Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Cherry Orchard Hospital, Ballyfermot, Dublin 10
Type of inspection:	Unannounced
Date of inspection:	05 August 2021
Centre ID:	OSV-0000508
Fieldwork ID:	MON-0033424

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	124

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 August 2021	08:20hrs to 17:45hrs	Niamh Moore	Lead
Friday 6 August 2021	08:10hrs to 15:50hrs	Niamh Moore	Lead
Thursday 5 August 2021	08:20hrs to 17:45hrs	Siobhan Nunn	Support
Thursday 5 August 2021	08:20hrs to 17:45hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

Residents spoken with during the course of the inspection described being happy and feeling safe in the centre. Inspectors observed that there was a relaxed and welcoming atmosphere in some of the units. However, poor physical premises in the Beech, Poplar and Hazel units negatively impacted on the quality of life for residents, preventing residents from exercising choice related to their environment. As a result of this, residents' right to autonomy was not respected.

The accommodation provided for residents of Cherry Orchard Hospital is comprised of six ground floor units on a hospital style campus, one of which was vacant and being renovated on the days of the inspection. Each of the five units that were operational functioned as a self-contained unit with dining and sitting room facilities in all. The inspectors met with many of the residents while visiting the individual units but spoke with eight residents in more detail and spent time observing residents' daily lives and care practices to gain insight into residents' lived experience in the designated centre.

The quality of the physical premises varied across the campus with the Willow and Sycamore units of better quality with single and multi-occupancy en-suite bedroom accommodation. Two residents told inspectors that their rooms were "lovely" and one reported about having a single room saying "I wouldn't have it any other way". Residents were observed spending time in private in their single occupancy rooms and some rooms were also seen to be personalised with resident's belongings. However, inspectors observed that some residents in multi-occupancy rooms did not have access to their personal belongings or to the television within the room. There was a variety of day and communal spaces available within both units that had undergone some renovations. However, floor coverings were worn and damaged throughout both of these units which was a repeat finding from the previous inspection in November 2020.

Sycamore and Willow units had fire contractors on site to address findings from the centre's fire risk assessment report. At times, noise levels were loud. One resident said "the noise is okay, they don't start too early" while another resident said "you just have to put up with it, there is no choice".

Residents in these two units (Sycamore and Willow) also had access to an enclosed garden which was well maintained and decorated. Staff had made these communal gardens a bright and welcoming space, with the addition of colourful plants and fencing that many residents had been involved with painting and decorating.

The four older units on the campus were called Aspen, Poplar, Beech and Hazel. The Poplar and Beech units were the dementia-friendly units, both of which accommodated 16 residents in four 4-bedded rooms, none of which were en-suite. The Hazel unit accommodated 17 residents in one 4-bedded room, three 3-bedded rooms and two 2-bedded rooms. These three units were observed to be in a poor

state of repair and were not fit for purpose. For example:

- Many multi-occupancy rooms, although meeting the regulatory size requirements in terms of overall space, did not afford each resident a minimum of 7.4 square metres of floor space. The measured space behind one resident's curtain was 4.6 square metres.This was also found in the newly renovated rooms in the Aspen unit.
- Residents did not have sufficient personal storage space.
- Multi-occupancy bedrooms were separated by partitions that had significant amounts of glass in them and although covering had been applied to render the glass opaque rather than transparent, light from one room permeated through all three rooms.
- Hand-wash sinks were installed in each room with little consideration of the impact of their location on the living space of residents and staff said to inspectors that they routinely entered a resident's screened area at night to wash their hands. Residents also identified this as a source of disturbance.
- The configuration and layout of rooms meant that the residents had little opportunity to personalise their living space.
- Available communal and dining space was inadequate for the number and dependency of residents living in the centre and did not support the development of homely living and dining spaces.
- Available bathrooms and showers were dark, poorly ventilated and uninviting.
- Doors, paint work and flooring were in a state of disrepair which meant that they could not be cleaned to the required standard.
- There was a lack of storage space which resulted in inappropriate storage throughout these units. For example the inspectors observed that a number of store rooms had items on the floor, three oxygen canisters were stored inappropriately beside a radiator, locked medication trolleys were not fixed to walls, food and cleaning items were stored together and items including disused equipment were inappropriately stored in the corner of multi-occupancy bedrooms.

Inspectors found that staff tried their best to make the environment homely for residents, for example the garden area in the Poplar unit had plenty of plants, a Dublin bus stop and an old style post box. Inspectors were told that this assisted and supported residents with dementia. However, there was a large awning covering part of this area which was not well maintained as ivy was observed growing on it and there was dirt and debris attached to it.

On the days of inspection, there were no residents accommodated in the Aspen unit, which was closed for refurbishment. The quality of decor, maintenance, fixtures and furniture were bright and welcoming and in stark contrast to the residents' lived environments in the Poplar, Beech and Hazel units. However, the newly renovated rooms had an institutional appearance and did not provide a homely environment. The layout of these rooms consisted of two beds facing another two beds, with clinical hand-wash basins nearby and very limited personal space and storage available for the residents living there.

The layout of most of the accommodation across the older buildings and within

some of the the multi-occupancy bedrooms in the Sycamore and Willow units did not allow residents the right to live their lives privately, which is a key aspect of their human rights.

Inspectors observed that the poor premises and inadequacy of storage in bedrooms and bathrooms impacted on the ability of staff to consistently adhere to correct infection prevention and control procedures. Inspectors observed throughout both days of inspection occasions of inappropriate wearing of personal protective equipment (PPE) and hand hygiene practices.

Inspectors observed staff engagement with residents and found them overall to be positive. Many interactions showed that staff knew the residents well and were able to engage in topics that were relevant to them. Inspectors reviewed a recent satisfaction survey and saw that 97% of responses by residents believed they had a good relationship with the staff who cared for them. In addition there was a comment from a family member stating "staff are always welcoming towards me". On the first day of inspection, a visitor told inspectors that they were very happy with the care their mother received and that staff showed respect for their mother's wishes.

However, inspectors also observed one example of poor practice during a mealtime in the Beech unit, and requested the intervention of the senior nurse on duty. Specifically, a staff member was observed providing assistance at a pace that was not in line with residents' needs. In addition, the presentation of the food on the plate was not appetising as staff had mixed all ingredients together into a paste.

Inspectors saw that there were activities occurring on both days of inspection. Staff were seen to engage with residents, tending to their hair, providing hand massages and hosting a gardening group. Staff had sourced a bird feeder for a resident who liked to spend time watching birds outside their bedroom window. In the Sycamore unit, there was an activity schedule with recorded activities available Monday to Friday. Inspectors were informed that activities also occurred at the weekend but this was not recorded on the activity board. One resident told inspectors that "it is boring, there are no activities really". In a recent resident survey, residents reported that they wanted more activities to be provided.

While residents stated that the staff team were very nice and could not do enough for them, overall inspectors found that residents' quality of life was impacted negatively by their living environment. The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Cherry Orchard Hospital is operated by the Health Services Executive (HSE). The

general manager for Community Healthcare Organisation 7 (CHO7) is the person delegated by the provider with responsibility for senior management oversight of the service. The person in charge works full-time in the centre and reports directly to the general manager. They are supported in their role by three assistant directors of nursing (ADONs) and a team of clinical nurse managers (CNMs). The inspector was informed that not all of these personnel worked full-time, however there was management support available night and day seven days a week.

Despite this clearly defined management structure, the provider's governance and management arrangements had failed to substantively address key areas of concern. For example, management systems were not in place to ensure the premises was maintained which impacted on residents' rights and infection prevention and control. Furthermore, the oversight of fire precautions within the centre required review.

This unannounced inspection was carried out to follow up on actions from the previous inspection and in response to the centre's application to renew registration. Previously, the provider had committed to replacing the premises by 31 December 2021 and confirmed that funding was approved for these plans, however these plans had not progressed.

Inspectors found that the staffing numbers and skill-mix of staff on both days of inspection was adequate to meet the needs of residents and to the size and layout of the centre. Inspectors were informed that there were a number of vacancies in healthcare assistant roles and there were also 13 staff members cocooning due to COVID-19. Regular agency staff were used full-time to cover these absences which meant that there was consistency of care for the residents. Staffing was organised and divided into teams for each of the buildings. Each unit had an assigned CNM2 and CNM1. Staff teams included nursing staff, healthcare assistants, activity staff, household staff and kitchen staff in sufficient numbers to meet the residents' needs.

A review of the centre's statement of purpose was required to ensure it recorded the total staffing complement within the designated centre as required under Schedule 1.

Inspectors reviewed records of management meetings and committee meetings within the centre. These meetings, such as the Clinical Incident Review Group, met on a quarterly basis and discussed the key performance indicators for the centre. There was also regular meetings and forums held with CHO7 older person's services. Through these forums, there was provider oversight including attendance by the general manager and person in charge of the centre. A review of meeting minutes of these groups showed that topics relevant to service delivery were discussed on a regular basis such as staffing levels, policies and procedures, COVID-19 and finance. In addition, some audits reviewed were driving quality improvements, for example new bedpan washers were purchased following the infection control audit on sluice rooms

However, inspectors were not assured that the management systems in place ensured that the service provided was safe and effectively monitored. For example,

these systems failed to ensure that findings of previous inspections were satisfactorily addressed, audits completed failed to identify deficits in care planning found by inspectors and improvements were required to ensure the provider had submitted notifications in accordance with time frames specified in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013) to the Chief Inspector of Social Services.

Regulation 15: Staffing

Based on a review of the staff roster and observations on both days of the inspection, inspectors found that the number and skill-mix of staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the centre.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the provider needed to improve the overall governance and management systems in the centre in order to ensure effective oversight and the sustainability of the safe delivery of care. For example:

- Action to comply with condition 8 on the centre's current registration had not been progressed and the provider had not made resources available to ensure that residents had suitable premises and facilities to meet their needs.
- Inspectors found that the provider had failed to make improvements required to the premises. This had been a repeat finding from the last three inspections and the centre had not identified or put a plan in place to address these findings.
- Some reviews and audits undertaken were not fully effective and had failed to identify issues detected by inspectors on this inspection.
- While the provider was addressing areas from the centre's fire risk assessment report, management systems for fire precautions relating to staff knowledge and fire drills within the centre were not adequate.
- The annual review for 2020 did not provide evidence of consultation with residents and their families.
- The centre was not operating in line with their statement of purpose. For example, resident committee meetings were not occurring as per the centre's statement of purpose which referenced them occurring monthly.
- Management systems had failed to address the inappropriate placement of a resident within the designated centre for over five years.

Judgment: Not compliant

Regulation 3: Statement of purpose

An updated statement of purpose was available in the designated centre which overall contained the information set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors found evidence where notifications in relation to suspected or confirmed incidences of COVID-19 and allegations of abuse to a resident in the designated centre were not submitted to the Chief Inspector as required.

Notifications submitted to the Chief Inspector did not include all occasions when restraint was used. For example, occasions when bedrails, the use of sensor alarms and when PRN medicines (medicines to be taken when required) were given to residents.

Judgment: Not compliant

Quality and safety

While residents' healthcare needs were overall being met to a good standard, the physical premises significantly impacted on adequate infection control, fire safety, residents' rights to privacy, dignity and access to their belongings.

Inspectors reviewed a sample of care records held in the centre. Inspectors found that a pre-assessment was completed prior to a resident's admission to identify and ensure the centre could meet the resident's needs before moving in. Staff used a variety of validated assessment tools to guide and inform each resident's care plan. Residents had 'Key to Me' documentation in place which outlined the resident's life story including their history, family details and hobbies. Assessments included those on the risk of falling, communication, nutrition and hydration and end of life. However, there were gaps seen in residents' records to ensure they clearly guided staff how to meet the needs of each resident and information provided was person centred.

There were a number of restrictive practices observed and reviewed on the days of

inspection. Care records reviewed indicated that where residents had a restrictive practice in place, such as bedrails or sensor alarm there was a risk assessment in place for its use. There was clear rationale in place for the introduction of restrictive practices which were subject to regular review. Residents' consent was obtained for bed rails or, if they were unable to provide consent due to cognitive impairment, discussions were held with family members. Inspectors noted that some residents had requested the use of bedrails for personal safety. However some improvements were required as inspectors were informed that consent was not obtained for the use of sensor alarms, such as bed and chair alarms.

Inspectors found that overall care plans for residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) sufficiently guided staff on how to care for residents and how best to manage and respond to the behaviour in accordance with national policy of the Department of Health *Towards a Restraint Free Environment in Nursing Homes* last updated on 26 October 2020.

Inspectors acknowledged that the registered provider had worked hard to ensure that safe visiting arrangements were in place to allow residents to maintain contact with their families and were working towards compliance with relevant national guidance. Residents could avail of four visits booked in advance per week. Residents told inspectors that they were glad to have visitors again and staff reported that visitors "raised residents' spirits". There was evidence that residents were also risk-assessed to facilitate visiting outside the centre.

The centre had recently introduced community newsletters for residents and family members with the second edition issued from January to April 2021. Residents were consulted using satisfaction surveys with records provided from a report dated March 2021. In the Willow unit, inspectors were told residents committee meetings did not occur this year and in the Sycamore unit evidence of one meeting was given to inspectors for the month of June 2021.

Activity workers were designated to individual units and on site Monday to Friday. Inspectors saw examples of good activity provision over the two days of inspection. Planned activities and outings had recently recommenced within the centre. A garden party had recently been held in the Willow unit and residents attended a day trip to a local shopping centre. Healthcare assistants were allocated to coordinate activities at the weekend. However, inspectors reviewed records of weekend activities over the month of July and were not assured activities were available at the weekend. Inspectors reviewed findings from an audit on activities which found a similar finding that if activity staff were off duty there was no record maintained in the activity document folder.

Improvements were required in respect of premises and infection prevention and control, which were interdependent. The inspectors observed how deficits in premises impacted on the resident's right to privacy, dignity and access to their belongings. In some three-bedded rooms, individual wardrobes were stored in the bed space of other residents, which meant that residents could not access their

clothes and belongings freely. Inspectors found other examples where the location of seating hindered residents from accessing their clothes as other residents' chairs were placed in front of their wardrobe doors.

Inspectors had engaged with the provider following the non-compliance identified in Regulation 28: Fire Precautions at the last inspection. The provider had commissioned a fire risk assessment which identified a large programme of work that needed to be completed to ensure appropriate fire safety arrangements were in place. While this programme of work was underway on the days of inspection and is due for completion in early 2022, inspectors were not assured that the provider had taken adequate precautions for fire evacuation.

A COVID-19 vaccination programme had taken place with vaccines available to residents and staff. There had been a high uptake of the vaccines among residents and staff. A review of documentation showed that regular COVID-19 management team meetings were convened to advise and oversee the management of COVID-19 at the centre. Audits of compliance with COVID-19 guidelines were also undertaken. However inspectors observed evidence of poor mask wearing by staff over both days of inspection.

Regulation 11: Visits

The centre had a visiting policy dated January 2018 which was updated regularly with COVID-19 guidance.

The centre was in the process of implementing the most recent Health Protection Surveillance Centre (HPSC) visiting guidance while at the same time complying with infection prevention and control advice.

Judgment: Compliant

Regulation 12: Personal possessions

Due to the layout of multi-occupancy bedrooms in the Willow and Sycamore units not all residents were able to retain control over their clothes. Two wardrobes were positioned at one end of these rooms, which meant that residents had to enter another resident's private space to access their wardrobe.

The layout of the multi-occupancy rooms within the older units was such that residents could not personalise their bed space with family photographs.

Judgment: Not compliant

Regulation 17: Premises

The registered provider failed to provide appropriate premises to ensure residents needs were met in a safe environment:

- The current layout of the multi-occupancy rooms will not achieve compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 S.I. 293 which is due to take effect on 1 January 2022 and there was no clear plan to address this.
- There was inappropriate storage seen across the designated centre which impacted on residents rights and infection control.
- Residents in the older units of Beech, Poplar and Hazel were unable to make choices relating to their environment due to the opaque glass which meant residents could not control light or noise in their bed spaces.
- Communal space in the older units was limited, poorly decorated and day and or dining rooms were not pleasant environments.
- The premises was in a poor state of repair. For example, there were cracks in paintwork and the flooring was heavily marked.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy which had been reviewed in January 2021. This policy met the requirement of the regulations, for example, it included the measures and actions in place to control the risk of abuse and the unexplained absence of any resident.

Judgment: Compliant

Regulation 27: Infection control

The following issues important to good infection prevention and control practices required improvement:

- The worn and defective surfaces on paintwork could not be effectively cleaned and decontaminated.
- Inspectors observed poor hand hygiene practices and face masks not being worn correctly by staff members.
- A crash mat at a residents bed space in the Hazel unit and the windows in

the Poplar unit were dirty.

- Hoist slings were stored on hooks in a store room and hanging off hoists. Inspectors were informed slings were shared among residents. The procedure for cleaning of slings reported to inspectors was not appropriate for good infection control. For example, inspectors were informed that slings were used multiple times and wiped after each use.
- There was no cleaning schedule for areas within one of the communal bathrooms in the Sycamore unit which was seen to have residents' items stored with rubbish.

Judgment: Not compliant

Regulation 28: Fire precautions

While the provider had engagement with a contractor to respond to the risks identified in the fire risk assessment report, inspectors were not assured that the provider was effectively managing fire safety within the centre. For example:

- Inspectors were not assured that staff had strong knowledge of fire safety procedures and what to do if a fire broke out. For example, removing residents from the building in the wrong direction.
- Floor plans were not located beside fire panels thus potentially causing delay to emergency evacuations.
- A review of fire drill reports in the Sycamore unit showed drills were completed monthly, however not all drills recorded the time taken to complete the evacuation.
- Gaps in fire documentation included missing monthly inspection for June and July and the weekly test of emergency lighting was not completed in the previous eight weeks in the Sycamore unit.
- There was inappropriate storage of residents' equipment which was a fire hazard. For example, the cord of a hairdryer had tape on it and a hot curling tongs was resting on a shelf.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Some improvements were required to ensure that formal reviews were person centred and met each resident's needs. For example:

- A resident's healthy eating plan completed by dietetics differed to what was recorded on the resident's nutrition and hydration assessment. As a result, this resident diet and nutritional preferences were not known by all staff.

- A resident's 'Key to Me' assessment differed to what was recorded in a care plan relating to this resident's children and their names.
- A resident who had a safeguarding need identified did not have an assessment or tailored care plan in place to support and guide staff in their safeguarding requirements.
- Activity care plans required further development to capture the choice and preferences of residents.

Judgment: Substantially compliant

Regulation 8: Protection

There was a policy in place for the prevention, detection and response to allegations or suspicions of abuse. Inspectors found that safeguarding incidents had been appropriately investigated.

Appropriate systems were in place to ensure the transparent management of residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents' rights to undertake personal activities in private were respected. For example:

- Residents in multi-occupancy rooms were seen to be sleeping without the curtains pulled.
- In the Beech unit, a toilet door did not have a lock. Inspectors were informed that none of the doors of the toilets on the unit could be locked as it was a dementia unit.
- An interpreter was not provided to a resident whose first language was not English, although they were assessed as needing this service prior to their admission. Their cultural and linguistic needs were not met.
- The layout of the day rooms in the Poplar and Beech units did not provide all residents with access to the television or sufficient seating areas.

Inspectors found that there were gaps seen in access to activities at the weekend, which was also a finding from the last inspection.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The restrictive practice register presented to inspectors did not indicate that practices relating to sensor alarms, which prevented residents from moving without staff notification, was seen as a restraint. In addition, there was no system in place to obtain consent for their use or to review or monitor their use.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant

Compliance Plan for Cherry Orchard Hospital OSV-0000508

Inspection ID: MON-0033424

Date of inspection: 06/08/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The providers plans a schedule of works (Sept 2021-December 2022) aims to improve the overall governance and management systems in the centre in order to ensure effective oversight and the sustainability of the safe delivery of care. This will included a actions that will deliver on the following 1. Works to progress the condition 8 on the centre's current registration 2. Resources made available to ensure that residents had suitable premises and facilities to meet their needs. 3. Refurbishment improvements required to the premises. 4. Address areas from the centre's fire risk assessment report. 5. Infection Prevention and Control audit tools are being reviewed and will be adapted to include all aspects of the physical environment. 6. Care plan audits will be increased to quarterly and an action plan will be developed and disseminated to all unit managers with timelines for responses. 7. Additional fire training has been sourced and provided to staff across the older persons services in August 2021 8. Unfortunately when the annual review was developed in 2020 the service were managing sporadic Covid-19 outbreaks across the units. No residents or staff were vaccinated at the time therefore maintaining direct consultation with residents and families relating to health and wellbeing was limited. Constant indirect communication with residents and families was sustained. For instance, a resident satisfaction survey was been completed and a targeted family satisfaction survey is being developed. The results of both will form part of the annual review for 2021. Resident focus groups have now recommenced on all units and feedback from these will also be used when developing the annual review for 2021. • In consultation with the resident and the disability services a transition plan is being developed to relocate a resident in the older person's service to the disability service as per discussion at the unannounced HIQA inspection in August, 2021	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A review into how notifications of incidents are submitted to the Chief Officer has taken place and systems put in place to ensure all incidents are notified as per Regulation 31.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
A targeted schedule of works (Sept-Dec 2021) to support the reconfiguration of a number of residents' living space in the multi-occupancy bedrooms in the Willow and Sycamore units to be compliance with SI 293/2016 (residents floor space not less than 7.4m²). This will ensure that each resident's area shall include occupied space for a bed, a chair and personal storage.

The schedule of works reference above will also address the layout of the multi-occupancy rooms within the older units to ensure that residents can personalise their bed space with family photographs etc

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A targeted schedule of works (Sept-Dec 2021) to support the following

• reconfiguration of a number of residents living space in the multi-occupancy bedrooms in the Willow and Sycamore units to be compliance with SI 293/2016 (residents floor space not less than 7.4m . This will ensure that each resident's area shall include occupied space for a bed, a chair and personal storage.

• Removal of the opaque glass in Beech, Popular and Hazel limited residents control of light

• Ensure appropriate storage across the designated centre which enhances residents rights and infection control requirement.

• Improve the communal space in the older units to address poor decorated day or dining rooms to increase residents satisfaction with the environment

• Improve premise areas identified to be in poor state of repair including cracks in paintwork and heavily marked flooring

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Providers schedule of work planned (Sept to December, 2021) for the unit will aim to address the worn and defective surfaces on paintwork to enable effective cleaning and decontamination.

Hand hygiene practices and the correct use of PPE has been reinforced with staff by the PIC and the CNM 2 in Infection Control. This infection control consultation also ensured all staff are up to date with IPC training.

The cleaning of crash mats is now included on cleaning schedules for each individual units in particular Hazel unit. Scheduled deep cleaning for all the units is in place which includes the washing of windows.

Individual slings are being sourced for residents and the cleaning of same is now included on a routine cleaning schedule for the unit.

All bathrooms in particular communal toilet areas are a specfic line item in the cleaning schedule for all units.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Additional fire training has been sourced to increase staff knowledge of fire safety procedures and what to do where a fire occurred. A key focus will to ensure staff are aware of the correction to remove residents from the building.

Floor plans will be relocated near the fire panels on all units.

Fire drill reporting documenatation in the Sycamore unit showed drills were amended to capture the time taken to complete the evacuation.

A review of gaps in fire documentation will be completed and where gaps identified these will be addressed.

Inappropriate storage of residents' equipment addressed with fire hazard concerns such as a hairdryer with tape removed.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Care plan audits will be increased to be completed on a quarterly basis with an action plan developed and disseminated to all unit managers with a specific timeline for responses.

Care plans were in place for a resident with a safeguarding concern but a specific safeguarding care plan has been developed and is in place.
The dietician will audit healthy eating plans to ensure recommendations are documented accordingly and an action plan will be developed to address any non-compliances.
All activity care plans are updated every 4 months with the residents to ensure their individual preferences are recorded.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All staff have been reminded of the residents rights to privacy and dignity and to ensure their rights are upheld at all times.

All bathrooms on Beech will be fitted with new locks.

Since admission the needs of the resident whose first language is not English have improved dramatically. The resident and staff have developed communication methods between them. 2 medical officers and some nurses speak his language. His care plan is reviewed with the assistance of one of the medical officers who speaks his language and

no changes are made to his medical/nursing plan without the medical officer providing interpreter assistance. His care plan for communication has been updated to remove the requirement for an interpreter based on the medical officer interpreter support. Staff on the unit have installed a Google Interpretation application on a laptop that assists with interpretation services if required. More than 1 medical officer speaks this resident's language to ensure there is always a communication method available for this individual to discuss this care needs.

Activities are being provided on the weekends however the staff were not documenting this appropriately. Training on the recording of activities currently being provided by all staff will be targeted specifically for the staff nurse managing the activities department.

The seating area in the Popular and Beech Unit day room is being modified to ensure all residents have full view of the television

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The use of sensor alarms is currently recorded in the residents Falls Alert Risk Register. All sensor alarms in use will be notified to the Chief Inspector on quarterly notifications going forward. Consent for censor alarms will be obtained, the use of sensor alarms are discussed at quarterly Clinical Incident Review Group meetings as well as individual residents Multi-Disciplinary meetings.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	31/12/2021
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Not Compliant	Orange	31/12/2021

	and other personal possessions.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Red	31/03/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Red	31/03/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/03/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Not Compliant	Orange	31/03/2022

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	31/03/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	31/03/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Red	31/03/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in	Not Compliant	Orange	31/12/2021

	charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	31/12/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/02/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is	Substantially Compliant	Yellow	31/12/2021

	not restrictive.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/12/2021
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Red	01/01/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Red	01/01/2022
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2022