Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Oranmore Care Centre
Centre ID:	0374
Centre address:	Bushfield Oranmore Co. Galway
Telephone number:	091-792301
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Email address:	adminomnh@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Paddy Keane
Person in charge:	Patricia Cormack
Date of inspection:	4 and 5 April 2012
Time inspection took place:	**Day 1 Start:**10:00 hrs **Completion:** 19:30 hrs **Day 2 Start:** 07:30 hrs **Completion:** 20:00 hrs
Lead inspector:	Finbarr Colfer
Support inspector:	Marian Delaney Hynes and Deirdre Byrne
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met 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*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Oranmore nursing home is a single-storey purpose-built centre which first opened in 1980. It was purchased by the current provider in March 2006 and has places for 55 residents. At the time of inspection 39 residents were living there.

Fifteen independent living units are on the same site and are contained in five bungalows. Each bungalow has three units comprising of one two bedroom apartment and two single bedroom apartments. In total, 20 can be accommodated in these units.

Communal accommodation in the centre consists of a variety of day spaces including two conservatories, sun room, day-room and a dining room. There are areas available where residents can meet visitors in private and a designated smoking room is located off the sun room. The kitchen is adjacent to the dining room and the laundry and sluice room are located in the central area of the building.

There are 40 bedrooms in total, 33 single bedrooms, three twin bedrooms and four four-bedded rooms. The majority of these bedrooms have en suite shower, toilet and hand-washing facilities. One single bedroom, two twin bedrooms and one four bedded room are without en suite amenities but are fitted with hand-washing facilities. There is one assistive bathroom with a shower, bath, toilet and hand-wash facilities and there is a separate toilet for residents' use only. There is a designated toilet for visitors' and a separate staff toilet is provided for both catering and non catering staff. The catering staff toilet and changing facility are located in an unused apartment beside the centre.

A coded security system is on the main entrance door and closed circuit television (CCTV) is in operation along the corridors and in the reception area. There is an outdoor enclosed courtyard provided for residents' use. The other outdoor space used by residents has a decked patio area and is also a fire escape route.

The centre is wheelchair accessible. Car parking for relatives, staff and visitors is available to the front.

Location

Oranmore nursing home is approximately three kilometres from the village of Oranmore and thirteen kilometres from Galway city, County Galway.

Date centre was first established:	January 2000
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	16

Dependency level of current residents	Max	High	Medium	Low
Number of residents	7	9	13	10

Management structure

The Provider is Paddy Keane and the Person in Charge is Patricia Cormack. Care assistants and household staff report to nursing staff who in turn report to the Person in Charge. There is an Administrator who provides support to the Person in Charge and the Provider. Kitchen staff and the Maintenance Person report to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	3 in am 2 in pm 1 at night	6 in am 5 in pm 2 at night	2	2	1	2*

*Provider and Maintenance Person

Background

This was the fifth inspection of this centre and the reports of the previous inspections are available on www.higa.ie.

A registration inspection was carried out in December 2011 and inspectors found that there continued to be a persistent non-compliance with the Regulations. Inspectors had significant concerns regarding the management of the use of restraint, aspects of falls management, nutritional assessment and care planning. Because of the risks to resident safety, an immediate action plan was issued requiring the provider to immediately address these issues. Following that inspection, the person in charge and manager resigned on 31 January 2012. The provider appointed a new person in charge on 1 February 2012 and the manager post was not replaced. Inspectors conducted a follow-up inspection in February 2012 and found that all of the policies and procedures in the centre had gone missing and there continued to be a lack of compliance with the Regulations. The newly appointed person in charge had started the week before that inspection.

During the February 2012 inspection, inspectors found that the wellbeing of residents was at risk. The provider was required to take immediate action to ensure the safe use of bedrails, respond to the nutritional needs of a specific resident and ensure

that the temperature of hot water from some of the sinks no longer presented a serious risk of scalding to residents. Inspectors also identified significant improvements that were required in a number of areas including other key care interventions, governance, staffing and the premises.

Because of the provider's consistent failure to achieve an acceptable level of compliance with the Regulations, the provider was requested to attend a meeting with the Authority on 20 February 2012 to discuss the implications for the provider's application for registration of the centre. At that meeting, the provider accepted that significant work had to be undertaken to comply with the Regulations and committed to achieving this as a matter of urgency.

Summary of findings from this inspection

This inspection focussed on the progress made by the provider in meeting the actions required on the previous inspection.

Inspectors were very concerned about the inadequate response to allegations of abuse and failure to take suitable and sufficient measures to protect one of the residents. In addition, inspectors were also gravely concerned about the inadequate response to a serious medication error and measures to ensure the safety of residents. The provider was required to take immediate action to protect the wellbeing of residents in relation to both of these issues. This was the third immediate action that the Authority had issued to this provider since the registration inspection in December 2011.

The inspectors found that while progress had been made on the some of the actions it was insufficient to allay the concerns of the inspectors or to meet the requirements of the Regulations and Standards.

Inspectors were concerned that risk management systems were inadequate and did not protect the safety of residents. A new risk management policy had been developed but it did not meet the requirements of the Regulations. Furthermore, there had not been an adequate assessment of risks in the centre and inspectors identified a number of risks to residents which were not being managed. Staff appointed since December 2011 had not received the mandatory fire training or manual handling training and had not been provided with any instruction in relation to these. This had been an issue on previous inspections. Inspectors found that fire exits continued to be obstructed and found that there was a general lack of awareness about the importance of keeping fire exits clear.

Inspectors found that while there had been some improvement in the management of restraint, falls management and nutritional care since the previous inspection, further improvements were required in these areas. However, inspectors also found that there were significant deficits in the provision of evidence-based practice to ensure the wellbeing of residents in the areas of wound care and management of behaviour that challenges.

Inspectors also found that improvements were required in the arrangements to ensure that staff were suitable to work in the centre, in staff training and in induction training for staff. The staff roster was not being monitored sufficiently and the assessed staffing requirements at night were not being consistently provided.

There continued to be deficits in such areas as the statement of purpose, the residents' guide, contracts of care and the directory of residents.

Inspectors found that some progress had been made on the development of policies and procedures. On the previous inspection, all of the policies and procedures had gone missing and the person in charge, on behalf of the provider, had to develop new ones. Some of the policies required in Schedule 5 of the Regulations had not yet been developed but the person in charge had plans to develop and implement these. However, inspectors found that some of the new policies had not been implemented effectively and were not yet guiding staff practice.

Other areas that inspectors found had been improved included the development of end of life care arrangements and the storage of residents' records in a manner that ensured confidentiality. Progress had been made on actions relating to the development of an emergency plan, access to health professionals, provision of nutritious food and the privacy and dignity of residents. However, further improvements were required in all of these areas.

Actions reviewed on inspection:

1. Action required from previous inspection:

Compile a Statement of purpose that describes the facilities and services which are provided for residents.

Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

This action had not been completed.

The provider had developed a combined statement of purpose and residents' guide but it did not contain all of the information required in the Regulations. Some of the information was not sufficiently detailed and some did not provide an accurate account of the services provided in the centre. For example, the statement of purpose did not contain the address or experience of the provider or person in charge. It stated that the centre provided care for residents with dementia or Alzheimer's but inspectors found deficits in this care during the inspection and there were no plans to provide adequate training to staff.

2. Action required from previous inspection:

Establish and maintain a system for reviewing and improving the quality and safety

of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Work had commenced on this action but it required further development.

In the action plan for the last inspection, the provider stated that areas of risk would be reviewed on a monthly basis. This had not happened. There was no up to date record of risks that had been identified or actions taken to manage those risks.

The person in charge had started to gather information on a monthly basis in relation to a range of clinical issues. One review had been completed for February 2012 and staff were in the process of completing the March review. The information had not yet been used to inform management and operational decisions.

The action plan stated that there would be an audit of the kitchen service in the centre. The inspectors found that this had been put in place. The provider had retained two separate contractors to review the kitchen service, food safety and quality of food provision. Additional training had also been provided to staff involved in the preparation and delivery of food. The provider was awaiting receipt of the contractors' reports to plan further improvements.

On the previous inspection, all of the policies and procedures for the centre had gone missing. Since then, the person in charge had been developing a range of policies and procedures and had developed a log to review the development and implementation of these documents.

3. Action required from previous inspection:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

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

Display the complaints procedure in a prominent position in the designated centre.

This action had not been completed.

While there was a complaints procedure, the complaints policy had not yet been implemented and a draft copy was provided to inspectors. The procedure did not meet all of the requirements of the Regulations. For example, a person had not been nominated to review complaints to ensure they were being recorded appropriately and that the satisfaction of the complainant was being included in the records.

The complaints log included two complaints that were received since the previous inspection. There was no record of an investigation or review of the complaints, of

feedback to the complainant and the satisfaction of the complainant with the outcome had not been recorded.

In addition, inspectors found that all complaints were not being recorded. Staff and residents told inspectors about complaints that had been made but which were not recorded.

4. Action required from previous inspection:

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

While there had been some work to address this action, inspectors found that it was not sufficient and the arrangements did not ensure the protection and well being of residents. The provider was required to take immediate action to protect the safety of one resident.

A policy on the prevention, detection and response to abuse had been developed. Most staff were knowledgeable about the policy but some were not clear on how to respond to suspicions of abuse. Not all staff had signed the policy to confirm that they had read it and understood it, and some staff who had signed it stated that they had not read the policy, but that it had been read to them at a handover meeting.

While the person in charge was able to tell inspectors what action she would take if there was an allegation of abuse, and had notified the Authority of a recent allegation, she had not taken sufficient action to protect the safety of one resident. Appropriate referrals had been made to the Health Service Executive (HSE) Case Worker, but the person in charge had not developed guidelines for staff on how to sufficiently protect the resident while awaiting advice from the Case Worker. Inspectors reviewed the actions taken, were not satisfied and required the provider to take immediate action to protect the safety and well being of that resident.

5. Action required from previous inspection:

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

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.

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

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

This action had not been completed.

The provider had developed a new risk management policy. However, the policy did not meet the requirements of the Regulations. While the policy provided guidelines on how to identify and assess risk, it did not include all of the specific risks required in the Regulations.

Although the provider had stated that risks would be identified and assessed by 27 April 2012, inspectors found that this action had not commenced. Inspectors found that there had not been sufficient progress to indicate that the action would be completed with risk management measures implemented within the timeframe. The person in charge stated that she had conducted an environmental audit of the premises to identify risks, but there was no report of this audit and no measures put in place to manage any risks that were identified. Inspectors identified a number of risks which were not being managed during the inspection including the laundry and sluice room doors being left open and the cupboard for cleaning chemicals being left open.

A new policy had been developed for reporting and responding to accidents or incidents. This included the development of a standardised reporting form. However, inspectors found that the new policy had not been fully implemented. While most staff were using the new form to record accidents and incidents, one of the records was hand written on a piece of blank paper and did not include all of the required information. In addition, the person in charge had not reviewed the forms as required by the policy and had not recorded the action taken following this review.

As part of the registration process, the provider is required to submit a letter from a competent person confirming compliance with fire and building control regulations. While the provider had previously submitted a letter confirming this, following improvement works to the sewage and drainage of the building, the provider had retained the services of a competent person to review compliance with these regulations. The competent person had provided a report containing 24 actions which the provider was in the process of having addressed. The report stated that the competent person would not be in a position to confirm substantial compliance with fire and building control regulations until all of the actions were completed.

A new policy had been developed for infection control but inspectors found that staff were not aware of the policy and were not clear on the infection control measures to take in the event of a significant outbreak of infection. However, inspectors did observe staff using effective universal infection control measures such as hand hygiene measures, the use of latex gloves and disposable aprons and the changing of cleaning cloths between rooms.

In the previous action plan, the provider stated that a Health and Safety Committee, which included staff representatives, would be established by 13 April 2012. Inspectors found that preparations were in place for the establishment of this committee. Minutes of staff meetings included a record of a discussion and an invitation for staff to express an interest in being on the committee.

6. Action required from previous inspection:

Provide adequate means of escape in the event of fire.

This action had not been completed.

Inspectors were very concerned that there was insufficient awareness amongst management and staff about the importance of keeping fire exits clear. In addition, inspectors also found that the provider had not provided the required fire training to new staff members.

On the previous inspection, inspectors found that fire exits were not being checked regularly and also that many of the fire exits were obstructed.

On this inspection, inspectors found that while the fire exits were being checked most days, there were regular entries in the records indicating that obstructions to the exits had to be removed. This indicated that staff were not aware of the importance of ensuring that fire exits were kept clear at all times. In addition, inspectors found that five of the exits were obstructed during the inspection. This was brought to the attention of the person in charge but inspectors found that some of these exits continued to be obstructed during the inspection.

Staff members who had been recruited since December 2011 had not been provided with mandatory fire training or with any instruction on fire response arrangements in the centre. Inspectors spoke with some of these staff and found that they were not clear on the actions to take in the event of a fire. The provision of fire safety training for all staff had been identified on previous inspections.

7. Action required from previous inspection:

Put in place an emergency plan for responding to emergencies.

Some progress had been made on this action, but further improvement was required.

While a new emergency plan had been developed which referred to a range of emergency situations, it did not give adequate guidelines on responding to those emergencies and did not provide details of alternative accommodation should it be necessary for residents to be evacuated from the centre.

8. Action required from previous inspection:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

While the provider had addressed most of the specific issues identified on the previous inspection, inspectors found that there had not been a full review of medication management arrangements and other improvements were required to ensure the safe management of medication for residents.

In particular, inspectors read an incident report relating to a serious medication error and found that the person in charge had not responded adequately to this issue to ensure the safety of residents. The provider was required to take immediate action in relation to this issue.

A new medication policy had been developed. It was centre specific and provided guidelines to staff on the management of most aspects of medication. However, the policy did not provide guidelines on the management of "as required" (PRN) medication.

Residents' medications were being reviewed at least every three months and the pharmacist had conducted an audit of medication processes. However, there had been no internal review of practice in the centre and inspectors found some practices that were not in line with the centre's policy on medication management.

The person in charge did not have up to date information on medication needs of residents. She informed inspectors that none of the residents were self medicating, but inspectors met a resident who managed her own medication. In addition, inspectors observed other residents with medications in their bedrooms.

Inspectors found that prescription and administration sheets for medication required improvements. The residents' addresses were not included on the medication sheets. Also, the route of medication was not recorded on many sheets and the maximum dose of "as required" medication was not consistently recorded. In addition, the administration times on the prescription and administration sheets did not correspond. Each of these issues increased the risk of medication error and result in a poor outcome for residents.

Inspectors also found that the general practitioner (GP) had not signed each medication individually, but was using a generic, computer generated signature, with a general hand written signature for all of the medication at the bottom of the prescription sheet. This did not comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors reviewed the management of medications that require additional precautions. They found that the medication was being stored securely and the balance of medication was being recorded at the change of each shift to ensure security and accountability. However, a number of entries did not have the signature of a second nurse to confirm the balance, as required by the centre's medication policy.

9. Action required from previous inspection:

Provide a high standard of evidence-based nursing practice.

While work had commenced on some issues identified on the previous inspection, limited progress had been made in a number of areas of concern and there continued to be a failure to provide a high standard of evidence-based nursing practice.

On the previous inspection, inspectors were concerned at the inadequate management of restraint, nutrition, falls and behaviour that challenges. Inspectors about specific residents on the previous inspection and had required the provider to take immediate action to respond to the needs of these residents. The provider had submitted an immediate action plan and during this inspection, inspectors found that the action plan for those specific residents had been implemented. However, there continued to be deficits in the provision of care to residents.

Inspectors found that there was insufficient care planning for residents who presented with behaviours that challenge. Inspectors identified a number of residents whose behaviour during the day was upsetting to other residents. There had been no assessment or care planning to provide staff with guidelines on how to respond to the needs of these residents and protect the wellbeing of other residents. Staff did not have a consistent approach to responding to these residents and this limited the effective management of these behaviours. Staff had not had training in the management of behaviour that challenges. However, the person in charge was planning a one day information session for staff during April 2012. Given the complexity of the needs of these residents, inspectors were concerned that there was no further plan for developing staff skills in this area. Issues relating to the management of behaviour that challenges had been identified on previous inspections.

Inspectors found that the management of wound care did not promote the health of residents. Records of wound care were insufficient and did not provide adequate information on the assessment of the wound and the progress of healing. Inspectors spoke with nurses and found that they were not basing their interventions on evidence based nursing practice but described making decisions on wound care based on what they felt was most appropriate at that time. There had been no training provided to nurses on wound care and no consultation with a tissue viability nurse. In addition, inspectors reviewed the management of air mattresses, which are used to prevent the development or promote the healing of pressure ulcers. The inspectors found inconsistencies in the provision of pressure reliving devices, for example some residents who had been assessed at high risk of developing wounds did not have an air mattress while others did. Nursing staff were unable to explain why this was the case. Nursing staff did not have sufficient knowledge about the appropriate setting of air mattresses based on the weight of the resident and described adjusting the pressure of the mattress based on whether they felt it was too hard or soft, an approach that could inhibit the therapeutic value of the air

mattress. Nurses had not been provided with sufficient training or guidelines on the use of these mattresses.

While there had been some progress on the management of nutritional risk, inspectors found that it was not being implemented consistently and staff were not complying with the guidelines provided. Inspectors found that there had been poor supervision and monitoring of the new nutritional management arrangements that had been introduced. Residents who had lost weight had been referred to a dietician and supplements were being prescribed by the GP. However, care plans were not being updated to reflect the needs of residents and provide guidelines to staff. The recommendations of the dietician were not being included in the care plans. The person in charge stated that residents who were at risk nutritionally were being weighed weekly but staff were not recording the weights.

The provider had developed a new policy on the management of restraint. The policy provided guidelines for staff, particularly in relation to the management of bedrails. The person in charge had also explored alternatives to the use of bedrails and some residents no longer required them. Those that continued to require bedrails had been assessed and a care plan had been developed to ensure the safe use of bedrails. However, some residents used lap belts during the day. They had not been assessed and there were no care plans to ensure the safe use of the lap belts. Staff were not recording the duration of use of the lap belts. The person in charge had developed a restraint register and inspectors found that it was not being kept up-to-date.

The provider had developed a new falls management policy. The person in charge had recently initiated a new falls diary as a way of monitoring any falls, and there were plans to establish a falls management committee. However, the policy did not provide sufficient guidelines to staff. For example, it did not advise staff on how to respond to residents who have had a fall that had not been witnessed or conducting neurological observations on residents who hurt their head as a result of a fall. Also, while incidents were being recorded, there was no evidence that the person in charge was reviewing falls and care plans had not been updated following a fall to reduce the risk of recurrence.

10. Action required from previous inspection:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

There had been some progress on this action but there were still considerable gaps in the provision of meaningful activities especially for those residents with special needs.

Since the previous inspection, the provider had increased the hours of the activities worker. Inspectors spoke with the activities worker and found that she had previous experience providing stimulating and interesting activities for residents to do. She had developed a range of activities for residents and was recording participation

levels and the interests of residents. She had plans for the development of a social history of each resident which would inform the activities provision.

However, the activities worker was not involved in the social assessment and care plans of residents, which limited her ability to participate in responding to their social needs. The social needs of residents were not integrated into the care provision and the activities worker had sole responsibility for the provision of activities. Other staff did not see this as part of their role. This limited the provision of activities to times when the activities worker was present in the centre.

There were no specific arrangements to meet the social needs of residents who had a cognitive impairment or dementia. One staff member was completing training in the Sonas Programme, an activity programme which promotes communication through use of the five senses, but there had been nothing put in place to respond to the social needs of these residents despite the provider stating in the statement of purpose that the centre caters for the specific needs of these residents.

11. Action required from previous inspection:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Set out each resident's needs in an individual care plan developed and agreed with the resident.

This action had not been completed.

On the previous inspections, inspectors found that some care plans were very general and did not reflect the specific needs of residents. Care plans had not been developed for some assessed needs and they were not being reviewed or updated. For example, one resident did not have a care plan for his wound. Care plans were not being developed and agreed with residents and were not being made available to residents. In the action plan, the provider stated that a new care planning process was being introduced and would be completed for all residents by 30 June 2012.

Inspectors reviewed a sample of residents' care plans and found that a new pre-admission process had been implemented to assist with planning for meeting the needs of new residents. The care plans included a range of assessments and contained an informative profile of each resident which could be used if the resident went missing.

However, care plans continued to be poorly organised, some assessments were duplicated and care plans had not been developed for the assessed needs of some residents. Some care plans referred to the involvement of other health professionals

but there was no other information or reports from those health professionals. There was little evidence of the involvement of residents or their representatives in the development and review of care plans.

The person in charge had introduced a log of care plan reviews. Inspectors found that this was not being monitored adequately and that some staff had signed the log to confirm that they had updated care plans but when inspectors reviewed the care plans, they had not been updated. Some care plans had staff initials and a date to indicate that they have been reviewed, but inspectors found no evidence to indicate that the changing needs of residents had been considered and that the care plans had been updated.

12. Action required from previous inspection:

Facilitate each resident's access to occupational therapy, or any other services as required by each resident.

This action had been partially completed.

There had been progress on this action. Inspectors reviewed residents' files and found that residents had access to a physiotherapist. The physiotherapist was attending the centre once a week and the person in charge stated that this was being increased to two days per week. There was also referral to such health professionals as dieticians, chiropodists and ophthalmic services.

The person in charge stated that it had been difficult to obtain the services of an occupational therapist, but showed inspectors referrals that had been made on behalf of residents. The person in charge stated that she would continue to seek access to this service for residents. Inspectors read in a resident's notes that a referral had been made to speech and language therapy services. However, there was no date on the referral or record of when the resident would be reviewed. The person in charge stated that she was in the process of securing the services of a speech and language therapist with the support of an independent contractor.

13. Action required from previous inspection:

Put in place written operational policies and protocols for end of life care.

Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

This action had been completed.

While there were no residents receiving end of life care at the time of inspection, inspectors reviewed the new end of life care policy and found that it provided staff with guidelines on the care of such residents. The policy had been localised to reflect the requirements of residents in this centre and included guidelines on how to meet

the holistic care needs of residents. The policy also included arrangements for families to stay with any resident who was receiving end of life care.

In addition, the person in charge had provided training on palliative care to all of the nurses, and nurses were able to tell inspectors about how they would implement the training.

14. Action required from previous inspection:

Provide each resident with food that is wholesome and nutritious.

While there had been progress on this action, further improvements were required.

On the previous inspection, inspectors found that residents did not have access to fresh fruit. On this inspection, residents were offered fruit regularly, and the fruit was presented in a manner that suited the individual needs of residents. In addition, there was ready access to water and to fruit juices and inspectors observed residents having drinks of fruit juice throughout the inspection.

The person in charge had retained the services of an independent consultant to assess and advise on the provision of nutritious food in the centre. This consultant had provided training to kitchen staff and care assistants who were involved with delivering meals and assisting residents. The person in charge was awaiting a written report from the consultant and planned to introduce further change in response to the recommendations.

However, inspectors found that the menu provided to residents did not reflect the food choices available to residents during the inspection. In addition, residents who required a soft or modified diet were provided with very limited choice at meal times compared with other residents. For example, the choice for evening supper for seven days a week was either eggs or soup.

15. Action required from previous inspection:

Agree a contract with each resident within one month of admission to the designated centre.

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

This action had not been completed, but was within the timeframe indicated in the action plan from the previous inspection.

Inspectors reviewed the contract of care and found that it did not meet the requirements of the Regulations. The contracts did not specify the fees to be charged and did not clearly state what services would be included in the fees.

The provider stated that he found the current contracts to be very legalistic and he intended developing a contract that would include the requirements of the Regulations but that would also be more accessible and easier to understand for residents.

The administrator had provided a copy of the current contract of care to all residents and families with a request for them to sign and return it. She had a record of when the contracts had been provided and when reminders to return the contracts had been sent to residents/families.

16. Action required from previous inspection:

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

While there had been progress on this action, inspectors found that some practices continued to impact on the privacy and dignity of residents and indicated a lack of awareness amongst some staff of how to protect the privacy and dignity of residents.

In general, inspectors found that staff were very attentive to residents, and interacted with them in a respectful manner. Staff were observed knocking on bedroom doors and awaiting permission to enter. When assisting residents, staff were observed taking the time to explain what they were doing, providing the assistance at a pace that was comfortable for residents and chatting with the residents in a calm, respectful manner.

However, inspectors found that one residents' bedroom was being used to store equipment, timber and wood panelling. This had been an issue on a previous inspection. In addition, inspectors observed staff members entering and leaving that room without due regard to the resident. Items for personal care of that resident were not stored properly and discreetly.

Another example where the dignity of residents was not assured was after lunch. Some residents who required assistance did not have the aprons used to protect their clothing during lunch removed for an extended period. By the time they were removed, the residents had gotten the debris from the aprons on their hands and clothes.

17. Action required from previous inspection:

Adequate arrangements were not in place to ensure residents were sufficiently consulted with and participated in the organisation of the centre.

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

This action had not been completed but progress had been made.

A new independent advocate had started to work in the centre and inspectors saw a poster with his details and details of the advocacy service posted on the notice board. The person in charge explained that the advocate was currently getting to know residents and after a number of weeks, would be facilitating a residents' meeting which would not be attended by the person in charge or any staff. She planned to use these meetings as a way of providing an opportunity for and encouraging residents to express their views of the service and make suggestions about the management of the service.

18. Action required from previous inspection:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

This action had not been completed.

Inspectors reviewed a newly developed recruitment and selection policy which provided centre specific guidelines on the recruitment and selection of staff, and included the requirements of the Regulations. However, the policy had not been implemented and recruitment practices continued to be of concern.

In particular, the person in charge had recently appointed a staff member without obtaining any of the required documents such as references or certification of physical and mental fitness for the role. Applications had not yet been forwarded for Garda Síochána vetting for a number of staff who had been recruited since January 2012.

Inspectors reviewed an audit of staff files and found that there continued to be gaps in the required documentation. However, the provider had given the timeframe of the 30 April 2012 for completion of this part of the action.

19. Action required from previous inspection:

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

This action had not been completed.

While some staff members had attended a training day in December 2011, inspectors found that staff were not knowledgeable about contemporary, evidence based care for residents with dementia or those who presented with behaviour that challenges. This had resulted in poor outcomes for residents, as discussed under Action 9.

This was of further concern because the provider had stated in the statement of purpose that the centre catered for the needs of residents with dementia or Alzheimer's disease. While there were plans for a one day information session on dementia care in April 2012, there was no plan for the further development of staff knowledge and skills so that they could effectively meet the complex needs of residents in the centre using a high standard of evidence-based nursing practice.

While recently appointed staff had been asked to shadow other staff members, they had been given no induction training and had not received any instruction on such key areas as preventing elder abuse, moving and handling and fire precautions.

20. Action required from previous inspection:

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

This action had been partially completed.

Inspectors found that the person in charge was not monitoring the rota sufficiently. The rota was being prepared by the administrator and the person in charge stated that she reviewed the rota to confirm staffing levels. However, inspectors found that two care assistants were rostered for some night shifts and three care assistants for other night shifts. The person in charge stated that she was currently recruiting staff and planned to have two nurses and two care assistants on every night. She stated that she had three care assistants on duty at night time until the additional nurses had been recruited and said she was not aware that this was not being implemented for all night duty.

The person in charge had recruited additional staff to increase staffing generally and to ensure that absences could be covered. Inspectors spoke with staff who said that sick leave was now being covered and that the rota was not being left short.

21. Action required from previous inspection:

Provide sufficient numbers of wash-basins fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

This action had been completed.

On the previous inspection, inspectors found that the hot water from some sinks was not thermostatically controlled, was very hot and presented a risk of scalding to residents. The provider was required to take immediate action to ensure the safety of residents. The provider submitted an action plan to the Authority following the inspection to state that all sinks had been fitted with thermostatic control valves.

Inspectors confirmed this during the inspection and found that the sinks identified on the previous inspection now had thermostatic control valves. Inspectors checked the water temperature in a sample of sinks and found that it was within acceptable levels.

22. Action 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.

Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Ensure that suitable provision is made for storage in the designated centre.

Some progress had been made on this action but further improvements were required.

The television had been relocated in the day room to a location where it could be viewed more easily by residents. Inspectors reviewed quotations for the replacement of floors which were in poor condition. This action was within the timeframe in the action plan and the provider confirmed that the floors would be replaced by the end of April 2012. Alternative storage had been provided for assistive equipment.

The provider stated that an engineer had developed plans for the provision of additional communal toilets near the day room and dining room and planned to complete this action by the end of May 2012. The provider stated that he also planned to upgrade soft furnishings and the décor of the centre, but work had not yet commenced on this.

The person in charge stated that she had developed new signage for the centre. However, inspectors found that she had not researched the appropriate signage that best meets the needs of residents with a cognitive impairment, but had obtained generic signage, some of which did not reflect contemporary recommendations.

23. Action required from previous inspection:

Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

This action had not been completed.

Inspectors reviewed a sample of residents' files and daily nursing notes and found that they remained poorly organised and did not provide an adequate account of the

care being delivered to residents or progress responding to such key issues such as nutrition care and wound care.

The provider had put measures in place to ensure that residents' records were kept secure and their confidentiality protected. A new partition had been provided at the nurses' station and a key code lock was used to secure the nurses' office where residents' records were stored.

24. Action required from previous inspection:

Put in place all of the written and operational policies listed in Schedule 5.

Produce a resident's guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

Establish and maintain an up-to-date directory of residents in relation to every resident in the designated centre in an electronic or manual format and make this information available to inspectors as and when requested.

Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

This action had been partially completely.

On the previous inspection, the provider informed inspectors that all of the policies to guide staff practice had gone missing and therefore there were no policies in place to guide staff. The person in charge had replaced a significant number of the policies listed in Schedule 5. Staff were able to tell inspectors about the policies and had signed to say that they had read them. The person in charge stated she planned to review whether the new policies were being fully implemented. Some of the required policies, such as the communications policy, had not yet been developed.

The provider had developed a combined resident's guide and statement of purpose. Inspectors found that this document did not contain all of the required information in the Regulations and a copy had not been provided to residents.

As stated in Action 23, residents' records were poorly organised and did not provide up to date, adequate information on the care of residents. However, they were now being kept in a safe and secure place.

The directory of residents did not contain the required information and was not being kept up to date. Inspectors found that while the person in charge had ordered a new directory of residents to ensure that all of the required information was included, she was no longer keeping the existing directory of residents up to date.

The person in charge and provider stated that the insurance cover met the requirements of the Regulations but were unable to provide a copy of the insurance documentation to confirm this.

25. Action required from previous inspection:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation of misconduct by the registered provider or any person who works in the designated centre.

The provider had submitted notification on this issue following the previous inspection.

Inspectors found that the person in charge was not sufficiently aware of other notifications that were required. Inspectors identified five instances where residents had grade 2 pressure ulcers and these had not been notified to the Authority.

26. Action required from previous inspection:

Residents' personal information was not kept in a secure and confidential manner.

Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

This action had been completed.

This action referred to the inappropriate storage of residents' records on the previous inspection. On this inspection, inspectors found that they were being stored in a safe and secure way which ensured the confidentiality of residents' personal information.

27. Action required from previous inspection:

The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre for older people and supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of the new person proposed to be in charge of the designated centre.

The registered provider shall in any event notify the chief inspector in writing, within 10 days of this occurring, where the person in charge of a designated centre for older people has ceased to be in charge and supply full and satisfactory information,

within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.

Following the previous inspection, the provider had submitted all of the required documentation relating to the appointment of the new person in charge. This information had not been submitted within the timeframe required by the Regulations.

The provider and person in charge stated that a nominated senior nurse provided cover for the person in charge when she was absent. The required documentation had not been submitted for this key management position and the provider did not demonstrate how he had ensured that the nominated person was suitable for the post.

Report compiled by:

Finbarr Colfer
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

11 April 2012

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**

10 and 11 March 2010	☐ Registration ☒ Scheduled ☐ Follow-up inspection ☐ Announced ☒ Unannounced
16 February 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
6 and 7 December 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
8 and 9 February 2012	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre:	Oranmore Care Centre
Centre ID:	0374
Date of inspection:	4 and 5 April 2012
Date of response:	03 May 2012

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: Arrangements for the protection of residents from abuse did not ensure the safety and well being of residents. The provider was required to take immediate action to protect the safety of one resident.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.
Action required: Take appropriate action where a resident is harmed or suffers abuse.

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

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The HSE elder abuse DVD has been shown to all staff members, issues arising discussed and a record of the training has been maintained. Evidence-based best practice Elder Abuse Policies and Procedures are currently being developed with staff and management input and these shall be effectively communicated to all staff The next multidisciplinary care team and multidisciplinary service team meetings are scheduled for the 10 and 17 of May, 2012. Agendas for these meetings will incorporate elder abuse to be further discussed with staff. All staff have be reminded to be extra vigilant for the possibility of elder abuse, and the director of care is undertaking additional supervision to protect all residents from abuse. Where any allegation of elder abuse is identified, it shall be managed in a standardised manner as per the policies and procedures that are currently being developed.	14 May 2012

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

There had not been a full review of medication management arrangements and further improvements were required to ensure the safe management of medication for residents. Issues included:

- there was an inadequate response to a serious medication error
- the medication policy did not provide guidelines on the use of "as required" (PRN) medication
- there was insufficient information on the prescription and administration sheets
- administration times on the prescription and administration sheets did not correspond
- each medication was not individually signed by the general practitioner (GP)
- the control measures for medication that require additional controls were not being consistently implemented.

The provider was required to take immediate action in response to the serious

medication error and to ensure measures were taken to prevent the recurrence and protect the safety of all residents.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Action required: Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Regulation 25: Medical Records Standard 13: Healthcare Standard 14: Medication Management Standard 15: Medication Monitoring and Review	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Medication management training for nursing staff is scheduled for 8 May 2012 with the Pharmacist. Attendance records will be kept on file. Medication management policies and procedures shall be redeveloped to ensure they reflect the current medication practices within the home, as well as evidence-based best practice. These are being developed in conjunction with the staff and the pharmacist. The administration practices surrounding PRN medication shall be incorporated into the revised medication management policies. The administration record shall be redeveloped and standardised. This shall include corresponding administrations times on prescription sheets and administration sheets, consistency in the documentation of the maximum dose required and of the route of administration.	 11 May 2012 21May 2012 Complete

A new incident report form has been introduced into the home. Staff nurses have been instructed by the director of care on the medication errors which warrant the completion of an incident report. A sample of such incidences has been made available on both drug trolleys for staff nurse reference. A new multidisciplinary care team meeting has been implemented which includes the review of incident reports with staff on a monthly basis. In addition these incidents shall be discussed at the new monthly management team meeting. The occurrence and likelihood of medication errors will be further monitored by the director of care through the introduction of a centre specific risk register. This register is currently being developed which will incorporate current and additional control measures to be implemented, with regards to medication management.	18 May 2012

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

There was insufficient awareness amongst management and staff about the importance of keeping fire exits clear.

The mandatory fire training had not been provided to staff who had been appointed since December 2011.

The premises were not in substantial compliance with fire and building control regulations.

Action required:

Provide adequate means of escape in the event of fire.

Action required:

Provide suitable training for staff in fire prevention.

Action required:

Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

Reference:

Health Act, 2007
Regulation 32: Fire Precautions and records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Fire training has been held on 23 and 30 of April and 1 May 2012. All staff have now received fire training. Attendance records for all fire training are available. Three hourly fire exit checks are being conducted and these are being closely monitored by the director of care and through awareness by all staff members. These daily checks are available upon request. Fire evacuation plans are being revised to ensure clarity of escape routes. This shall be displayed in all key areas. A competent person will provide Oranmore Nursing Home with confirmation that all requirements of the statutory fire authority has been complied with.	 Complete On-going 28 May 2012 31 May 2012

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

Risks to residents' safety had been identified on some previous inspections and further risks were identified by inspectors on this inspection.

The risk management policy did not meet the requirements of the Regulations.

There had been no risk assessments in the centre and inspectors identified a number of risks that were not being managed including the laundry and sluice room doors being left open and the cupboard for storage of cleaning chemicals being open.

The accident and incident policy had not been fully implemented.

The infection control policy had not been implemented.

The emergency plan did not provide sufficient guidelines for staff.

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, 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: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.	
Action required: Put in place an emergency plan for responding to emergencies.	
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 centre-specific risk register is currently in development. A centre specific risk management policy shall accompany this register which shall identify identification and assessment of risks within the home. A new management meeting agenda is currently being implemented to ensure that risk management is reviewed on a monthly basis. The risk register will incorporate risks associated with the unexplained absence of residents, assault, accidental injury to residents or staff, aggression, violence and self harm. Evidence-based best practice policies and procedures shall be redeveloped in conjunction with the staff. The policies and procedures shall include, key risk areas including infection control. An emergency plan for the home is shall be developed. This plan will be communicated to all staff once operational through monthly staff meetings, handover and through daily interaction with the director of care. These discussions will guide staff on the correct procedures to follow in such events as fire, loss of water or electricity within the home. The laundry has now a key pad insitu to the main door to prevent unauthorised access. All household staff have been instructed to ensure that all chemicals are to be maintained within lockable	18 May 2012 Ongoing 31st May, 2012 Complete

cupboard within the house hold room or lockable storage cupboard in the laundry.	

5. The provider has failed to comply with a regulatory requirement in the following respect: There were significant shortcomings in the protection of residents' health and wellbeing through a high standard of evidence based nursing practice. Areas that required improvement included: ▪ wound care ▪ management of behaviour that challenges ▪ restraint management ▪ nutrition management ▪ falls management ▪ dementia care.	
Action required: Provide a high standard of evidence-based nursing practice.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Health Care Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Immediate staff training is currently being carried out. This includes training in the areas of medication management, behaviour that challenges, residents rights, privacy and dignity, wound care, restraint, elder abuse, fire and falls management. These training sessions are scheduled to take place with staff over a two week period. Training facilitators have been outsourced to facilitate these training sessions. To ensure evidence-based provision of care to the residents of Oranmore Nursing Home all policies and procedures shall be revised to be reflective of best practice. These policies and procedures shall guide the care provided in relation to wound care, management of behaviour that challenges, restraint management, nutrition management, Falls management, dementia care. All policies and procedures shall be developed with input from staff and shall be effectively communicated to	21 May 2012 Ongoing

staff following approval. An evidence-based best practice policy and procedure on the management of residents with dementia shall be developed, specific to the needs of the residents in Oranmore Nursing Home. The director of care shall audit the care in relation to pressure sores, restraints, weight loss, falls, and incidents on a two weekly basis. All aspects of care shall be reviewed and discussed at the monthly multidisciplinary care team, and issues of concern, at the management team meetings	 18 May 2012 Commenced Commencing 24 May 2012

6. The provider has failed to comply with a regulatory requirement in the following respect: Inadequate arrangements had been made to meet the social needs of residents with a cognitive impairment and residents who were unable or did not wish to participate in group activities.	
Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Key to Me assessment tool and the meaningful activities assessment tool have been introduced to facilitate the social assessment of residents with cognitive impairments. The activities coordinator is currently assessing residents against these. Findings from these assessments shall be used to formulate individual social care plans for residents with cognitive impairments. The process of establishing a residents' committee has commenced. All residents have been invited to join the committee. The first residents' committee meeting is scheduled to be held on 31 May 2012. Resident feedback on the activities	 Commenced 8 May 2012

schedule shall be sought at this meeting. Minutes for this meeting shall be maintained.	

7. The person in charge has failed to comply with a regulatory requirement in the following respect: Care plans were still organised poorly, they did not provide clear guidelines to staff on responding to the needs of residents, they did not include the recommendations of health professionals, there was little evidence of appropriate review of care plans and care plans had not been developed and agreed with residents.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequent than at 3-monthly intervals.	
Action required: Revise each resident's care plan, after consultation with him/her.	
Action required: Notify each resident of any review of his/her care plan.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new resident record system is currently being implemented. This record shall be based on the NHI template and utilise only validated assessment tools. Resident care plans shall be re-developed based on assessment findings and in conjunction with residents and/or their relative/representative. A record shall be maintained of the involvement of the resident/relative.	31 May 2012

Care plan training is scheduled for 11th May 2012.This training session shall incorporate attendance from both nursing and health care assistants to ensure all member of the care team are involved and comprehend the documentation process involved for all residents. The resident care plan review schedule will be redrafted to ensure timely three monthly reviews. The review schedule will identifies a named nurse for each resident to ensure consistency in the review of resident assessments and care plans. The schedule will be displayed in the nurses' station to ensure compliance.	11 May 2012 8 May 2012

8. The person in charge has failed to comply with a regulatory requirement in the following respect: Daily nursing notes did not provide sufficient information on the health and condition of each resident and the treatment given.
Action required: Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.
Reference: Health Act, 2007 Regulation 25: Medical Records Standard 13: Healthcare Standard 14: Medication Management Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new resident record system is currently being implemented. This record shall be complete, and maintain in a safe and accessible place. The comprehensive record shall incorporate the nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with the newly created best practice policies and procedures. Care plan training is scheduled for 11 May 2012. . This training session incorporates the variances in the documentation of	31 May 2012 11 May 2012

nursing progress notes and the documentation of resident care plans. Where resident daily documentation requires counter signatures by the staff nurse on duty, this will be outlined to all staff nurses and health care assistants as part of the training session.	

9. The provider has failed to comply with a regulatory requirement in the following respect: The complaints policy was in draft form and had not yet been implemented. The complaints procedure that was being used did not meet the requirements of the Regulations. All complaints were not being documented and the complaints that were documented had not been investigated and responded to in a timely manner.	
Action required: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.	
Action required: Investigate all complaints promptly.	
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.	
Action required: Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(7) maintains the records specified under Regulation 39(7).	
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An evidence-based best practice, centre-specific, complaints policy and procedure shall be developed. This shall incorporate	11 May 2012

Oranmore Nursing Homes revised independent appeals process. An overview of the complaints process shall be displayed within the main entrance for resident, visitor and staff reference. A complaints specific recording form has been implemented. This form allows for the documentation of the nature of complaints, the action taken, preventative action and whether or not the complainant was satisfied with the outcome. The complaints specific folder has been allocated to the Director of Care's office to facilitate the systematic storage and review of all complaints.	Complete

10. The person in charge has failed to comply with a regulatory requirement in the following respect: Residents who required a modified consistency diet were not provided with sufficient choice at meal times. The menu for other residents did not reflect the choice of meals that was available.	
Action required: Provide each resident with food that is varied and offers choice at each mealtime.	
Reference: Health Act, 2007 Regulation 20: Food and nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The assistance of an external nutritional organisation has been secured in advising Oranmore Nursing Home on the re-development of the daily food menu for residents who are in use of modified consistency diets. Based on this input the menu schedule will be redeveloped to incorporate a more varied diet for these residents. Evidence-based nutritional policies and procedures shall be developed, and effectively communicated to staff. This shall incorporate the appropriate documentation for communication of resident dietary preferences.	31 May 2012 31 May 2012

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

Some practices such as the storage of building materials in a resident's bedroom and arrangements for removing protective aprons after meals did not promote the dignity of residents.

Action required:

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 4: Privacy and Dignity

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All inappropriate materials, building or otherwise, have been removed from inside the nursing home. All related areas have been thoroughly cleaned. Residents rights, privacy and dignity staff training is scheduled for 11 of May 2012. This session shall incorporate the privacy and dignity of residents at mealtimes and ensuring they can undertake personal activities in private. The provision of care in progress cards, for resident's doors, will be made available to further protect resident's privacy and dignity during the delivery of personal care.	Complete Complete

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

While there were plans to consult with residents through a residents' committee, this had not yet been put in place.

Action required:

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

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation

Standard 2: Consultation and Participation	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A resident committee is in the process of being established. All residents have been invited to join the committee. The first residents' committee meeting is scheduled to be held on the 31 of May 2012. A schedule of resident committee meetings has been developed for 2012/2013. Resident committee meetings are scheduled to occur on a three monthly basis. The residents' committee shall have a direct line of communication to the management team. The management team shall review all issues raised by the resident committee. The Oranmore Nursing Home team structure shall be displayed with the Nursing Home.	Ongoing

13. The provider has failed to comply with a regulatory requirement in the following respect: The Resident's Guide did not contain all of the information required in the Regulations and a copy had not been provided to residents.	
Action required: Produce a Resident's Guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.	
Action required: Supply a copy of the residents' guide to each resident.	
Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Standard 1: Information	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	

The Residents Guide has been redrafted to meet all requirements, including a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector. A copy of this guide shall be issued to each resident and a copy shall be maintained within each resident bedroom.	18 May 2012

14. The provider has failed to comply with a regulatory requirement in the following respect: The statement of purpose did not contain all of the information required in the Regulations, some of the information provided was not sufficient and it did not accurately describe the services provided in the centre.	
Action required: Compile a statement of purpose that describes the facilities and services which are provided for residents.	
Action required: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose and function for Oranmore Nursing Home has been redeveloped to ensure it meets all requirements. It now contains all of the information required in the Regulations, including the accurate description of the services provided in the nursing home, and consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	9 May 2012

A copy of the revised statement of purpose and function shall be made available for residents, staff and visitors within the home.	

15. The person in charge has failed to comply with a regulatory requirement in the following respect: Staff were not provided with sufficient relevant training to enable them to respond to the needs of residents and provide a high standard of evidence based practice. Recently appointed staff had no induction training and were given no instruction on key areas such as prevention of elder abuse, moving and handling and fire precautions. There was inadequate supervision of staff to ensure the implementation of new care practices in the centre.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Action required: Supervise all staff members on an appropriate basis pertinent to their role.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A staff training programme has been developed which outlines mandatory and additional training undertaken by staff members of Oranmore Nursing Home. The programme shall ensure that staff members are provided with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice. Additional immediate staff update training is currently being carried out. This includes medication management, behaviour that challenges, residents rights, privacy and dignity, wound care, restraint, elder abuse, fire and falls management. A staff induction and programme has been developed. A record shall be kept of all training received by staff upon induction, including the	Ongoing 15 June 2012

introduction to centre specific policies and procedures and orientation to the home including fire safety. The director of care shall actively continue to supervise all staff on the floor. This shall be enhanced by the attendance of the Director of Care at morning handovers and the creation of a staff performance review programme.	

16. The provider has failed to comply with a regulatory requirement in the following respect: A staff member had been appointed and was working in the centre, and the provider had not obtained any of the documentation required in the Regulations to indicate that the person was suitable to work in the centre. Other staff files did not contain all of the information required by the Regulations to indicate that staff members were suitable to work in the centre.	
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.	
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: Staff files are currently being audited to ensure all documents related to Schedule 2 are within each staff file and any gaps are being actively rectified. The format in which staff files are filed is also being revised to incorporate a staff file index which clearly outlines the content and location of all Schedule 2 documents within each staff file. Best practice recruitment procedures shall be developed to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person. This shall be monitored by the nursing home administrator.	8th May 2012 31 May 2012

17. The person in charge has failed to comply with a regulatory requirement in the following respect:

There was inadequate supervision of the staff roster to ensure that the required staffing levels were in place for each night shift.

Action required:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Reference:

Health Act 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The staff roster shall be reviewed on an ongoing basis by the director of care to ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents and the nursing home. This shall be carried out for both night and day rosters. The numbers of staff allocated shall be carried out in line with the Regulation and Quality Improvement Authority (2009). Staffing Guidance for Nursing Homes. All staffing allocations shall be based on dependency levels of the residents in the nursing home.	Ongoing

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

Not all of the policies that had been developed since the previous inspection had been implemented effectively and not all of the policies required by the Regulations had been developed and implemented.

Action required:

Put in place all of the written and operational policies listed in Schedule 5.

Reference:

Health Act, 2007
Regulation 27: Operating Policies and Procedures
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Evidence based policies and procedures are being developed/revised for all aspects of service and care delivery in the Oranmore Nursing Home. These policies and procedures shall be developed with the input of staff. Upon approval by the director of care all policies and procedures shall be effectively communicated to staff. All related Schedule 5 policies and procedures are currently in development. These policies and procedures are being developed with the input of staff. Upon approval by the director of care all policies and procedures shall be effectively communicated to staff.	Ongoing 15 June 2012

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

While staff had begun gathering information, this had not been reviewed and used as a means of improving the quality and safety of care. A process had not yet been put in place to review the quality of life in the centre.

Action required:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The director of care shall audit the care in relation to pressure sores, restraints, weight loss, falls, and incidents on a two weekly basis. All aspects of care shall be reviewed and discussed at the monthly multidisciplinary care team, and issues of concern, at the management team meetings. An additional comprehensive audit	Commenced

programme shall be implemented as part of the ongoing development of the quality and safety of care. A resident/relatives survey shall be carried out to ensure appropriate input into the ongoing development of the quality and safety of care. A care practice audit has been developed for Oranmore Nursing Home. This audit schedule outlines a timetable of audits pertaining medication management, infection control practices, residents' rights practices, quality of life, wound management, restraint practices and care planning. Auditees have been identified for each audit.	29 June 2012 Ongoing

20. The person in charge has failed to comply with a regulatory requirement in the following respect: The directory of residents did not contain all of the information required in the Regulations and was not being kept up to date.	
Action required: Establish and maintain an up-to-date directory of residents in relation to every resident in the designated centre in an electronic or manual format and make this information available to inspectors as and when requested.	
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An audit of the residents register shall be conducted in line with the regulations to determine it is up to date in relation to every resident in the nursing home. The Director of Residents shall be updated to ensure its compliance with the information specified in Schedule 3	 31 May, 2012

paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.	

21. The provider has failed to comply with a regulatory requirement in the following respect: The contracts of care did not contain information on the fees to be charged, services that were included in the fees and the specific other services that were available in the centre.	
Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.	
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new contract of care has been developed for Oranmore Nursing Home. The contract deals with the care and welfare of the resident in the home and includes details of the services to be provided for that resident and the fees to be charged. All residents/relatives will be provided with a copy of the new contract and asked to sign it.	31 May 2012

22. The provider has failed to comply with a regulatory requirement in the following respect: There was no evidence available to confirm that the insurance arrangements complied with the requirements of the Regulations.
Action required: Ensure that the designated centre is adequately insured against accidents or injury to residents, staff and visitors.

Action required: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).
Action required: Put insurance cover in place against loss or damage to the assets and delivery of the service.
Action required: Ensure out-sourced providers are appropriately insured.
Reference: Health Act, 2007 Regulation 26: Insurance Cover Standard 31: Financial Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Confirmation of the insurance arrangements for Oranmore Nursing Home shall be received to demonstrate that the designated centre is adequately insured against accidents or injury to residents, staff and visitors. This includes insurance cover against loss or damage to the assets and delivery of the service. In line with the regulations appropriate insurance cover is in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2). Where Oranmore Nursing Home insurance cover is not appropriate all outsourced providers to Oranmore Nursing Home will be requested to submit confirmation of their insurance details which shall be maintained on file by the home.	4 June 2012

23. The person in charge has failed to comply with a regulatory requirement in the following respect: The person in charge was not aware of the requirement to submit notifications for incidents of pressure ulcers grade 2 or greater and had not made the appropriate notifications.

Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Education was provided to the Director of Care in relation to all notifiable events. As such Oranmore Nursing Home shall ensure to notify the Chief Inspector without delay of the occurrence of any serious injury to a resident. Information pertaining to notifiable events has also been put within the director of care's office and the nurses' station to enhance awareness on which incidences warrant notification.	Completed

24. The provider has failed to comply with a regulatory requirement in the following respect: The required documentation for the senior nurse who provided cover for the person in charge when she was absent had not been submitted and the provider had not confirmed the competency of the nominated person to fulfil this function.	
Action required: Provide full and satisfactory information on all persons who participates in the management of the designated centre, as set out in Schedule 3 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009.	
Reference: Health Act, 2007 Regulation 4: Application for Registration or renewal of Registration Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Following revision of the organisational structure for Oranmore Nursing Home, an open competition for the senior staff nurse position is currently being held. The newly appointed senior staff nurse will provide support to the director of care. When the appointment has been made, the relevant documentation will be submitted.	Commenced

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

Work had not been completed on addressing a number of physical deficits with the premises:

- replacement of floor areas that were defective and uneven
- provision of a suitable number of toilets which are convenient to communal areas of the premises
- provision of signage that is appropriate to the needs of residents with a cognitive impairment.

Action required:

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.

Action required:

Provide sufficient numbers of toilets and wash-basins which incorporate thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A capital development plan shall be created to 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.	Commenced

A varied colour scheme will be adapted so as to facilitate resident orientation to the different corridors within the home. A resident redecoration survey has been carried out with residents so as to incorporate their input into determining the colour scheme to be selected. Directional signage is also being sourced to further enhance resident orientation.	15 June 2012
Replacement of floor areas that are defective and uneven shall be carried out. The capital development plan shall ensure the provision of a sufficient numbers of toilets and wash-basins which incorporate thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	15 June 2012
All water temperatures shall be recorded on a weekly basis to ensure they do not exceed 43C.	7 May 2012

Any comments the provider may wish to make:

Provider's response:

We are fully committed to providing the highest quality of care to our residents and in using the Health Information and Quality Authority's Standards to assist us. As such, we welcome the feedback from the inspection report.

Provider's name: Paddy Keane
Date: 3 May 2012