is designed to meet, as well as how those needs would be met. The admission criteria were outlined and were seen to be implemented in practice. The Statement of Purpose also outlined requirements such as staff, visiting arrangements, well being and safety and the complaints procedure.

The Provider and Person in Charge were aware of the need to keep this document up to date.

**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 there was a lack of adequate clinical governance in the centre which had resulted in poor outcomes for residents. Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 11, healthcare, risk management and insufficient staffing arrangements as outlined in Outcome 18.

Inspectors found that the management systems in place did not ensure that services provided are safe, appropriate to residents' needs, consistent and effectively monitored. There were no formal arrangements in place to review resident's needs and plan the service.

The roles of the person in charge and nurse managers were not being implemented in practice. For example, the supervision of care, they explained that due to the number of admissions and assessment of new day care attendees per day and their case load, they were not effectively supervising and reviewing care.

There were no clear lines of accountability for decision making and responsibility for the delivery of services to residents. A new nominated provider was employed in April 2014, who was supported by an operations coordinator, however, the provider was not adequately aware of his responsibilities under the regulations. The person in charge carried out some of the roles of the provider such as assessment of risk and was not supported to carry out this role. Inspectors found there was a lack of clarity regarding the roles of management in complaints and incident reporting.

Staff nurses explained that due to the number of admissions and discharges on a Monday in the centre. Care was not being supervised and a review of complaints showed that there were poor outcomes for residents who were discharged. Due to the availability of nurses on that day, admission assessments and care plans were of a poor quality and the actual care of residents was not being supervised.

Inspectors found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as medication management, risk management and healthcare issues as discussed throughout this report.

There was no formal system in place to review the safety and quality of care provided. The person in charge had reviewed some of the practices in the centre, for example, nutrition and medication practices, however, there was limited evidence that all of the recommendations identified were implemented. Inspectors noted that the issues identified on inspection had not been identified in these reviews. The provider was not aware of any review of the care being delivered. Inspectors found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as medication management.

**Judgment:**

Non Compliant - Major

***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):**

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

**Findings:**

While information was provided to residents, it was not always provided in an accessible manner to meet the needs of residents with dementia.

Contracts for Provision of Service and the Residents' Guide met the requirements of the regulations.

Inspectors reviewed a sample of the Contracts for Provision of Services. These clearly set out the services being provided for the care and welfare of residents, and the fee charged for these services.

The Residents' Guide included information on the centre's aims and objectives, respite facilities, admission and duration of stay, complaints, dignity and quality of life in the centre. This was presented in an accessible manner.

Inspectors observed that there were a significant number of signs on display throughout the centre.

There were several notices communicating meal times throughout the centre.

Inspectors observed, a sign saying water station next to a water station or directions (e.g. a sign saying 'use hand rails' next to the hand rails). Inspectors noted that these could be enhanced with the use of pictures for residents with dementia.

There was also a notice board communicating information about the daily social activities within the centre. While this was generally positive, it again appeared to have an over-reliance on words which many of the staff said that residents with dementia could not access.

**Judgment:**

Non Compliant - Minor

**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):**

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

**Findings:**

Inspectors found that while there was a person in charge of the centre the governance arrangements were not satisfactory.

The person in charge was a registered nurse and met the criteria set out in the



Regulations. The person in charge demonstrated a commitment to delivering good quality care to residents and was aware of residents' needs. Residents spoke highly of the person in charge. Most of the documentation requested by inspectors was readily available.

However, he was not been supported to carry out his role as per the requirements of the Regulations. While he worked full-time in the centre he was not full-time in the post of person in charge as he also provided front line nursing duties at times. As a result inspectors were concerned that he had not managed the service effectively. Inspectors identified non compliances in the areas of adequate clinical leadership as outlined in Outcome 11 and insufficient staffing arrangements as outlined in Outcome 18.

The arrangements for cover in the absence of the person in charge were not sufficient. While there was a clinical nurse manager (CNM) appointed to deputise in the absence of the person in charge, she was involved in delivering care to residents and in the assessment of new residents and did not have a role in managing the centre in the absence of the person in charge.

The person in charge had kept himself up to date and had completed a management course, certificate in gerontology and dementia care for example. However, he was not applying the principles of his learning to ensure a high standard of nursing practice as outlined in Outcome 11 and medication management.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

An up to date insurance policy was in place for the centre which included cover for resident's personal property.

Records were stored securely at all times during the inspection.

Inspectors were not satisfied that the records listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

The designated centre did have all of the written operational policies as required by Schedule 5 of the Regulations. However, they were generic and were not adapted to guide practice in the centre. This included the policy on the protection of vulnerable adults, medication management, wound care and nutrition. Staff were not fully aware of the content of the policies available as they had not received training in these areas.

The directory of residents did not include all aspects of the Regulations. This did not include the name of the referring organisation.

Inspectors found that resident's records were not completed in line with Schedule 3 of the Regulations. Records were not maintained of the medication errors in relation to each resident. A record of the treatment provided to residents with a pressure ulcer was not completed. Details of any specialist communication needs of the resident and methods of communication that may be appropriate to the resident were not detailed. A record of all money or valuables deposited and or received. One residents money was in safe keeping but there was no record of this in place. See outcome 17.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge***

*The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There was awareness by the person in charge of the responsibility to notify the Chief Inspector of the absence of the person in charge.

**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):**

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

**Findings:**

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

The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. However the provider was not knowledgeable on the process for investigating an allegation.

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 "they could talk to any of the staff if they had an issue". A review of incidents showed that there were no allegations of abuse in the centre.

There were no restrictive practices or residents who displayed responsive behaviours in the centre during the centre. However inspectors noted sufficient policies were available but were not being followed for residents who presented with this behaviour to guide staff should the need arise. Staff had not received training on restrictive practices and were not knowledgeable in this area.

There were not appropriate systems in place to manage residents' finances in line with the centres policy.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management***

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Inspectors generally found that the provider had put some risk management measures in place however they needed to be significantly improved.

The risks associated with medication management, healthcare as per Outcome 11, manual handling practices and staff nurse levels as per Outcome 18 also required significant improvement.

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

Inspectors observed poor manual handling practices twice during the inspection, which

may cause injury to the resident.

Records showed that not all staff had received manual handling training, Manual handling assessments were in place, but they were not completed by staff that were competent in this area and were not sufficiently detailed to guide staff.

Inspectors observed a liquid and sewing needles were on a press in one of the day rooms, which may be a risk to residents with dementia.

Inspectors read the Health and Safety Statement for 2014. This was centre specific but was not being implemented in practice. The person in charge had developed a number of risk assessments for the unit in an attempt to reduce the risks. The provider or any other staff members were not aware of the content of the statement of the risk assessments.

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

The risk management policy did not meet the requirements of the Regulations. It did not include the actual practice for the identification and management of risk and the measures to control the risks.

A number of accident and incidents for 2014 were being recorded, and these were being reviewed by the person in charge. Preventative measures were not consistently recorded. The person in charge held meetings with staff at the handover to implement a system to reduce the risk of future falls. There was no evidence that the action was taken and its effectiveness. Falls management is discussed further in outcome 11.

The provider had recently introduced management meetings where some of the incidents were discussed, however all clinical risk were not identified or discussed, while the person in charge was recently collecting information on the number of falls per month, there was no formal system to review or analyse incidents with a view to learning from them and reducing the risk of recurrence.

Overall fire safety was well managed. There were areas for improvement; all staff on duty had not been provided with fire training. There was one record of a fire drill carried out by staff, while the person in charge said these were being completed monthly, the documentation did not include the staff included in the drill, the length of time and any learning. Personal evacuation plans had not been developed for residents, there were no risk assessments undertaken for the evacuation of residents who had reduced mobility and those who required a wheelchair to ensure their safety.

There was an emergency plan which identified what to do in the event of emergencies such as lost of power and heat. The plan included contingency arrangements for the evacuation of residents from the building in the event of an emergency.

Inspectors viewed the fire training records and found that not all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. There was conflicting reports from staff as what to do in the event of a fire. The fire procedures did

not guide practice staff, residents or relatives to the nearest exit.

Inspectors viewed the fire records which showed that most of the fire equipment had been regularly serviced. Records showed that all equipment was not routinely maintained. Inspectors found that all internal fire exits were clear and unobstructed during the inspection. There was a robust system whereby staff checked fire exits daily and this was documented.

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

Inspectors found that there were measures in place to control and prevent infection. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre.

**Judgment:**

Non Compliant - Major

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

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

**Findings:**

As there was such a high rate of admissions and discharged each Monday, the procedures for medication management were complex. The person in charge and nurses told inspectors that a significant amount of time was spent clarifying prescriptions. Inspectors observed poor practice in the administration of medication, the nurse signed the medication administration records prior to administration of medications.

The use of faxed prescriptions and the process of transcribing were not in accordance with professional guidelines and evidence based practice.

A policy on the management of medication was reviewed by inspectors. This policy was generic and did not guide practice, in receiving, administration, transcribing medication, telephone orders, medication errors and withholding medication. For example, the policy on the use of PRN (as required medication) was not being followed in that the maximum dose in a 24 hour period was not recorded.

The temperature of the fridge which was used to store medication was checked daily. This contained medication for residents. Inspectors observed that the date was not entered when these medications were opened. The temperature on the day of the inspection was recorded as minus 2 degrees Celsius but there was no plan to address this.

The process for the receipt and disposal of medication was not sufficient. Residents medication was checked when received in the centre and throughout the week of admissions. However inspectors noted that the count of medication did not compare with the number of medications that should have been held for the resident and there was no process to address this.

There was a system in place to review and monitor the medication management practices but there actions identified had not been completed and they did not include the medication errors and issues identified by inspectors.

Medication error reports were completed in 2014, however, these reports were only partly completed and did not include the learning or any response taken to address the error identified, such as informing the General Practitioner. Errors included the administration of medication to the wrong resident or residents who received medication which was not prescribed.

There was no photographic identification in place for two of the residents who were receiving medication.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked a sample of balances and found them to be correct.

**Judgment:**

Non Compliant - Major

***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:**

Overall practice in relation to notifications of incidents was satisfactory.

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 the inspectors, all relevant incidents had been notified to the Chief Inspector by the person in charge.

**Judgment:**

Compliant

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**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):**

No actions were required from the previous inspection.

**Findings:**

While residents' healthcare needs appeared to be met in some areas, this was not consistent. Significant improvements were required in assessment and care planning and the associated policies to guide practice. Staff explained how they would respond to significant changes in residents' needs and would transfer them to the acute hospital. While staff described the care they delivered, this was not documented.

Significant improvements were required in falls management, restraint, nutrition and wound care.

Inspectors reviewed the records for residents and found that they had access to a general practitioner one day during their admission.

The person in charge said that residents did not access other health professionals during their stay, however referrals to other services and the GP would be made if required. Inspectors reviewed a sample of residents' files and noted that a brief assessment of residents' needs was completed by the nurse on admission. This was not comprehensive. While some of the residents had clinical risk assessments such as falls, and pressure sore assessments completed, they were not consistently completed for all residents and had not been updated for some of the residents from their previous admission, despite a change in their needs.

**Nutrition**

Inspectors noted that residents were not routinely weighed on admission and there was no MUST assessment completed. Staff were not trained in these assessments and were not taking appropriate action should the need arise. There were no care plans to guide the care for these residents. In discussion with the staff they were unable to outline the care that was to be delivered to one resident since the previous admission.

While some residents had care plans, they were generic and did not guide care. Other residents did not have care plans to guide their care. Inspectors noted that care plans for some residents were located in other residents files. There was no evidence of residents involvement in the development of the care plans. Care plans were not updated on this admission.

#### Falls prevention and management:

While there was a system in place to assess falls, the management of falls required improvement. Records showed that some residents had unwitnessed falls in 2014. There was insufficient evidence that neurological observations were completed following these falls. All nurses did not have access to the appropriate equipment to carry out these assessments.

While there were post falls assessments, these were not routinely completed and were not comprehensive. There was no falls diary or any indication how many falls a resident had sustained, which would be useful information in planning the service for the residents. The care plans did not guide care.

#### Wound care:

Three residents had wounds which had not developed in the centre. Respite was also provided to residents who had reduced mobility and may have been at risk of developing a pressure sore. Wound charts had not been completed for residents with wounds. Therefore it could not be ascertained if appropriate wound care was being delivered. Inspectors also noted that the wound dressing was applied based on the dressing's available to staff at the time.

There were no care plans to guide care, such as the frequency of the change of dressing or the type of dressing required. Staff had not been provided with any training in wound care and they provided care which conflicted with evidenced based practice. Staff were not knowledgeable on the classification of pressure sores and the use of the pressure relieving equipment and this was not available for all residents at risk. Inspectors noted that pressure relieving devices were incorrectly set for the needs of the resident.

#### Equipment

In addition to the lack of pressure relieving devices such as mattresses and cushions, there were an insufficient number of slings available to be used in the transfer of residents using a hoist.

#### Restraint Management

Inspector found that there were a small number of residents using bedrails. However, there were no alternatives available. Training had not been provided to staff on the use of restraint. Risk assessments were completed but were not updated for the use of bedrails. Inspectors were not satisfied with the appropriateness of the use of bedrails for all residents. For example, one resident's risk assessment stated the resident gets out of the bed at night, and that bumpers were required. These were not in place and no other alternative had been tried to keep this resident safe. There was a system in place to monitor all residents using restraint.

#### **Judgment:**

Non Compliant - Major

#### ***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)*



**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

Overall the physical environment in the centre met the requirements of the Regulations and the needs of all residents.

All bedrooms were single and included a toilet and sink, nine of the bedrooms had ensuite bedrooms with showers and toilets.

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

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

The centre was clean, comfortable, welcoming and well maintained both internally and externally. Inspectors found that the communal spaces and bedrooms were homely in design, decor and furnishings and this was also frequently mentioned by residents and their relatives.

The provider furnished the Authority with a certificate of compliance with planning orders and building regulations.

There were handrails and safe floor covering throughout the centre. Inspectors viewed the servicing and maintenance records for equipment such as hoists and found they were up to date.

Inspectors visited some residents' bedrooms and found that despite the centre being for short stay residents, they could personalise their room with their possessions.

Inspectors found that the communal spaces and bedrooms were homely in design, decor and furnishings and this was also frequently mentioned by residents and their relatives.

The kitchen was found to be well equipped. Inspectors observed a plentiful supply of fresh food. Inspectors read the recent environmental health officer report and found that the actions identified were addressed.

Residents had access to a secure garden area with seating area and planting which they said they enjoyed. The external grounds were well 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:**

Complaints were well managed informally but there were areas for improvement. While there was a complaints procedures on display. The complaint's policy did not fully meet the requirements of the Regulations. Managers described the procedure which was conflicting with the procedure on display, for example, the nominated person as per Regulation 34.

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

Complaints and feedback from residents were viewed positively by the provider and the person in charge. A complaints log was maintained and inspectors found that it contained details of the complaints; however it did not include the actions taken to respond to the complaint. The satisfaction with the complaint was also not recorded. There was an inadequate appeals process as the independent person was not available at present to carry out the role as defined by the regulations.

**Judgment:**

Non Compliant - Moderate

**Outcome 14: End of Life Care**

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

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

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

Due to the deficits in care plans, there was no system in place to capture resident's wishes, this was discussed in Outcome 11.

Inspectors noted that residents would receive support from the local palliative care team when required.

Staff had not received training in end-of-life care.

**Judgment:**

Non Compliant - Moderate

**Outcome 15: Food and Nutrition**

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

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

Inspectors saw residents being offered a variety of drinks throughout the day. Inspectors met with the chef who demonstrated knowledge of residents dietary needs, likes and dislikes and this was documented. However the records in the kitchen were conflicting with the records in the residents files. One resident did not receive the prescribed meal as required.

While appropriate assistance was provided to most of the residents. Inspectors noted that this could be improved. All residents were not sat in an appropriate and safe positions to eat their meal which may have placed them at risk.

There were improvements required for residents with dementia. While there was some picture menus in use, this was not in place for all of the meals and when it was introduced during the meal on the second day, it appeared to improved the dining experience for residents.

There were areas for improvement identified in the management of nutrition, see Outcome 11.

**Judgment:**

Non Compliant - Moderate

**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:**

Staff were observed facilitating communication with residents in a manner respectful of rights, dignity and consultation. Residents' interests and daily routines were respected throughout their respite stay.

On arrival residents were consulted with in order to build a life story. These detailed daily routines, important interests and recreation preferences. There were several types of life story being used, some word based and some picture based. Picture based life stories appeared more accessible. These life stories were used to ensure meaningful social activities were available for residents. There was adequate space available for these activities.

Inspectors observed that residents' autonomy was respected where they chose not to participate in group activities, or expressed preference for a different or solitary activity. Resident's autonomy and choice was also respected in how staff facilitated communication and preferences at meal times and choices around daily routine, such as getting up and going to bed.

There were no restrictions in place on visiting. There was sufficient space available to conduct these visits in private should residents wish to do so. Inspectors observed that one resident was taken on a visit out of the centre with relatives.

Residents had access to newspapers, telephone and televisions. Religious arrangements were in place through a weekly prayer service and information on local religious locations and service times.

Inspectors identified an issue with the dignity of residents accessing showering facilities. This is discussed further under Outcome 12.

**Judgment:**

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:**

There was adequate storage for residents' personal possessions. Arrangements were in place for residents' clothing to be laundered. Inspectors found that improvements were required with regards to property lists, laundry practices and storage of valuables. Residents were seen to be positively encouraged to bring familiar items and personalise their rooms.

Inspectors found that each resident had sufficient storage space in their room. Each resident had a lockable wardrobe and a bed side locker.

The centre had adequate washing and drying facilities for residents' laundry. There were sufficient arrangements for separation of clean and dirty clothing, and for the isolation of clothing if needed. Inspectors noted that there were a considerable number of complaints regarding resident's clothes going missing. This is discussed further under Outcome 13.

A locked facility for storage of valuables was available in the nurse's office. Inspectors found improvements were required in the management of property lists. While these included personal items that residents brought to the centre, they were not counter-signed by a resident and/or their representative and did not include all financial property. While there was a policy in place, it was not being implemented.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

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

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that there was a very committed staff team with low turnover. Staff told inspectors they felt well supported by the person in charge. Staff knew the residents well from their frequent visits to the centre for respite and the day services. There were also new admissions to the centre.

Inspectors found that the staff number and skill mix was not sufficient to meet the needs of residents. Staff stated that at times, there were inadequate levels of staff on duty.

Inspectors noted that there were increased care staff levels on duty on the first day of the inspection. Inspectors observed that due to the high rate of admissions and discharges on Monday's, this resulted in nursing staff spending significant time on admissions and had little time for assessments and care planning, risk management, training and the management of staff, residents or the care of other residents in the centre.

A sample of staff files were examined and inspectors noted that all relevant documents were present.

Inspectors reviewed all files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014.

Inspectors found that there were no performance reviews of staff in place to identify good practice and any training needs of staff. Staff including the provider were not aware of the Act and any regulations made under it.

Training records outlined the training for all staff. However, the records included staff who were no longer employed in the service. Records showed that while staff had received dementia training, mandatory training was not provided to all staff. There was no system to identify those who had received any training and any deficit. Staff did not have access to appropriate training including refresher training in order to meet the assessed need of residents. Staff had not received training in wound care, falls management, dysphagia to provide care to residents. The person in charge and operations coordinator held monthly debriefings for staff which included areas such as infection control and records of these meetings were seen. However not all staff were present during these sessions. There was no training plan developed to ensure evidenced based care could be delivered to residents.

**Judgment:**  
Non Compliant - Major

## **Closing the Visit**

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

### **Acknowledgements**

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

### ***Report Compiled by:***

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	The Orchard Day and Respite Centre
<b>Centre ID:</b>	OSV-0000691
<b>Date of inspection:</b>	09/12/2014
<b>Date of response:</b>	09/01/2015

### Requirements

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

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

### Outcome 02: Governance and Management

**Theme:**

Governance, Leadership and Management

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

The centres policies were generic and did not guide practice.

**Action Required:**

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated

<sup>1</sup> 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 policies (schedule 5) will be reviewed and adopted locally for the centre. The update and review of the policies will be completed within the given time frame. A Quality Safety and Practice Development Manager is being newly employed within the Society to support and advise the Registered Provider and Person in Charge on best practices/ policies to implement. Staff team briefing will be increased and be delivered twice a month to guide staff in the provision of care. Further training for Elder Abuse, Health & Safety of residents, staff and visitors, Nutrition, Medication Management and Risk Management will be organised for relevant staff by 30 April 2015.

**Proposed Timescale:** 30/06/2015

**Theme:**

Governance, Leadership and Management

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

The management systems in place did not ensure that services provided are safe, appropriate to residents' needs, consistent and effectively monitored.

**Action Required:**

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

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

Training will be undertaken by the registered service provider to support and understand his role and responsibility as required by the regulation. He will be further supported by the newly appointed Quality Safety and Practise Development Manager which will be in situ on the 19th January. Register provider will be in the centre to oversee the provision of care at least one day a week and will be available on call. During their time in the centre a formal weekly meeting will be held with the Person in Charge/Deputy Person in Charge. On a regular basis this meeting will include the Quality Safety and Practice Development Manager.

The centre will have a clear and well-defined structure of management to promote robust reporting, assessment, implementation / action planning, learning outcomes and evaluation/audit.

Regular inspections by the Quality Safety and Practice Development Manager will also take place with key recommendations implemented where necessary.

External audit of the centre will be conducted by an external Health and Safety consultancy.

A risk committee will be set up in the centre and their terms of reference will be completed within the given timeframe. Their scope will be to drive continuous

improvement of care within the centre and will includes examining any health and safety audit recommendations as well as advice from the Quality Safety and Practice Development Manager

**Proposed Timescale:** 31/03/2015

**Theme:**

Governance, Leadership and Management

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

There were no clear lines of accountability for decision making and responsibility for the delivery of services to residents.

**Action Required:**

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

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

The Registered Provider will endeavour to establish well defined roles for the Person in Charge and the Deputy Person in Charge. This is aimed to identify authority and accountability and well-supported roles to achieve a positive outcome of care. To achieve this, an overall review of the centre staffing requirements will be completed.

We aim to establish stronger clinical governance through the newly appointed Quality Safety and Practice Development Department which consists of a manager and area link nurses. Their function will be to support / advise the registered provider to reach decisions in relation to the delivering of quality services to residents through best practice and policies. This department will also actively engage with the Risk Committee to address health care issues of the client which will be reinforced through the regular care meetings. These will include a review of action plans and learning outcomes including developing a system for reviewing the quality and safety of care. The Quality Safety and Practice Development Department will also assist with the reviewing and continuous improvement of the quality and safety of care.

**Proposed Timescale:** 31/03/2015

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

**Theme:**

Governance, Leadership and Management

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

The directory of residents did not include all aspects of the Regulations.

**Action Required:**

Under Regulation 19(3) you are required to: Ensure the directory includes the

information specified in paragraph (3) of Schedule 3.

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

The centre client's directory has been updated. It currently includes the referring body and meets all the aspect of regulation.

**Proposed Timescale:** 09/12/2014

**Theme:**

Governance, Leadership and Management

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

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

**Action Required:**

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

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

The client's assessment forms were reviewed. A revised comprehensive form is in place. Staff nurses are trained to carry out a comprehensive assessment to guide care plan and health care practices.

Spot checks on the completion of these assessments will be conducted by the Quality Safety and Practice Development Manager

**Proposed Timescale:** 31/03/2015

**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:**

All staff had not received training on identifying and responding to allegations of elder abuse.

**Action Required:**

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

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

Mandatory training on identifying and responding to allegations of elder abuse will be provided for all staff and volunteers. This refresher / induction training will be made available to staff when required in conjunction with the centre's training matrix.

The up to date list of staff training records was forwarded to the HIQA following the

inspection.
<b>Proposed Timescale:</b> 31/01/2015
<b>Theme:</b> Safe care and support  <b>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</b> Residents finances were not well managed in line with the policy.  <b>Action Required:</b> Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.  <b>Please state the actions you have taken or are planning to take:</b> A new comprehensive client property list is in place. The form includes the client's financial record. The form also has a section for mid-week and end of week checks for all short term stay respite clients.
<b>Proposed Timescale:</b> 15/12/2014

#### **Outcome 08: Health and Safety and Risk Management**

<b>Theme:</b> Safe care and support  <b>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</b> The systems for the identification, assessment, management, recording and investigation of risk required improvement.  <b>Action Required:</b> 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.  <b>Please state the actions you have taken or are planning to take:</b> Formation of a Risk Management Committee as part of clinical governance to manage health care risk and to improve reporting, action planning and learning outcomes. The committee will hold regular meetings on risk management and ensure that internal audits are completed. This committee will also be supported by the newly appointed Quality Safety and Practice Development manager.  This will drive both the training and learning required by all staff to improve the management of risk in the centre present system.
<b>Proposed Timescale:</b> 31/03/2015
<b>Theme:</b> Safe care and support

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

All staff on duty had not been provided with fire training.

**Action Required:**

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

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

Fire training records were submitted to the HIQA following the inspection. Outstanding staff to be provided the mandatory training on fire training. Training of staff with the localised Emergency Response Plan on fire safety to be completed.

**Proposed Timescale:** 31/01/2015

**Theme:**

Safe care and support

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

Fire drill were not adequately documented.

**Action Required:**

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

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

Person in charge to carry out drills that are also fully supported with comprehensive recording. Person in charge started a fire preparedness scenario meeting to ensure preparedness and response in the event of fire.

**Proposed Timescale:** 31/01/2015

**Theme:**

Safe care and support

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

Records showed that the fire alarm had not been serviced quarterly.

**Action Required:**

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

The fire panel and fire fighting devices servicing certificates were not seen by the inspectors during the inspection, copy of certs have been forwarded to HIQA. The 2 panels passed the quarterly compliance with corresponding compliance stickers and certs.

**Proposed Timescale:** 17/12/2014

### **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:**

A comprehensive assessment of residents health, personal and social care needs was not completed on admission.

**Action Required:**

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

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

A new comprehensive assessment form is now in place. Staff nurses are trained on how to conduct the nursing assessment.

The client admission on Monday to be decreased from 11 clients to 7 clients and admission of 4 clients every Wednesday.

The Person in Charge will endeavour to complete pre-admission assessments or through other appropriate health care professionals.

A review of the centre staffing requirements will be completed.

**Proposed Timescale:** 31/03/2015

**Theme:**

Effective care and support

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

Care plans are not based on the assessed needs of residents as referred to in the Regulations. Many residents did not have care plans to meet their needs.

**Action Required:**

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

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

Implementation of comprehensive assessment forms that will support better comprehensive care planning. Staff nurse training on care planning is to be conducted. Training for health care staff in how care should be guided through care plans. Develop individual care plan summaries to allow staff quick access to relevant client information.

Introduction of monthly clinical audits of assessments and care plans by Person in Charge/Deputy Person in Charge.

The introduction of spot check clinical audits of assessments and care plans by the newly appointed Quality Safety and Practice Development Manager will also take place

The client admission on Monday to be decreased from 11 clients to 7 clients and with the remaining admission of 4 clients to take place every Wednesday.

The Person in Charge will endeavour to complete pre admission assessments or through other appropriate health care professionals.

A review of the centre staffing requirements will be completed.

**Proposed Timescale:** 30/06/2015

**Theme:**

Effective care and support

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

A high standard of evidenced based nursing care was not delivered in the areas of falls, nutrition, wound care and restraint.

**Action Required:**

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

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

Nutrition:

All Clients will be weighed on admission and a MUST Assessment will be completed. MUST Training will be provided to staff when required in line with the training matrix. A Food and Nutrition Audit will be carried out on a monthly basis and identified issues are acted upon immediately.

Development of a personalised nutrition Care Plan will be in place for every resident with a MUST score of greater than one. Residents/Family will be involved in the development of these Care Plans if appropriate.

Compliance checks will be carried out by the PIC / Quality Safety and Practice Development Manager as arranged by the registered provider.

Falls Prevention and Management:

<p>The system for reviewing, assessing and managing of falls will be reviewed. Where there is an unwitnessed fall, a 3 day post fall monitoring will be introduced to include neurological observations. All the necessary equipment will be provided to help nurses carry out these assessments.</p> <p>Falls diaries will be in place and regularly updated.</p> <p>Revised Care Plans will be in place to guide care for staff to include the appropriate use of existing low-low beds, environmental considerations, appropriate lighting, suitable footwear, landing mats if applicable.</p> <p>Ad hoc inspections of this Fall log will be conducted by the Quality Safety and Practice Development manager to review and recommend better practices</p> <p>Wound Care:</p> <p>Wound Care Training will be provided to relevant staff. All identified clients with wounds being admitted will be assessed and the appropriate Care Plan developed in line with best practice. The necessary dressings will be procured by the respective families which will be agreed pre-admission. All details will be included in their care plan assessments</p> <p>Restraint Management:</p> <p>Training will be provided to all staff in the use of restraint. All Restraint Risk Assessments will be reviewed and updated. Alternatives to the use of bedrails such as Landing Mats and use of pressure alarms will be explored.</p>
<p><b>Proposed Timescale:</b> 31/03/2015</p>
<p><b>Theme:</b> Effective care and support</p> <p><b>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</b> Inspectors observed poor manual handling practices.</p> <p><b>Action Required:</b> Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.</p> <p><b>Please state the actions you have taken or are planning to take:</b> The up to date list of staff training records was forwarded to HIQA and all outstanding staff to be given mandatory training on manual handling.</p> <p>The Person in Charge/Deputy Person in Charge to oversee manual handling practises in the centre.</p>
<p><b>Proposed Timescale:</b> 28/02/2015</p>
<p><b>Theme:</b> Effective care and support</p>



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

Poor medication management practices were found as identified in outcome nine.

**Action Required:**

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

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

The following to be completed:

- Medication management training to all nursing staff
- Up to date HSE land medication management training
- Team Briefing for all nurses on medication management

The Medication Management Policy will be reviewed and guidelines developed on receiving, administration, transcribing medication, telephone orders, medication errors and the withholding of medication. The review of this policy will be guided by the advice from the Quality Safety and Practice Development Manager and best practices.

All Staff Nurses will have read and understood the Guidance to Nurses and Midwives on Medication Management (An Bord Altranais, 2007) to ensure that all Staff Nurses are aware of their roles, responsibilities and legal obligations.

A review of the current process in clarifying prescriptions on admission will be carried out and a more robust system to be put in place.

A process for medication reconciliation will be developed and to explore the possibility of using Monitored Dosage Systems.

Medications that required refrigeration will be labelled with the opening dates. The fridge temperature is being checked daily, and the thermostat was adjusted to regulate the fridge within 2-8 degrees C. –Immediately

Medication Management Audits will be carried out on a monthly basis, and actions completed and learning outcomes communicated to all Nurses.

Medication Error Reports will be completed and reported to resident's GP if appropriate. Actions and responses taken to address the errors will be clearly documented to aid learning.

Photographic Identification for all residents receiving medication will be in place. – Immediately.

**Proposed Timescale:** 28/02/2015

## **Outcome 12: Safe and Suitable Premises**

### **Theme:**

Effective care and support

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

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

### **Action Required:**

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

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

Two proposals to be produced and costed:

- transform one of the rooms with a bath into a wet room.
- add showers to remaining 3 bedrooms

**Proposed Timescale:** 31/03/2015

## **Outcome 13: Complaints procedures**

### **Theme:**

Person-centred care and support

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

The complaints policy did not meet the requirements of the Regulations.

### **Action Required:**

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

The centre specific complaints policy has been submitted to HSE for approval. This will include adding a process to ensure actions identified / satisfaction of investigations are recorded. It has been agreed that all Clinical complaints will be investigated by the Quality Safety and Practice Development manager or one of the Area Link Nurses.

Monthly audit of all complaints to be completed by Person in Charge/Deputy Person in Charge. A monthly spot check of complaints to be completed by the Registered Provider. A regular summary of complaints to be regularly reviewed by the Senior Management Team discussion.

**Proposed Timescale:** 30/04/2015

### **Theme:**

Person-centred care and support

### **The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

There was insufficient evidence to show the actions taken to respond to the complaint. The satisfaction with the complaint was also not recorded.

**Action Required:**

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

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

The centre specific complaints policy has been submitted to HSE for approval. This will include adding a process to ensure actions identified / satisfaction of investigations are recorded. It has been agreed that all Clinical complaints will be investigated by the Quality Safety and Practice Development manager or one of the Area Link Nurses.

Monthly audit of all complaints to be completed by Person in Charge/Deputy Person in Charge. A monthly spot check of complaints to be completed by the Registered Provider. A regular summary of complaints to be regularly reviewed by the Senior Management Team discussion.

**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:**

All residents were not seated in an appropriate and safe position to eat their meal which may have placed them at risk.

**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:**

Staff training to be completed on Nutrition and Dysphagia.

Person in Charge / Deputy Person in Charge / Staff Nurse to oversee meal times.

**Proposed Timescale:** 31/03/2015

**Theme:**

Person-centred care and support

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

One resident did not receive the prescribed meal as required.

**Action Required:**

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

The staff nurse on admission days will provide an updated Nutrition list to the Kitchen.

Training in nutrition including different type of diets and fluid grades.

Use of picture demos/samples to identify the actual diet for the client.

**Proposed Timescale:** 31/03/2015

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**

Person-centred care and support

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

There were a number of complaints regarding residents clothes going missing.

**Action Required:**

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

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

A revised client property list form produced. The new form includes mid week and weekend checks. The family and clients are encouraged to sign the inventory of property list on admission and discharge.

Family are also being advised to put labels on all properties as part of pre-admission process.

**Proposed Timescale:** 15/12/2014

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Inspectors found that the staff number and skill mix was not sufficient to meet the needs of residents.

**Action Required:**

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

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

A review of the centre staffing requirements will be completed.

Training needs analysis to be completed within the centre and will be submitted to the Training Manager.

**Proposed Timescale:** 30/04/2015

**Theme:**

Workforce

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

Staff did not have access to appropriate training including refresher training in order to meet the assessed need of residents.

**Action Required:**

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

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

Provide staff the appropriate mandatory training including refresher training as required by the regulation and managed through the training matrix.

Training needs analysis to be completed within the centre and will be submitted to senior management team.

**Proposed Timescale:** 31/03/2015

**Theme:**

Workforce

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

Staff including the provider were not aware of the Act and any regulations made under it.

**Action Required:**

Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.

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

Staff training on health act and regulation and the standard of care for older person to be provided. This will also be supported by guidance and advice by the Quality Safety and Practice Development Manager

**Proposed Timescale:** 30/04/2015