Health Information and Quality Authority
Social Services Inspectorate

Immediate Action Plan

Centre:	Avondale Nursing Home
Centre ID:	0195
Date of inspection:	15 June 2011
Date of response:	21 June 2011

This centre closed on 30 August 2011 following cancellation of the centre's registration by the Authority.

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

There were no adequate management arrangements in place. On a triggered inspection to ascertain the availability of the person in charge/provider or nominated key senior manager inspectors spoke with the nurse on duty, examined rosters and found that;

- according to the roster and nurse on duty the person in charge had not been present in the centre since 8 June 2011 when she undertook the role of nurse on duty from 08:30hrs until 13:30hrs
- rosters available to the inspectors concluded on 3 July 2011 and did not show evidence that the person in charge was available in the intervening period. The nurse on duty clarified that these were the only rosters available at the time
- the nominated key senior manager was not rostered to be present in the centre during this time on the rosters available to inspectors
- inspectors were informed by the nurse on duty that both the person in charge and designated key senior manager were out of the country.

The nurse on duty informed inspectors that it was her understanding that they would return on 27 June 2011 but was not certain of this fact.

The nurse on duty informed inspectors that she had been asked to cast an eye over the place and otherwise the nurse on duty on any given day was in charge.

This staff nurse commenced employment in the centre in late April 2011. Inspectors found on a follow-up inspection on 12 May 2011 that adequate recruitment and vetting procedures to safeguard residents had not been followed in the recruitment of this staff nurse and other staff members.

Action required:

Make immediate and adequate arrangements for the full time management of the centre in the absence of the person in charge.

Action required:

Implement a clearly defined management structure with specified roles and detailed responsibility.

Action required:

Provide evidence to the Authority of the actual date on which the person in charge shall resume full time duty in the centre.

Reference:

Health Act 2007
Regulation 15: Person in Charge
Regulation 6: General Welfare and Protection
Standard 27: Operational Management
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Authority's Timescale:**
Provider's response: In relation to the first "action required" point, the person in charge stated in the factual inaccuracy form which was returned to the Authority prior to the issuing of this second draft, that the person in charge already made arrangements for the full time management of the centre prior to the person in charge and key senior manager taking annual leave. The acting person in charge met with the inspector during the inspection. The acting key senior manager is Sumi Jacob. Both staff members agreed to these acting roles and all staff and residents were aware of these changes and that both the person in charge and key senior manager were taking annual leave together.	Immediate

In relation to “action required” - implement a clearly defined management structure with specified roles and detailed responsibility, management have included an 'organisational structure chart' in the statement of purpose information booklet. This chart identifies the title of roles staff have within Avondale Nursing Home and whom the role reports to however, the person in charge will review the organisational chart and add a detailed responsibility section to each mentioned role. The statement of purpose information booklet will then be re-printed. This task will be completed by 31 August 2011. In regard to “action required” - provide evidence to the Authority of the actual date on which the person in charge shall resume full time duty in the centre". In the factual inaccuracy form that was returned to the Authority prior to this second draft, the person in charge stated that the rosters available in the centre at the time of this inspection concluded on 10 July 2011. All weekly rosters are held together in a bound folder. Therefore, the acting person in charge, who was also the nurse on duty during this inspection would not have “clarified that these were the only rosters (concluding on 3 July 2011) available at the time”. The roster coving the period 4 July 2011 to 10 July 2011 clearly shows when the person in charge is next scheduled to work a staff nurse shift, which is 8 July 2011 and 9 July 2011. However, as stated in the factual inaccuracy form, the roster only records when the person in charge or key senior manager carries out a staff nurse shift, not any other supernumerary managerial shifts. The person in charge will be present in the centre, in a supernumerary managerial capacity prior to these dates. A copy of the rosters from 4 July 2011 to 10 July 2011 have been sent to the Authority’s Head Office, Cork today (21 June 2011).	31 August 2011

Any comments the provider may wish to make:

Provider's response:

There are several inaccuracies within this report, which the person in charge listed in a factual inaccuracies form. There were adequate management arrangements in place to cover the person in charge and key senior manager's annual leave which staff, residents and relatives were aware. As already stated, these arrangements were put in place prior to the taking of their annual leave. The acting person in charge informed the inspector during this inspection that she agreed to act as person in charge and that all staff know to contact her if there is a problem and that her telephone numbers are in Avondale's phone book. However, this is information is not included in this report.

The report states that the person in charge was not present in the centre since 8 June 2011. This is incorrect and this inaccuracy was recorded on the factual inaccuracy form. The person in charge was last in the centre was 10 June 2011. If the inspector had spoken to staff or residents, she would have become aware of this fact. When either the person in charge or key senior manager is in the centre in their managerial role, it is not written on the rosters.

Furthermore, this report states "inspectors found on a follow-up inspection on 12 May 2011 that adequate recruitment and vetting procedures to safeguard residents had not been followed in the recruitment of this staff nurse and other staff members". This is incorrect and the person in charge stated this in the factual inaccuracy form. This staff nurse's personnel file was not in Avondale on 12 May 2011 as she had only commenced employment less than two weeks prior to this. It is Avondale's policy to have new staff members personnel files completed and in Avondale within two weeks of employment. Furthermore, the inspectors conducting the inspection on 12 May 2011 did not review any staff personnel files.

The person in charge is disappointed with the inaccuracies in this report and the fact that when these inaccuracies were highlighted to the Authority through the factual inaccuracy form, not many amendments had been made.

Provider's name: Miriam Holmes

Date: 21 June 2011