

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Orwell House
Centre ID:	OSV-0000078
Centre address:	112 Orwell Road, Rathgar, Dublin 6.
Telephone number:	01 499 9000
Email address:	info@orwellhealthcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Orwell House Limited
Provider Nominee:	Peter Jones
Lead inspector:	Deirdre Byrne
Support inspector(s):	Nuala Rafferty; Gearoid Harrahill
Type of inspection	Announced
Number of residents on the date of inspection:	78
Number of vacancies on the date of inspection:	23

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 23 November 2015 08:00 To: 23 November 2015 20:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This was an announced inspection by the Health Information and Quality Authority (the Authority) was in response to an application by the provider to vary the conditions of their registration with additional residents under the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. Inspectors also carried out a monitoring inspection of the operating centre to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The application to vary the condition of registration was submitted by the provider in order to provide additional accommodation for a maximum of 69 adults within a new premises on the grounds of the present operating nursing home located in South Dublin. This would increase the maximum number of residents who may be accommodated in the centre to 170. As part of the application to vary the condition of registration, the provider submitted documentation relating to compliance with fire safety and planning requirements. The new centre consisted of 33 single occupancy bedrooms and 18 twin occupancy bedrooms. The lower ground floor of the new building was still undergoing building works and the garden for the new premises

was not yet completed. The provider nominee was advised by inspectors that the Authority was required to be provided with confirmation of completion of building of the new unit and the garden.

As part of the monitoring inspection of the centre, inspectors met the management team, staff and residents and reviewed documentation including care plans, medical records, policies and procedures. There are currently 78 residents presently residing in the centre. Inspectors found the provider nominee and joint persons in charge were aware of their legal obligations in operating a designated centre. Overall compliance was identified across all outcomes with evidence of good practice however, areas of improvements were found in Outcomes 2 (Governance), 12 (premises), 8 (Health Safety and Risk Management) and 11 (health care needs).

The action plan at the end of the report identifies those areas where improvements were required.

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

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors found there was a clearly defined management structure in place and a full time person in charge to oversee the management of the centre. However, improvements were identified in relation to the roles of staff in the centre and the on going review of the quality and safety.

The centre is operated by Orwell House Limited. The provider nominee had ensured there were adequate governance arrangements in place. There was a senior management team in place. It included the provider nominee and the medical director. There was a person in charge and assistant director of nursing who were based full time in centre. In addition, there was a facilities manager and accommodations manager. While the lines of authority and accountability of senior staff were clear, the responsibilities of staff at unit level in the centre were unclear, and these are outlined in Outcome 7.

Senior management team meetings were held on a regular basis, and minutes were read. A range of matters were discussed at the meetings which included fire safety, falls, complaints, staffing and regulatory issues.

Inspectors were informed that clinical governance meetings also took place to review the quality and safety in the centre. These were attended by the provider nominee, medical director, person in charge and assistant director of nursing. The last meeting was held in June 2015 and the minutes of the meeting confirmed areas of clinical governance were discussed. In addition to these meetings, a nutritional management meeting took place in October 2015, the minutes read contained a range of issues pertaining to food and nutrition in the centre. Inspectors found there were regular meetings with the management meetings, and staff and clinical nurse manager meetings were also held.

There were systems in place to monitor the quality and safety of care. However, improvements were identified. Inspectors were informed by the person in charge of care plans audits, however, these were not completed since June 2015. Following the inspection a list of audits completed in the centre was submitted to inspectors.

The provider had developed an annual report on the overall review of the safety and quality of care of residents for 2014. It was submitted at the end of the inspection. The report included a detailed analysis was carried out on key performance indicators such as end of life, skin care, falls, restrictive practices and complaints. It contained a comparison with findings from 2013. There was evidence of analysis of the information, trending of the data and actions were proposed to improve practice. The provider was aware of the legal requirement to prepare the report in consultation with residents and their families.

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:

Inspectors were satisfied the centre was managed full-time by a registered and experienced nurse in the area of nursing of older people. The post of person in charge was held by the director of nursing. Inspectors met the person in charge during the inspection.

The person in charge demonstrated a good knowledge of the Regulations, the Authority's Standards and their statutory responsibilities. She had been interviewed when she commenced in the role in March 2015. Inspectors found the person in charge managed the centre with authority and accountability. The staff said they regularly met with her, and she had regular staff meetings held, minutes of which were read by inspectors.

Inspectors spent time with the person in charge and found she was familiar with the residents and their health and social care needs, and observed her interacting positively with them during the inspection.

The persons in charge was supported and deputised by an assistant director of nursing (ADON) was also met during the inspection. He sat a fit person interview during which

he demonstrated his knowledge of the Regulations. He was familiar with the residents and their health care needs.

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 reviewed this outcome in terms of two components, the directory of residents and residents' records.

Inspectors reviewed residents' records. Overall, all records were well maintained, securely stored and easy to access. An area of improvement was identified in the completion of some records for residents as per Schedule 3 of the Regulations. For example, there was inconsistent evidence of documented medical records for some residents at the time of their admission to the centre. This was discussed at feedback during the inspection.

A directory of residents was requested for review. However, there was none available. Inspectors were informed there was no directory and all information was available on each resident electronic file. Following the inspection, the person in charge submitted a copy of the electronic directory of residents that complied with Schedule 3 of the Regulations.

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 were satisfied that systems were in place to protect residents being harmed or suffering abuse, there were measures in place to ensure a positive approach to behaviours that challenge and restrictive practices were in accordance with the Regulations.

The centre was guided by policies on the protection of vulnerable adults. The policy guided practice and referenced the National Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" 2014.

There was regular staff training in the protection of vulnerable adults. Records read confirmed staff completed training. However, a of a sample of staff files read, four staff had not completed training. The person in charge advised inspectors that dates had been scheduled for this in December 2015 (this is discussed in Outcome 18). Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. She was aware of the requirement to notify any such allegation to the Authority. While no allegations of abuse had been notified prior to the inspection, the person in charge outlined the procedures that would be followed as per the policy. She was aware of the requirement to complete a report if an investigation was carried out. A number of residents told inspectors that they 'felt safe' and secure in the centre, and attributed it to the staff who worked in the centre.

The systems in place for safeguarding residents' money were not reviewed during this inspection and will be reviewed at the next inspection.

Inspectors read a policy on the management of behaviours that challenged which provided good guidance for staff practice. There was good access to psychiatry of older age if required as outlined by the person in charge. A small number of residents presented with responsive behaviours. Inspectors reviewed a sample of care plans developed to support staff. It was noted that one residents care plan had not been updated after a resident was prescribed an "as required" (PRN) medication to manage their behaviours or include the protocols in place to guide staff (this is discussed in Outcome 11).

A policy on the use of restraint guided staff which reflected the Department of Health National policy "Towards of Restraint Free Environment". It was evident that the policy on the use restrictive practices was implemented in practice. Overall, a restraint free

environment was promoted, for example, only 15 residents of the 78 residents required bedrails in the centre, there was limited use of chemical restraint. The person in charge and provider ensured the least restrictive form of restraint was used, and a range of alternatives were considered before its used. There was evidence of consultation with residents and their representatives prior to a decision being made. There was regular review of the use restrictive practices, and risk assessments were completed every four months and maintained on residents files. Each resident had a care plan developed and regular monitoring checks were carried out. The use of alternatives was encouraged and "low low" beds were available.

Judgment:

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 the provider had ensured there were systems in place to protect and promote the health and safety of residents, visitors and staff. However, improvements were required regarding the staff knowledge of the fire evacuation procedures.

The systems in place to respond to a fire alarm and knowledge of staff in the centre required review. The centre presently consists of two separate buildings, with a third one due for opening. Inspectors discussed the fire evacuation procedures that staff would follow if the alarm went off in their building. However, not all staff were aware that the fire alarm went off in the two buildings or that staff could be called on to support them to assist in moving residents at night time. A fire marshal was allocated in each building and this was reflected in the staff roster. The staff and managers spoken to were aware of the role of fire marshal however, some were not aware who was the designated fire marshal on the day of the inspection. This could lead to confusion as to who was responsible to take action in the event of a fire in the centre.

Inspectors found there was a lack of clarity in the procedures in place to ensure the safe evacuation of all residents. For example, information read by inspectors in residents' personal evacuation plans stated that residents were assessed as needing the assistance of one or two staff, while some staff stated some highly dependent residents would require up to three or four staff to evacuate. This was discussed with the person in charge and the facilities manager, who assured inspectors the residents were assessed and the documentation reflected the requirements in place.

Records read confirmed all staff had received regular training in the prevention and

response to fire. The training programme was discussed with the facilities manager and person in charge during the inspection. While these persons were aware of the procedures to be followed, staff at unit level were not. Following the inspection a satisfactory action plan was submitted by the provider that outlined measures taken to address these issues. These matters are also discussed in Outcome 2 (governance).

There were fire orders displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits unobstructed. There were regular fire safety checks which included fire exits.

The centre kept a detailed fire folder which kept record of all daily, weekly, monthly and annual checks and tests including fire alarms, emergency routes and fire equipment.

A safety statement was seen by inspectors. There were health, safety and risk management policies in place. Risks were identified, evaluated and had controls in place for mitigation.

There were systems in place to manage the risk of unexplained absences of residents'. Prior to the inspection the Authority had been notified of three unexplained residents' absences from the centre. There was evidence of appropriate action had been taken and the policy on the management of this had since been reviewed since these had occurred.

While staff were very familiar with the residents, one staff spoken with was not aware of one resident who was at risk of leaving the centre. The residents had a care plan in place also. But it did not fully guide practice. For example, the residents level of independence, their ability to choose to leave the centre, the agreement in place with the resident to report when they wish to leave the centre. The same care plan stated that hourly observations were to be completed by staff however, records read showed gaps of up to six hours between records during the day (see outcome 11).

Inspectors were also shown a draft risk register for the new building. The risk register included hazards relating to the general premises, the outdoor areas, kitchen, use of equipment, bathrooms and showering, administration of needle medication, staffing levels, and waste management. All of these risks were evaluated by impact and likelihood, and any actions or follow-up notes for learning were documented.

There was a health and safety committee that meet regularly and minutes read by inspectors confirmed issues and updates were discussed around hazards, incidents and staff training in the centre.

There were arrangements in place to manage adverse events involving residents'. There was evidence of learning and improvement to prevent these incidents from happening again. For example, the management of falls, with evidence of prevention of falls and serious injuries in the centre.

Inspectors observed staff encouraged residents' to be as mobile as possible, and were seen being escorted around the centre. There was a physiotherapist employed in the

centre. Staff followed best practice in the movement of residents' who required assistance. There was safe floor covering and handrails throughout the centre. There was regular training provided to staff in the movement and handling of residents.

An emergency plan was in place which gave instruction to staff on procedures in the event of an emergency and evacuation. The plan refers to the roles of staff members, emergency contacts, guidance on using equipment to assist in transporting residents, and the order of priority of resident evacuation based on needs and location relative to the emergency point. In addition a risk assessment of each residents had been carried out that included the location to evacuate individual residents to, for example, hospital or another nursing home.

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 found the designated centres' had policies and procedures for medication management, and overall this outcome was compliant.

A comprehensive medication management policy was seen by inspectors. Inspectors read completed prescription and administration records and overall they were in line with best practice guidelines.

There was written evidence that residents medications were reviewed by their general practitioner (GP) every four months.

Medications were securely stored in the centre. At the time of the inspection there were no residents self medicating. Procedure were in place to guide staff if required.

Medications that required strict control measures (MDAs) were carefully managed, stored and administered in keeping with professional guidelines.

Inspectors read records that confirmed all staff nurses involved in the administration of medications had undertaken training updates in best practice.

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 found residents had good access to general practitioner (GP) services, and to a range of allied health professionals. Inspectors found arrangements were in place for residents' social care needs. Nurses had a good understanding of the care needs of the residents, however, some improvements were identified in the completion of medical records for residents and the documentation of care plans.

Inspectors found that residents were regularly reviewed by general practitioners or visiting clinicians. The records of the visits were recorded by the nursing staff in care plans and progress notes. However, the records of medical reviews were not always available either in written format or electronic. For example, there were no records maintained until two months after one resident was admitted, and there were no records for another resident who had been admitted to the centre in the previous week. This is discussed under Outcome 5 (Documentation).

The residents' care plans were in electronic format and a sample were reviewed by inspectors. Overall, there were good practices found and residents were regularly assessed for a range of health care needs with care plans in place to guide care. There was evidence of consultation with residents or their representatives where required on the development of care plans. However, inspectors found care plans were not developed for all residents identified needs, for example, epilepsy.

In addition, care plans did not consistently guide practice in some areas. For example, a falls care plan contained out of date information which could put the resident at risk. A care plan for an indwelling catheter did not outline the frequency for it to be changed. Some care plans were not updated as residents needs changed, for example, skin condition or mood. This could have a negative impact on the residents care.

As reported in Outcome 7, a care plan for a resident at risk of elopement did not reflect the residents' level of independence or the close supervision required, this could cause confusion where support was required.

There were good practices in the management of falls, with an area of improvement

identified. A policy was in place that guided care, and generally it was implemented in practice. There was evidence of completion of neurological observations for residents suspected of suffering head injury. Inspectors found all falls were reported and, resident were re-assessed, with a post falls assessment completed following each fall. There was access to a physiotherapist within the centre who met residents after a fall to provide exercises and mobility classes. However, the records for one resident who had a head injury could not be found. This was discussed with staff during the inspection.

There were good practices found in the management of wound care. Inspectors reviewed care plans for a number of residents with wounds. These residents had been assessed, and detailed care plans were in place outlining the care to be provided. There was access to a tissue viability nurse and residents had been reviewed. There was specialist pressure relieving mattresses provided for residents.

Inspectors reviewed the arrangements in place for the management of restrictive practices, behaviours that challenge, and nutrition and found evidence of good practices in this area. There were policies in place to guide staff and staff had received training to enhance their knowledge of these areas. There was evidence that residents were regularly assessed and where a need was identified, a care plan were developed.

Inspectors found residents had a range of needs in the centre and the provider and person in charge had arrangements in place to meet their social care needs. A care plan was developed that outlined the social care supports and interests of the residents. Two activities coordinators were employed to facilitate activities in the centre's two units. An activities programme was displayed in both units. During the inspection some residents were observed watching television or receiving visits from relatives.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

The primary purpose of this monitoring event was to inspect the new building as part of the providers application to vary the conditions of the registration of the designated

centre. Inspectors visited the new premises which was a four storey purpose built building. The new building was presently unoccupied, and has capacity for 69 persons. The new building can be accessed via the original nursing home which was presently operating as a designated centre. Elsewhere on the grounds, a second purpose built premises was also operating.

The new building was visited by inspectors, who were accompanied by the provider and senior management. It was noted that the lower ground floor of the new building was still under construction during the inspection in addition to the external grounds and garden attached to the new building. Following the inspection, the provider submitted confirmation that building works were completed, the decoration had been carried out and an alternative garden beside one of the operating units was available to residents while the new garden was being landscaped.

The centre was built and decorated to a high standard, with consideration given to best practice in design for persons with a dementia. The provider had researched and utilised the dementia design principles from international evidence based practice.

In total, over the four floors there are 33 single occupancy bedrooms and 18 twin occupancy bedrooms, all provided with an en suite shower and toilet. Inspectors visited all four floors of the building. Three were at completion stage, with the lower ground floor still in construction as outlined above.

Bedrooms were of suitable size and layout for residents, with appropriate furnishings and sufficient space for personal belongings, including lockable storage for valuables. There were some minor works to be carried out such as the provision of curtains and screens in the two bedded rooms. The provider submitted photographic confirmation of these following the inspection, and a site visit on the 10 December 2015 confirmed these had been carried out.

Inspectors observed the premises to be well lit and ventilated. Hallways and stairwells were fitted with handrails which were contrasted against the wall for increased visibility. The floor coverings were of a non-slip material and all on one level without trip hazards, including door thresholds and ensuite bathrooms. There were communal bathrooms on each floor as well as ensuite toilet and shower facilities in each bedroom. Bathrooms were sufficiently large for wheelchairs and rollators and included grab rails, low ware and level wetroom floors for residents with poor mobility.

In addition to resident's bedrooms, there was sufficient space in which visitors and family could be received privately.

Each floor had a large open living room cum kitchen and dining area, as well as smaller living spaces along the corridors. Some of these were accompanied by balconies, which were suitably sheltered and equipped with safety rails and could be utilised as space for smokers. Communal areas, bathrooms and bedrooms were fitted with emergency call bell facilities, which had the option of detaching from the wall for easy access. Nurse stations were located in suitable positions for visibility and location relative to the residents.

Each floor was equipped with a lockable sluice room. Primary laundry facilities were outsourced to another company with supplementary facilities located in the basement for more immediate needs. All floors could be accessed via two elevators.

Some aspects of the current operating building required work in general upkeep, particularly in the worn condition of the carpets in the original building. The provider advised that work on this would be addressed upon completion of the current construction project.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

Inspectors reviewed a sample of personnel files for nurses and care assistants in the centre and found them to contain the documentation required by Schedule 2 of the Regulations. Staff rosters were clear and detailed, specifying roles, shift times, location, staff on training days or leave, duty hours of the person in charge and the identity of the fire warden for that shift.

Inspectors reviewed the files a sample of ten staff training records. Of these, all had received fire safety training in the past 12 months. There were no records maintained of four staff members training in protection and prevention against elder abuse. Records read confirmed staff had also received training in specific clinical areas such as nutrition, falls prevention, wound care, diabetes and end of life care. The human resources (HR) team described the system in place to identify staff training and gaps in training needs. Regular reports were run to identify staff missing or due for refresher courses in their mandatory training. The HR team scheduled staff the next available training day where gaps were identified

The centre did not require the use of agency staff. At the time of inspection, two staff nurses were on induction, and systems were in place for these staff to shadow senior staff and to be assigned to a mentor nurse. In addition these persons were scheduled to

complete mandatory training later in the week.

At the time of inspection, two volunteers worked in the centre, and inspectors found there was vetting records for these people.

Judgment:
Substantially 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:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	Orwell House
Centre ID:	OSV-0000078
Date of inspection:	23/11/2015
Date of response:	19/04/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

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

The system of monitoring the safety of care in the centre requires improvement.

1. Action Required:

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

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 following systems are in place to monitor the quality and safety of the nursing home:

Clinical Governance meetings which are chaired by Dr Mary Jones, Medical Director, are held monthly to discuss quality and safety issues.

Management meetings are held every 2 weeks.

Heads of Department and Clinical Nurse Manager meetings are held monthly.

Health and Safety walkabout every 2 weeks.

Fire drills are held weekly.

Clinical and non-clinical audit plan is in place for the year.

A planned staff appraisal system is in place for the year.

Proposed Timescale: 22/02/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was a lack of clarity between the evacuation procedures and staff practices.

Fire safety drills and training did not include the evacuation procedures to be followed.

2. 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:

Action plans have already been submitted in relation to the evacuation procedures and staff practices (submitted via email: 27.11.15).

The following are in place:

Fire training on induction and annually thereafter specific to job role

Fire drill weekly to include simulated situations and evacuation procedures

Review and evaluation of training provided to staff

Fire Marshall is highlighted on each roster and identified at handover on each shift

Annual review of fire safety policy

Proposed Timescale: 22/02/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Care plans were not consistently updated after a change in residents needs for example, mood and skin integrity

3. Action Required:

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

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

1. A care plan audit tool is used by Clinical Nurse Managers to audit the care plans of 4 residents per week. Audit findings are communicated to the named nurse to review and update and the care plans are then re-audited by the CNM after 2 weeks.
2. Care Plan Audits are reported as part of the Key Quality Indicators at Clinical Governance meetings.

Proposed Timescale: 01/06/2016**Theme:**

Effective care and support

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

Care plans did not consistently guide staff in the care to be delivered. For example, falls and indwelling catheter care.

Care plans were not consistently developed for all residents identified needs for example, seizure activity.

4. 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:

1. All nurses are provided with assessment and care plan training as part of their induction within 6 weeks of commencing employment. A care map is provided to guide staff in the development of person-centred care plans for the 18 domains of care.
2. An immediate care needs and risk assessment is carried out on all admissions to the facility. A full comprehensive assessment and care plan is completed within seven days of admission.
3. Care plans are evaluated as part of the audit procedure as outlined in Action 3.

Proposed Timescale: 01/06/2016

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:

With regard to Schedule 6 of the Regulations:

- The external grounds belonging to the new building are not safe and accessible to residents.
- The internal construction of parts of the residential space is not complete.
- Aspects of the general maintenance of the existing building are in need of improvement (as outlined in the report).

5. 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:

The garden is now safe and accessible to residents.
The building works contract is now complete.
The new flooring to the existing building is complete.

Proposed Timescale: 22/02/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

There were no records maintained of four staff members training in the protection and prevention against elder abuse.

6. 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:

1. Elder abuse training was scheduled for 1st December 2015, which was seen on our roster on the day of inspection. Further sessions have taken place in line with the annual training plan.
2. A training needs analysis was completed by our Director of Education to identify any

staff who needed refresher training in Elder Abuse.

3. All new staff have Elder Abuse training during their induction period.

Proposed Timescale: 22/02/2016