Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Oranmore Nursing Home
Centre ID:	0374
Centre address:	Bushfield
	Oranmore
	County Galway
Telephone number:	091 792301
Fax number:	091 779021
Email address:	oranmorenh@yahoo.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Patrick Keane
Person in charge:	Patricia Cormack
Date of inspection:	14 August 2012
Time inspection took place:	**Start:** 10:00 hrs **Completion:** 15:00 hrs
Lead inspector:	Fiona Whyte
Support inspector:	N/A
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ 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. There are 45 places for long and short-term residents and some residents have dementia-related conditions.

Communal accommodation in the centre consists of a variety of day spaces including two conservatories, a sun room, a day room and a dining room. There are areas available where residents can meet visitors in private. The smoking room has been relocated to a conservatory at the rear of the centre. 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 33 single bedrooms and six twin bedrooms. Thirty one single rooms and four twin rooms have en suite facilities. There is one assistive bathroom with a shower, bath, toilet and hand-washing 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:	1980
Number of residents on the date of inspection:	40
Number of vacancies on the date of inspection:	5

Dependency level of current residents	Max	High	Medium	Low
Number of residents	0	13	16	11

Management structure

The Provider is Patrick Keane and the Person in Charge is Patricia Cormack. The provider has recently appointed a Clinical Nurse Manager (CNM) who supervises the care delivery. 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. The CNM deputises in the absence of 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	7	2	3	0	2*

* The provider and the activities coordinator.

Background

This was the eight inspection of this centre by the Health Information and Quality Authority (the Authority) and the reports of previous inspections are available on the Authority's website www.hiqa.ie.

An unannounced inspection took place on 11, 12 and 26 June 2012. While inspectors were concerned on the first two days of the inspection, regarding the fitness of the provider and person in charge and their ability to comply with the Regulations, on the third day of the inspection, inspectors found that significant improvements had been made in all areas outlined above. The areas of immediate risk had been addressed. The provider had improved the clinical governance of the centre with the appointment of a CNM. The provider also agreed not to admit any more than 40 residents until such time as they demonstrated sustained improvements. The centre was registered on 29 June 2012.

Summary of findings from this inspection

This report outlines the findings of an unannounced inspection that took place on 14 August 2012. The inspection was a follow up inspection and focused on the action plan from the previous inspection.

There were ten actions identified at the previous inspection, of those only two were fully completed, three were partially completed and four were not completed. The timeframes for the completion of these actions had passed.

The inspector had concerns in relation to the clinical governance. As well as having failed to recognise and manage an allegation of abuse, which as a result had put residents at increased risk, the person in charge still did not have effective systems in place to monitor and supervise staff practices.

The inspector was also very concerned regarding the management of an allegation of abuse which had occurred in July 2012. An immediate action plan was issued to the provider and the person in charge. They were required to conduct a full investigation into the allegation of abuse and submit the investigation report to the Authority by 17 August 2012 along with details of any actions or measures taken. The inspector also had to request measures be put in place to ensure the safety of all residents prior to completion of the inspection.

Non-compliances were identified in areas such as:

- medication management
- management of allegations of abuse
- fire safety and moving and handling training
- auditing and monitoring
- daily nursing notes.

The provider had retained the services of a consultancy group to support him in making the required improvements. He agreed to adhere to the current agreement with the Authority and not admit any more residents until sustained improvements were demonstrated.

These issues are discussed further in the body of the report and are included in the Action Plan at the end of the report.

Issues covered on inspection

General Welfare and Protection

The inspector was very concerned that residents were not protected from harm.

A notification was received by the Authority in July 2012 relating to an allegation of abuse by a staff member against a resident. The notification was not submitted within the required timeframe. However, it was accompanied by a report which detailed actions to be taken as part of the overall investigation into the allegation. The inspector requested from the person in charge a copy of the completed investigation and details of the outcome and measures taken following the investigation. While the person in charge had carried out a preliminary investigation and concluded that abuse could have taken place she did not carry out a formal investigation. There were no actions taken or control measures put in place to ensure the safety and protection of all residents. This was contrary to the process outlined in the centres policy on the protection of residents. The staff member against whom the allegation was made was rostered on duty in the centre with no systems in place to supervise this staff member.

An immediate action plan was issued to the provider and the person in charge. They were required to conduct a full investigation into the allegation of abuse and submit the investigation report to the Authority by 17 August 2012 along with details of any actions or measures taken. The inspector also requested details of what interim measures were going to be in place to ensure the safety of all residents prior to completion of the inspection. The provider allocated the staff member against whom the allegation was made to work under the direct supervision of another senior staff member until the investigation was complete and would not be allocated on night duty. The provider assured the inspector that once the investigation was complete additional actions would be taken in accordance with the findings.

Clinical Governance

In addition to the inadequate management of the allegation of abuse as outlined in above, the person in charge did not have effective systems in place to monitor and supervise staff practices. As a result there were negative outcomes for residents. For example, two residents had recently developed grade 3 to 4 pressure ulcers. These residents were assessed and identified of being at risk of developing pressure ulcers. However, effective measures to prevent pressure ulcers developing had not been put in place. In addition two separate drug errors which occurred several days prior to the inspection were not identified and investigated by the person in charge. The person in charge was also unable to locate training records and had no systems in place for easy retrieval of records when required.

The provider also outlined his concerns regarding the clinical governance in the centre and stated that he fully recognised this as a current deficit. He stated he had a plan in place and was in the process of making changes to the management structure in the centre to ensure robust clinical governance arrangements would be implemented as soon as possible.

Actions reviewed on inspection:

1. Action required from previous inspection:

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

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.

While some improvements were made this action was not fully completed.

The inspector reviewed the register of controlled drugs and found two separate drug errors which occurred several days prior to the inspection. The balance of the medication was incorrectly recorded on two separate days. The CNM stated that an incident report would be completed and an investigation would be carried out.

Crushed medications were still not individually prescribed. The provider stated that he would arrange to discuss this issue with the general practitioners (GP) with a view to addressing the issue.

The route by which medication was to be of administered was not documented on the prescribing charts.

A secure cabinet had been provided for medications that required special control measures in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984.

One resident identified at risk of malnutrition was referred to the dietician for review. The dietician recommended supplements be prescribed for the resident. These supplements had not been prescribed by the GP.

A review of the incident reports demonstrated detailed reporting of medication errors or near misses. Audits had been undertaken by the pharmacist and a meeting had been held with the person in charge, the CNM and the pharmacists to discuss the errors, some of which were attributed to pharmacy dispensing. Minutes of the meeting reviewed indicated detailed discussion was held including actions to be taken in order to reduce the number of errors. The CNM and the documentation reviewed also confirmed that she was carrying out regular audits of medication management practices. Minutes of meetings with the nursing staff showed that discussions had taken place regarding medication practices. The CNM confirmed that improvements had been made and errors had reduced.

The risk register had been updated to include medication management as a risk and included the control measures in place to minimise the risks. However, it did not include the audits being carried out as an additional control measure.

While auditing and monitoring had commenced and learning was evident there was no comprehensive auditing carried out to identify trends and improve safety. The CNM stated that she would be doing this on regular basis into the future.

2. Action required from previous inspection:

Provide suitable training for staff in fire prevention.

The inspector was not satisfied that sufficient evidence was available to demonstrate that this action was completed and that all staff had now received fire training.

The person in charge told the inspector that all staff had received fire training, with the last training held on 17 July 2012. However, there was no record or documentary evidence of this training available. The person in charge stated that the administrator had responsibility for maintaining the training records but she was on leave at the time of inspection. Staff spoken with did state that they had received training and they were knowledgeable of what procedures to follow in the event of a fire.

The training matrix viewed was not up to date to include the training held in July 2012.

The person in charge did not have appropriate systems in place to allow for easy retrieval of important information and records.

3. Action required from previous inspection:

Provide training for staff in the moving and handling of residents.

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

This action was partially complete.

The person in charge stated that moving and handling training had been provided to some staff but confirmed that not all staff had received this training. Records of recent moving and handling training were unavailable again due to inappropriate systems in place for record retrieval.

The training matrix viewed was not up to date to include the training held in July 2012.

The risk management policy had been updated to include medication practices as detailed under Action 1. The policy also now included the risks associated with resident absconsion, use of restraint, self harm and elder abuse.

4. Action required from previous inspection:

Provide a high standard of evidence-based nursing practice.

This action related to the use and management of restraint and was completed.

A restraint register was in place and updated daily. It confirmed that 21 residents were using bedrails and three residents were using lap belts. The policy had been updated to reflect the HSE National Policy on the use of Physical Restraints in Designated Residential Care Units for Older People (2010). The inspector found that appropriate assessments had been carried out and alternative strategies prior to the use of bedrails and restraint had been considered such as low-low beds and crash mats. Consent forms were completed and appropriate care plans were in place. There were records on the duration and release of the restraint.

Training on the use and management of restraint had been provided to staff in June 2012.

5. Action required from previous inspection:

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

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 three-monthly intervals.

This action was partially complete.

The inspector reviewed the files of a number of residents with wounds, at risk of malnutrition and with catheters in situ. Comprehensive nursing assessments were in place and up to date. Additional risk assessments were carried out and residents had care plans in place for all identified needs.

A named nurse had responsibility for a number of residents and their care plans. The care plans viewed were up to date and records showed they were reviewed on a three-monthly basis or sooner.

While there was evidence that some residents and/or their representative were involved in the care planning process this was not the case for all residents. The person in charge confirmed this to be the case and said that she was working on addressing the issue.

6. 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 was not complete and related specifically to the recording of entries in the daily nursing notes.

The inspector viewed the daily nursing notes of a number of residents and noted that there was now an entry for each shift. However, the nurses were still recording the shift time instead of the actual time of the entry. This issue was more frequently noted to occur on the night shift.

7. 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 was complete.

The inspector reviewed a number of staff files and noted them to be well organised and structured.

The provider had obtained all the documentation required in the Regulations including information such as proof of the person's identity, evidence of Garda Síochána vetting, documentary evidence of relevant qualifications, three written references and evidence that the person employed was physically and mentally fit.

8. Action required from previous inspection:

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.

This action was not complete.

Clinical data was being collected in areas such as infections, residents with wounds and pressure ulcers, those experiencing pain and residents on psychotropic medications. Data relating to individual residents was discussed at staff handover meetings. However, there was no comprehensive auditing of this information to identify trends and improve practice.

The person in charge and minutes of staff meetings confirmed that a falls prevention committee and a health and safety committee had been established with a view to reviewing and improving the quality and safety of care in these areas. Neither committee had met to date.

There was documentation relating to an official audit programme. The programme detailed the various audits to be carried out, on what date and by whom. The programme had yet to commence.

9. Action required from previous inspection:

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 was in progress.

New contracts of care had been developed in line with the requirements of the Regulations. The inspector viewed one such contract which had been signed and returned and found it complied with the Regulations. The person in charge stated that all residents and their families had been sent an updated contract for signing however they had not all been returned as yet.

10. Action required from previous inspection:

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.

This action was due for completion within the next few days.

The inspector noted that building works were ongoing and nearing completion to provide sufficient toilets and wash-hand basins for residents. The floor in the assisted bathroom was also being replaced at the time of inspection.

Report compiled by:

Fiona Whyte

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

15 August 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	Oranmore Nursing Home
Centre ID:	0374
Date of inspection:	14 August 2012
Date of response:	31 August 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 person in charge has failed to comply with a regulatory requirement in the following respect:

The person in charge had failed to take appropriate action following an allegation of abuse resulting in a risk to residents.

Action required:

Take appropriate action where a resident is harmed or suffers abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An independent investigation was carried out by an external organisation on 15 of August 2012 into the said allegation. Recommendations and timeframes for completion were identified to address the non-conformances identified in the management of the allegation. Recommendations and timeframes for actions to be undertaken to further protect residents were also identified with clear lines of responsibility. Final investigation report was submitted to the Authority on 17 August 2012.	Complete

2. The provider has failed to comply with a regulatory requirement in the following respect: Two drug errors which had occurred a number of days prior to the inspection had not been recorded or investigated. Crushed medications were still not individually prescribed by the GP. The route or method of administration was not documented on the prescribing charts. Recommendations made by the dietician had not been prescribed by the GP. There was no comprehensive auditing and monitoring of medication errors to identify trends and improve safety.
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.

Action required:

Maintain, in a safe and accessible place, a record of any medication errors or adverse reactions in relation to each resident.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Investigations into the two medication errors identified during the inspection process were carried out on 16 and 17 August 2012. Corrective actions and timeframes for completion were identified to further prevent similar errors from occurring. The investigation reports were submitted to the Authority on 17 August 2012.	Complete
The registered provider is scheduled to meet with GP services on 3 September 2012 to discuss issues surrounding the prescribing of crushed medications and supplements.	03/09/2012
A meeting was held with the dispensing pharmacy on 24 August 2012. The routes of administration are documented on resident kardexs which are issued by pharmacy.	Complete
The registered provider is meeting with GP services on 3 September 2012 to discuss the documentation of administration routes where resident kardexs are issued by the residents GP.	30/09/2012
An incident report trending spread sheet has been created to monitor the occurrence and nature of incidences within the home. The trending sheet will specifically identify the prevalence of medication errors and monthly reports shall be discussed by the acting person in charge as part of monthly care team meetings.	Commenced

3. The provider has failed to comply with a regulatory requirement in the following respect: There was no evidence that fire training had been provided to all staff.	
Action required: Provide suitable training for staff in fire prevention.	
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 was conducted on 10 July 2012 for newly recruited staff. The fire training certificates were submitted to the Authority on 17 August 2012.	Complete

4. The provider has failed to comply with a regulatory requirement in the following respect: All staff still had not received moving and handling training.	
Action required: Provide training for staff in the moving and handling of residents.	
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: Manual handling training is scheduled for all remaining staff on 12, 21 and 28 September 2012. All staff have been informed of the scheduled dates and confirmation of attendance and training shall be maintained.	28/09/2012

5. The person in charge has failed to comply with a regulatory requirement in the following respect: Not all residents and/or their representative were involved in the care planning process.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Outstanding signatures on resident care plans were identified and since signed by the residents and/or their relatives/representatives. A maintenance record of resident signatures is being maintained by the clinical nurse manager to ensure resident signatures are obtained for future care plans in a timely manner.	Complete

6. The provider has failed to comply with a regulatory requirement in the following respect: Daily nursing notes still did not indicate the time of the entry in accordance with professional guidelines.
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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A care team meeting was held on 23 August, 2012. The importance of documenting the time of entry within nursing communication notes was reiterated to all staff nurses. Compliance will be closely monitored by the clinical nurse manager.	Ongoing

7. The provider has failed to comply with a regulatory requirement in the following respect: While clinical information was being gathered, this had not been sufficiently reviewed and used as a means of improving the quality and safety of care.	
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: A falls prevention team was identified at the care team meeting on 23 July 2012. A member of nursing staff, a healthcare assistant, housekeeping and maintenance staff were nominated to participate. The team are scheduled to meet on a two-monthly basis to discuss the occurrence and nature of resident falls, resident reassessment, and identification of potential falls/hazards and preventative actions. The first falls prevention meeting is scheduled for 17 September 2012. An incident reporting trending sheet has been developed to monitor the nature and occurrence of reported incidences within the home. This shall be maintained by the acting person in charge and trends shall be communicated to staff at monthly team meetings to facilitate the implementation of preventative actions.	Commencing 17/09/2012 Ongoing

The audit schedule has been revised to include the appointment of new lead auditors. Monthly audits shall continue and quality improvement actions carried out to improve practices within the home.	Commenced

8. The person in charge has failed to comply with a regulatory requirement in the following respect: New contracts of care had been issued to all residents but were not all signed and returned.	
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: Contracts of care were issued to all residents and/or their relatives/representatives in June 2012. A record of all returned contracts is being maintained by Administration staff. Residents and/or their relatives have been informed to return all contracts by 10 September 2012. The record shall be updated accordingly by administration staff to ensure Oranmore Nursing Home is in receivership of all contracts.	17/09/2012

9. The provider has failed to comply with a regulatory requirement in the following respect: The person in charge did not have appropriate systems in place to retrieve records.
Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A daily wound care documentation check is being conducted by the clinical nurse manager on a daily basis. This check ensures the appropriate assessments and care plans are in place for each resident identified with same. This check further ensures consistency and clarity in the daily documentation of wound care. The staff training record is currently being updated by administration staff. Retrieval of staff training records been demonstrated to the acting person in charge and the clinical nurse manager.	 Ongoing 10/09/2012

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

The person in charge had failed to display adequate knowledge of the management of clinical issues in the centre. She did not manage the allegation of abuse as detailed in the centres own policy and so put residents at risk. She did not have effective systems in place to supervise staff practices which resulted in negative outcomes for residents.

Action required:

Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they have the skills and experience necessary for such work.

Action required:

Supervise all staff members on an appropriate basis pertinent to their role.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Regulation 17: Training and Staff Development
Standards 22: Recruitment
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The management structure of the home has been revised. The revised structure includes the appointment of an acting person in charge and clinical nurse manager. Job descriptions have been issued for these revised roles and the organisational structure has been re-developed to illustrate same. The registered provider is onsite two mornings each week to offer support and guidance to the acting person in charge and clinical nurse manager. This is evidenced within the staff rota. The recruitment procedures have been revised and approved to ensure no staff member is employed without the appropriate skills and experience for the role.	Complete

Any comments the provider may wish to make:

Provider's response:

Oranmore Nursing Home welcomes all feedback from the inspection team. All actions shall be continually addressed to improve ongoing quality of care and resident safety.

Provider's name: Paddy Keane
Date: 31 August 2012