Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Omega Nursing Home
Centre ID:	0151
Centre address:	The Commons Belturbet County Cavan
Telephone number:	049 - 9522630
Email address:	omeganursinghome@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Omega Nursing Home Ltd
Person authorised to act on behalf of the provider:	Maureen Dennehy
Person in charge:	Geraldine Donohoe
Date of inspection:	8 January 2013
Time inspection took place:	**Start:** 09:30 hrs **Completion:** 17:15 hrs
Lead inspector:	P.J Wynne
Support inspector(s):	N/A
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	19 (2 in hospital)
Number of vacancies on the date of inspection:	1

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 their 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
- 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This inspection report sets out the findings of a monitoring inspection, in which 10 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☒ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☐
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This report set out the findings of an unannounced monitoring inspection. This inspection took place over one day and was the fourth inspection carried out by the Health Information and Quality Authority's Social Services Inspectorate (the Authority). The findings of previous inspections concluded that improvements were required to meet all of the requirements in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). These inspection reports can be found at www.hiqa.ie.

There were 14 non-compliances of the Regulations outlined in the action plan of the inspection report dated 2 February 2012. The inspector found that 12 of these actions relating, mainly to physical improvement of the building, had been completed satisfactorily. The remaining two required further work to meet the Regulations namely, reviewing the adult protection and risk management policy. These actions are reinstated in the action plan of this report.

As part of this monitoring inspection the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.The inspector focused on regulatory requirements relating to safeguarding and safety, risk and incident management, resident care, quality of life and the environment to assess how care was being delivered and to determine the extent to which these impinged on the delivery of care and provision of positive safe outcomes for residents.

The Authority received an application to vary two conditions to the certificate of registration from the provider on 12 November 2012. Namely, the maximum number of residents that maybe accommodated at the centre is proposed to increased from 22 to 40 and the name by which the centre is known is changed from Omega Nursing Home to Oak View Nursing Home. The name by which the provider entity operates remains unchanged. This application was assessed during the inspection.

Overall, the inspector was satisfied the centre was operating in compliance with the conditions of registration granted to the centre. The inspector found that there was a good standard of care and a commitment on the part of the person in charge and provider as demonstrated in improvements to the quality of service. This was evidenced by a range of reviews of staff training and the further development of the premises. The healthcare needs of residents were met and residents had good access to general practitioner (GP) services and to a range of other allied health professionals.

The atmosphere in the centre was relaxed as staff and residents interacted and participated in the routine activities of the day. There was a structured program of activities in place facilitated by an activity coordinator.

The centre's services and facilitates have been enhanced by the development of a new extension specifically designed to meet the requirements of Regulation 19 and to meet the needs of dependent older people with sufficient personal and communal space for residents.

The Action Plan at the end of the report identifies areas where mandatory improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Areas for improvement identified include reviewing the health and safety procedures and fitting restrictors to all windows. The layout of the restraint record document was not clear and required review.

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

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

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Actions required from previous inspection:

Compile a statement of purpose that describes the aims, objectives and ethos of the designated centre and includes all matters listed in Schedule 1 of Regulations.

Inspection findings

The statement of purpose is kept under review by the provider and had been updated in January 2013 and contained all the requirements of Schedule 1 of Regulations. The statement of purpose set out the services and facilities provided in the centre. The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

Outcome 3

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

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The post of person in charge was full time and there was a clinical nurse manager who deputised for the person in charge in her absence. The person in charge was present in the centre on the day of inspectionThe inspector found that she was well known to residents, relatives and staff.

She demonstrated that she had good knowledge of the Regulations and the Authority's Standards throughout the inspection and was aware of the areas that needed improvement to fully comply with legislative requirements. She was familiar with residents care needs including the specialist needs and preferences of residents. The inspector was satisfied she had the qualifications, skills and experience to ensure the centre meets its stated purpose, aims and objectives as defined in the statement of purpose. The person in charge demonstrated evidence of continued professional development and had completed a master's degree in dementia in 2012.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Residents' Guide

Substantial compliance ☒ Improvements required * ☐

The Residents' Guide in place did not meet the regulatory requirements on the last inspection. The inspector reviewed the revised Residents' Guide and noted it contained all the requirements of the Regulations.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

Policies governing the centre's operations were identified as requiring improvement on the last inspection. The inspector reviewed a selection of polices to include the medication management policy, recruitment, selection and vetting of staff, the adult protection policy and the risk management policy. Each policy had a review date and was revised since the last inspection. However, the risk management and adult protection policy required further review and are discussed in more detail under Outcome 6 and 7.

Staffing Records

Substantial compliance ☐ Improvements required * ☒

The improvements related to staffing records are discussed in more detail under Outcome 18.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

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.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Actions required from previous inspection:

Maintain an up to date record of each resident's personal property that is signed by the resident.

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Inspection findings

The adult protection policy was reviewed and updated since the last inspection. The policy defined the various types of abuse, reporting arrangements and the contact details of the elder abuse officer in the Health Service Executive (HSE). However, clear steps to investigate any allegation of suspected or confirmed abuse, who had responsibility to investigate and the protective measure to ensure residents safety were not clearly outlined. Furthermore, the policy did not include protected disclosure procedures to guide staff in their reporting of a suspicion of abuse or procedures on how to manage an allegation of abuse against a senior member of the management.

Staff spoken with were aware of the types of elder abuse and their responsibilities in reporting suspected concerns and they stated that had received training by the person in charge. The inspector reviewed the training course material and aids used to educate staff and documentary evidence of training attendance by staff.

The person in charge informed the inspector that she monitored safe-guarding practices in the centre by regularly speaking to residents and relatives, and by reviewing the systems in place to ensure safe and respectful care. Residents spoken with confirmed to the inspector that they felt safe in the centre and spoke positively about their care and the consideration they received. The provider had Garda Síochána vetting obtained for all staff members. This was evidenced by a review of staff files. The outcome of Garda Síochána vetting was available for staff in each file reviewed.

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector. A petty cash system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. The ongoing balance was transparently managed and receipts were provided for each lodgement and withdrawal. However, only one signature verified each financial transaction in the management of residents' comfort money. The person in charge indicated she would review having records of transactions signed by a second witness to make the process more robust.

The provider was an agent to manage pensions on behalf of three residents. There was one member of staff assigned specifically to the management of resident's accounts and financial transactions. Resident's accounts were being regularly audited and balances were found to be correct.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Actions required from previous inspection:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre:

- ensure radiators are not too hot to touch
- ensure chemicals are stored safety in a secure space
- ensure the food store room is rodent proof.

Provide staff members with access to education and training in safe moving and handling to enable them to provide care in accordance with contemporary evidence-based practice.

Inspection findings

Hand testing indicated radiators were not hot to touch and were suitably controlled and did not pose a risk of burns to residents. The inspector visited the chemical stored which was secured by a coded access panel to restrict access in the interest of residents and visitors safety. The food storage room examined was suitably secured to ensure it was rodent proof.

The inspector viewed records which indicated staff had been trained in the safe moving and handling of residents. This was evidenced by a review of staff files. A certificate of training attendance was provided in each file examined. Moving and handling risk assessments were available in each resident's bedroom to guide all staff in their care interventions. Safe moving and handling practices were observed during the course of the inspection.

There was health and safety statement and policy in place. There was an organisational safety structure in place and roles and responsibilities were defined in the statement. For example:

- there was a missing person policy available and profile description sheets were maintained in residents' case files
- there was an emergency plan available
- there was a comprehensive infection control policy in place
- the inspector viewed evidence staff were trained in infection control and hand hygiene
- there was a food safety system in place and the inspector viewed records indicating staff had been trained in food safety
- Sluice rooms, cleaning areas and access to stairways were restricted in the interest of residents and visitors safety.

There were arrangements in place for recording and investigating untoward incidents and accidents. All incident and near miss events were recorded on a computer based system which were reviewed by the person in charge. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether the GP and next of kin had been contacted. The inspector noted that falls and near misses were well described and that observations and remedial actions to prevent a reoccurrence were evident in

care records. A post falls review was undertaken in each sample examined and care plans updated accordingly.

The risk management policy included procedures on assault, self harm and accidental injury. The policy outlined the procedure for incident reporting and investigating. The person in charge said that learning from incidents to minimise the possibility of a similar incident reoccurring was discussed at handover meetings and staff team meetings. However, the policy required further review to clearly outline the arrangements to ensure learning for all staff to minimise the risk of repeat occurrence.

The risk management policy required updating to include an environmental and clinical identification of hazards and assessment of risk throughout the centre, specifically to identify any potential hazards in the new extension. While routine checks were undertaken on a regular basis, precautions to control or minimise risk identified were not clarified in detail in the existing risk management policy examined. While the majority of windows examined in the new extension were fitted with restrictors, the inspector identified some windows in the communal areas which were not secured.

During this inspection the inspector found a high level of fire safety awareness. A plan to ensure fire safety was developed for the new extension. Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building. The procedure to follow on hearing the fire alarm was displayed along corridors. All fire exits were clear and unobstructed. Contracts were in place to ensure fire equipment was suitably serviced and maintained.

Written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent people was available. The inspector viewed records of fire safety training which had been completed by all staff. Records indicated all staff had been trained in fire safety procedures in the past 12 months by a fire safety consultant. Additionally records indicated staff had participated in fire drills which took place on a routine basis. Updated fire training was planned for staff in February 2013 to ensure they understood the fire safety precautions and evacuation techniques for the new extension.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The medication management policy reviewed was comprehensive. The procedures provided sufficient detail to guide staff to manage aspects of medication from ordering, prescribing, storing and administration. The policy included procedures to guide staff in the handling and disposal of unused or out of date medication.

The inspector visited the clinical room which was secured to restrict access in the interest of safety to residents and visitors. The clinic room was neatly maintained and stocks of drugs were checked routinely. Surplus supplies and out of date drugs were returned to the pharmacy on a frequent basis. Medications that required special control measures were kept in a double locked cabinet. A register was maintained which was viewed by the inspector. Medications were counted by two nurses and recorded on each occasion at the change of each shift.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear, legible and distinguished between PRN (as needed) and regular medication.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent

Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 12: Health Promotion Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence Standard 21: Responding to Behaviour that is Challenging
Action(s) required from previous inspection: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities. Revise each resident's care plan, after consultation with him/her.

Inspection findings

The provision of meaningful activity and recreational opportunities to all residents was identified as an issue during the previous inspection. A full time activity coordinator was recruited. There was a structured program of activities in place which was facilitated by the activity coordinator who had completed Sonas training (a group session involving stimulation of all five senses particularly useful for people with cognitive impairment). Staff demonstrated good knowledge and understanding of each resident's background. 'A Key to Me' was included in each resident's plan of care. Activities forming part of the weekly program included bingo, quizzes, card games and storytelling. Dog therapy had been introduced on a weekly basis and an exercise to music class was provided twice weekly by an external facilitator. Residents were facilitated to practice their religious belief. Mass took place regularly and a Church of Ireland religious service was held each Tuesday.

In the sample of care plans reviewed there was evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated.

The inspector found that there was good use of a range of evidence-based risk assessments by nursing staff when completing care plans. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration. For example, continence care, vulnerability to falls, mental health needs and nutrition levels were noted to be completed. Care plans had been developed for all identified risks. These assessments were being regularly reviewed.

The arrangements to meet residents' assessed needs were set out in individual care plans which were completed by nursing staff on a computer based system. Each resident had a care plan completed in the sample reviewed. The inspector reviewed three care plans in detail and certain aspects within other plans of care. The inspector found that all files reviewed were comprehensive. In the sample of care plans reviewed there was evidence care plans were updated at the required three-

monthly intervals or in a timely manner in response to a change in a resident's health condition.

Residents had good access to GP and healthcare professionals. A review of residents' medical notes showed that GPs visited the centre regularly. The GPs reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files. The residents had access to the services of healthcare professionals such as chiropodists, dieticians and a psychiatric consultant as required and records of referrals were maintained on residents' files.

The person in charge confirmed there was one resident with a pressure wound. The inspector reviewed the resident's case file. Monitoring strategies were in place. Staff had completed skin assessment records, and completed daily wound progress assessment charts to track the progress and healing of the wound. Care plans had been developed to guide staff in the delivery of wound care and the care plan was being regularly reviewed and updated by staff. From speaking with the clinical nurse manager and on review of the wound documentation, it was clear that the wound was improving and healing. The resident was provided with appropriate pressure reliving equipment.

A pre-admission assessment was completed by the person in charge prior to all admissions, to ensure the needs of the potential residents could be met. The person in charge told the inspector how she went to the hospital and to resident's homes to meet prospective residents. The inspector viewed the completed assessments in care plans.

The national policy on promoting a restraint free environment was implemented by the person in charge. Restraint practices included the use of bedrails by two residents and a lap belt by one. A risk assessment was completed prior to the use of the restraint measure. Signed consent was obtained by the resident or their representative and the GP was involved in the decision making process. Alternatives were trialled prior to the use of a restraint measure. All beds purchased to accommodate residents in the new extension were low beds. A restraint record was maintained daily for the resident at immediate risk for falling who wore a lap belt. The documentation recorded the time the lap belt was secured and released. However, the layout of the record document was not clear and it was not transparent to the inspector the times the lap belt was released in each two hour period to provide an opportunity for motion and exercise.

Outcome 12
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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Actions required from previous inspection:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents that are to meet the needs of low to maximum dependent residents.

Provide suitable facilities for each resident to meet visitors in communal accommodation and, a suitable private area which is separate from the residents' own private rooms.

Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

Provide suitable changing and storage facilities for staff.

Provide adequate sitting, recreational and dining space separate to the residents' private accommodation.

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs particularly in relation to the five bedded room, suitable sized laundry and separate cleaning rooms for catering and non catering staff.

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

Inspection findings

The centre's services and facilitates have been enhanced by the development of new extension specifically designed to meet the requirements of Regulation 19 and to meet the needs of dependent older people with sufficient communal space for residents. The redesign provides the physical environment to achieve the aims and objectives set out in the statement of purpose. The new communal space included day sitting rooms, dining room, private visitor's room, an oratory, a treatment room, a hair salon and a smoking room. The communal areas were spacious, bright and airy.

There was suitable heating provided in all areas. Bedrooms and communal areas were found to be comfortably warm. All radiators had low heat emitting surfaces to prevent risk of burns. Adjustable thermostats were provided to radiators allowing residents to individually adjust the temperature setting to suit their needs.

A selection of bedrooms were measured by the inspector and noted to be suitable in size as required by the Authority's Standards. Bedrooms were spacious and equipped to assure the comfort and privacy needs of residents. The new extension will allow the majority of residents the choice of a single room. There are two twin bedrooms available. There was a call bell system in place at each resident's bed and phone available to residents. Suitable lighting was provided and switches were within

residents reach. There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to day rooms for residents' convenience.

The en suite facilities in each bedroom were suitably adapted to meet the comfort and assessed needs of residents. Showers are level with the floor finish allowing for ease of use by the residents. There are emergency call points provided in each en suite bathroom and grab rails by each toilet, wash-hand basin and shower. Hand testing indicated the temperature of the hot water did not pose a risk to residents' safety on the day of the inspection.

New staff changing facilitates were provided to include separate changing facilitates for care and catering staff. Facilities were provided for showering and changing uniforms with locker space for storing personal belongings.

New cleaning rooms and separate sluice rooms to include bed pan washers were provided on each floor of the building. A new laundry was provided with sufficient space to ensure soiled and clean clothing was suitably segregated to minimise the risk of cross infection.

A safe enclosed outdoor space was available for use by residents. Two enclosed gardens, one which the person in charge confirmed will include multi sensory features.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Actions required from previous inspection:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Inspection findings

The complaints procedure was displayed in the entrance lobby. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The inspector reviewed the complaints policy and procedure. A named person to whom complaints can be made and an independent appeals process was outlined in the complaints procedure. A nominated person who would monitor that the complaints process was followed and recorded was identified.

The complaints log since the last inspection was reviewed. All relevant information about the complaint, investigation made and the outcome was detailed. The documentation reviewed found complaints were addressed in a transparent manner with due consideration to the sensitivities of all concerned, and a clear documentation of the outcome and satisfaction level of the complainant was recorded. Records of complaints were maintained separately from resident's case files.

Outcome 16
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Actions required from previous inspection:

Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.

Inspection findings

The inspector reviewed minutes of meetings held frequently with both residents and their relatives. The minutes of the meeting reflected the fact that residents with a range of cognitive abilities were enabled to attend and the meeting provided a forum for residents to raise issues and discuss procedures. The minutes indicated the menu

was discussed and residents' views were sought on food choices, mealtimes and where they liked to eat.

An independent advocate attended the centre every two weeks to meet with residents and assist them in communicating and raising issues on their behalf.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The provider employs 36 staff in total which includes a whole-time equivalent of 6 registered nurses and 10 care assistants. In addition, there is catering, cleaning and laundry staff employed. The inspector viewed the staff duty rota for a four week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty.

The inspector was able to form the view that the numbers of staff on duty and skill-mix were appropriate to meet the needs of residents on the day of the inspection. The rota indicated the person in charge had sufficient time for management and governance tasks and to support and supervise staff.

The person in charge indicated new residents would be admitted on a phased, planned basis and any increase in the number of residents would be supported by a continuous review to ensure a suitable staffing level and skill mix is maintained. The inspector reviewed the proposed staffing plan to meet the needs of prospective residents.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Staff undertook an interview and were requested to submit names of referees.

A sample of five staff files were examined to assess the documentation available, in respect of persons employed. The staff files were maintained in good order to ensure the required information was easily retrievable for review. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed. However, all files examined had a self declaration in relation to certification of physical and mental fitness. None had been certified by a medical practitioner and this was not sufficient evidence of physical and mental fitness.

There was a training matrix available which conveyed that staff had access to on-going education and a range of training to ensure continuous professional development. The inspector found that staff had attended training sessions on infection control, hand hygiene, medication management, behaviours that challenge and care of residents with dementia.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

P.J Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

17 January 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre Name:	Omega Nursing Home
Centre ID:	0151
Date of inspection:	8 January 2012
Date of response:	4 February 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of 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*.

Theme: Safe care and support

Outcome 6: Safeguarding and safety

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

Clear steps to investigate any allegation of suspected or confirmed abuse, who had responsibility to investigate and the protective measure to ensure residents safety were not clearly outlined.

The policy did not include protected disclosure procedures to guide staff in their reporting of a suspicion of abuse or procedures on how to manage an allegation of abuse against a senior member of the management.

Action required:

Revise the elder abuse policy to include protected disclosure procedures to guide staff in their reporting of a suspicion of abuse or procedure on how to manage an allegation of abuse against a senior member of the management.

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

Action required: Outline clear steps in the policy to investigate any allegation of suspected or confirmed abuse, who has responsibility to investigate and the protective measure to ensure residents safety.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Our Elder abuse policy will be reviewed and updated to include the actions required above and all staff will be informed of the changes within the policy.	04/03/2013

The provider is failing to comply with a regulatory requirement in the following respect: Only one signature verified each financial transaction in the management of residents' comfort money fund.	
Action required: Put in place all reasonable measures to protect residents from all forms of abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident's personal property policy will be updated to ensure that changes that are required to ensure protection from financial abuse are included. This will include the requirement that 2 signatures are required when pocket money is lodged and/or withdrawen from the resident's account. A copy will be left in the resident's pocket money envelop and a copy given to the resident	04/03/2013

and/or their family.	

Outcome 7: Health and safety and risk management

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

The risk management policy required further review to clearly outline the arrangements to ensure learning for all staff to minimise the risk of repeat occurrence.

The risk management policy required updating to include an environmental and clinical identification of hazards and assessment of risk throughout the centre, specifically to identify any potential hazards in the new extension.

While the majority of windows examined in the new extension were fitted with restrictors, the inspector identified some windows in the communal areas which were not secured.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

Ensure that the risk management policy covers the arrangements for investigation and learning from serious or untoward incidents or adverse events involving residents.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A comprehensive risk management policy will be developed ensuring it covers all of the above actions required. All restrictors have been fitted in the library.	 18/02/2013 and will be under constant review 04/02/2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: The layout of the restraint record document was not clear and it was not transparent to the inspector the times the lap belt was released in each two hour period to provide an opportunity for motion and exercise.
Action required: Put in place appropriate and suitable practices relating to the restraints in accordance with evidenced based practice
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 6: General Welfare and Protection Standard 11: The Resident's Care plan Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The resident's restraint recording document has been updated and is currently in use. It will be reviewed in a month.	 04/02/2013

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: All files examined had a self declaration in relation to certification of physical and mental fitness. None had been certified by a medical practitioner and this was not

sufficient evidence of physical and mental fitness.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The recruitment policy has been updated to ensure all newly recruited staff must have a fitness to work form signed off by their GP prior to commencement of employment. Current staff employed have been requested to get their GP to sign their fitness to work form.	 04/02/2013 04/03/2013

Any comments the provider may wish to make[1]:

Provider's response:

Both Geraldine and myself would like to take this oppurtunity to thank PJ for his courtious, honest and informative manner throughout our inspection.

Provider's name: Maureen Dennehy
Date: 4 February 2013

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