Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

# Issued by the Chief Inspector

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| Name of designated centre: | Oaklodge Nursing Home |
| Name of provider: | B & D Healthcare Company Limited |
| Address of centre: | Churchtown South, Cloyne, Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 27 July 2023 |
| Centre ID: | OSV-0000261 |
| Fieldwork ID: | MON-0040936 |

## About the designated centre

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

Oaklodge Nursing Home is a single-storey building set in a scenic rural location in Cloyne. Nursing care is available on a 24-hour basis. There are fifty-one bedrooms in the centre which is registered to accommodate 65 residents. Bedroom accommodation is composed of 43 single occupancy rooms, four double rooms, two three-bedded rooms and two four-bedded rooms. There are adequate communal areas including a spacious, furnished entrance lobby, a restful conservatory, a large well-lit dining room, a sitting room and visitors' room. The north and south corridors of the premises are linked by a central corridor which also provides bedroom accommodation for a number of residents. The south corridor of the nursing home caters predominantly for the needs of residents with dementia. A secure garden area had been designed for these residents. There is a comprehensive complaints process in place. Residents' independence and activity is promoted.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 63 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Thursday 27 July 2023 | 09:00hrs to 19:00hrs | Mary O'Mahony | Lead |
| Thursday 27 July 2023 | 09:00hrs to 19:00hrs | Robert Hennessy | Support |

## What residents told us and what inspectors observed

Inspectors met with the majority of residents during this unannounced inspection of Oaklodge Nursing Home, and spoke with six residents in more detail. Inspectors also met a number of relatives who were visiting family members. Overall, while inspectors found that some residents living in the centre gave positive feedback about the centre and were complimentary about the staff and the care provided, other residents and their relatives were not content with communication, care and activities. Additionally, inspectors were not satisfied that the overall governance and management of the centre was sufficiently robust, which will be discussed later in the report.

The centre was located near the coastal village of Cloyne and was set in spacious gardens, which were designed for residents' use. There was ample car parking available near the building, as well as scenic rural views of the surrounding countryside. Two inspectors arrived, unannounced, at the centre and following an opening meeting with the person in charge and the director who represented the provider, they were accompanied on a walkabout of the premises. The centre consisted of three separate areas, the South wing, incorporating the Suaimhneas unit, for those residents with a diagnosis of dementia, the north wing and the centre wing. As the centre was designed as a single-storey building, each area was seen to be easily accessible and this encouraged residents to remain mobile. Residents were seen to walk about independently or using assistive devices, such as walking aids. Residents told the inspectors that they were happy with their rooms, especially having toilet and shower facilities en suite. Clocks, photographs and calendars were seen in each room and rooms had been personalised for a number of residents.

The design and layout of the centre comprised of a large central, open plan sitting room and a nicely decorated, interlinked dining room, which were the main rooms used for daily activities. The dementia specific unit, Suaimhneas, which was a secure unit, had an 'open door' policy of maintaining easy access to the main centre, for meals and some activity. There were also additional quiet rooms overlooking the patios and gardens for residents' use, even though these were found to have limited use on the day of inspection. During the walkabout, inspectors observed that some doors, floors, woodwork and walls required repair and painting and a small number of bedrooms were found to have a strong 'musty' odour. Further description of the premises, particularly in relation to the required maintenance upgrade, both inside and outside, was outlined under Regulation 17: Premises.

Inspectors observed that most of the residents sat in the large sitting room during the day and were accompanied to the nearby dining room for their meals. The inspectors observed that the activity staff engaged with residents, however, due to the large number of residents, up to 30, present in the room, they were not able to engage fully with all residents. In addition, the TV was very loud and the noise overwhelmed other activities and conversation. Inspectors saw that individualised attention and intervention could not be assured in these circumstances. Later in the

day, inspectors observed that a more convivial atmosphere was created when a staff member played music for residents, and some residents sat around a central table in the sitting room, with more staff in attendance to support them. Residents spoken with in this room said they felt comfortable and were used to the routine of the day. A number of residents liked to sit in the main entrance hall and observe the comings and goings of staff. They said they were satisfied with staff, with access to outings, with the care and with their daily lives.

Inspectors observed that there were times when a staff member in the central sitting room and separately a staff member in the Suaimhneas (dementia care) unit were seen to be standing and observing a group of residents, but not engaging with residents in any meaningful way. This indicated to inspectors that the staff members would benefit from further training in person-centred care approaches.

This was addressed throughout the report under the relevant regulations. This observation was also substantiated by residents, relatives and staff spoken with, who felt that care was not optimal and activities were not sufficient in the Suaimhneas unit. They also indicated that there was inadequate relaxation or sitting space for residents, outside of their bedrooms, in Suaimhneas. Inspectors saw that sitting space was available in the small hallway of this unit where only eight residents could be comfortably accommodated. The small conservatory, dining area in the Suaimhneas unit was used during the day for one or two residents, requiring a lot of space for a large specialised chairs. There were in all 24 residents in the unit and while some residents stayed in their bedrooms, in general, there appeared to be times when inspectors observed that residents crowded around the hallway space. For those with dementia, being in close proximity with other residents with dementia can create anxiety in the group. By way of example, one resident was seen by inspectors to attempt to hit out at another resident, who entered their personal space. This was resolved, by an experienced health care assistant, who distracted and comforted both residents. The issue of additional communal space was previously pointed out and had been somewhat mitigated by the use of a dining area outside the Suaimhneas unit. However, this room was not generally in use for relaxation or activities during the day and staffing levels would require review, to enable sufficient support and individualised care, if this room was to be utilised by residents all day.

A number of staff spoken with were dedicated to their roles, however, inspectors observed that at times there were insufficient, suitably trained staff available to respond to the needs of residents, which placed a burden on other staff, who said they felt under pressure to provide the good care that they wanted to. Examples of this included, one resident told inspectors that there were delays in staff responding to the call bell ringing and also in removing their meal trays. A second resident was seen in a very unclean room, sitting alone, without meaningful interaction for most of the day. Another example involved one resident who walked into other residents' rooms, making them fearful and requiring two residents to request safety gates to be erected on their bedroom doors. Staffing was discussed in greater detail under Regulation 15 and Regulation 16, particularly in relation to staff supervision and

training, as identified by information received prior to the inspection, inspectors' observations, and staff and residents' comments throughout the inspection day.

On a positive note, inspectors saw that the door to the garden area in the Suaimhneas unit was open all day, enabling residents to come and go independently to the outside. Nevertheless, the provider acknowledged that the gardens, patios and hedging required a lot of attention and they undertook to attend to this and also to add additional tables to the patio and gardens, for residents' and relatives' use .

The dining room in the main centre, was located next to the kitchen so that the chef was at hand, if required, to speak with residents. This room was beautifully decorated as before, with a mural of a local seaside area and private, bright alcoves for residents' privacy during the day, if they wanted an alternative seating area for activity or visiting. Inspectors observed residents' dining experience at various times during the day. A number of residents attended the morning breakfast club where fresh baking and coffee was served. Residents generally said that they liked the food. However, the supervision of food intake for those residents eating in their bedrooms at mealtimes, required review, due to the absence of records and documentation on food and fluid intake. In addition, it was very difficult to distinguish the contents of one "modified" meal seen, as all the contents were mixed together.

A large group of visitors were seen coming and going during the inspection and were welcomed by staff. The centre's receptionist ensured that visitors signed in and completed safety checks, in line with the centre's ongoing infection control protocol.

The next two sections of the report present the findings of this inspection in relation to, the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

## Capacity and capability

Inspectors found that, while there were governance and management arrangements and systems in place for monitoring the care of residents, the systems were not adequate to ensure that the service provided was safe, appropriate, consistent and effectively monitored. One of the senior clinical nurse managers (CNMs) had resigned recently and another two CNMs worked part-time, which meant that there were times when there was a lack of nurse managers on duty, to provide oversight and supervision of staff members. The provider stated that an assistant director of nursing and an operational manager were under recruitment to fill this deficit, and they were confident that this increase in management staff would enable compliance with the regulations and consequently improve care to residents.

The previous inspection of this centre was undertaken on 11 January 2023. Seven of the regulations inspected against on that occasion were found to be substantially compliant. However, on this inspection a number of those required actions had not been addressed and overall findings in other aspects of care and the premises required action. Prior to the current inspection, inspectors had been made aware of a number of concerns, particularly about the care of those residents who resided in the dementia specific unit. Examples of the serious issues notified to the Chief Inspector included, allegations of insufficient staffing levels to address the needs of residents, inadequate oversight of care and alleged inadequate holistic care for those with dementia. While some of these concerns had been addressed prior to the inspection, a number of other concerns were substantiated on inspection, and these are described throughout this report. Inspectors found that action was required in the areas of staffing, training and staff development, rights, care planning, health care, infection control, notifications, managing complaints and premises upkeep, as addressed under the relevant regulations below.

The registered provider for the centre was B and D Healthcare Ltd. There were four directors in the company. A director of the company attended the centre daily and a second director, a nurse, acted as clinical lead. The staff team in the centre comprised of the person in charge, two part-time CNMs, a team of nurses and health-care staff, as well as administrative, catering, HR, household and maintenance staff. There was evidence of regular meetings between the provider and the nurse management team. Complaints management and key performance indicators (KPIs, such as falls, restraint and antibiotic use) were reviewed and discussed at these meetings, as evidenced in the minutes viewed. The audit schedule was set out at the beginning of the year and a number of aspects of residents' care were audited monthly.

The duty roster was examined and showed that the person in charge worked in a full time capacity. The CNMs provided managerial support but did not work full time. The person in charge and the CNMs operated an on-call rota, to provide support to the service on weekends. Staffing levels were of concern, as discussed under Regulation 15, in greater detail. For example, there was continuity of care with some staff having worked in the centre for a long time, however, a number of these staff stated that they felt unsupported, and they felt that the centre was short staffed. They told the inspectors that they felt that induction and supervision of new staff was not adequate, which meant that they felt they could not spend sufficient time with residents, while also supporting these staff to undertake or complete their duties. On the day of inspection there were adequate staff available to meet the needs of residents, nonetheless, inspectors were not assured that the skill mix of staff and staffing levels were consistently sufficient, to support residents' needs, as described in the report. According to records of residents' dependency levels, at least 23 of the residents required two staff, working together, to support their care and 28 residents had care needs which were either assessed as maximum or high needs. In addition, the provider confirmed that additional staff were made available in the centre on the day of inspection, to support the inspection process and to provide additional activity. This meant that concerns about staffing levels could not

be fully evaluated and this issue was brought to the attention of inspectors, by staff and relatives.

Evidence of training undertaken by staff was available on the training matrix. While this training was up to date, the fact that most of the training was delivered through an on-line forum did not appear to meet the needs of all staff and residents, particularly staff who were not very familiar with the centre or with the specific needs of those with dementia. This finding was based on inspectors' observations, concerns received and discussion with staff, relatives and residents in relation to meeting healthcare needs, care planning, communication, residents' rights and person-centred approaches.

Findings of concern were outlined in more detail under the specific regulations pertaining to governance and management in this section of the report and further regulations, relating to care needs, were addressed under the quality and safety dimension of the report.

## Regulation 15: Staffing

Inspectors were not assured that the number and skill mix of staff were appropriate, having regard to the needs of the residents and the layout of the centre.

This was of particular concern as the centre had a 24 bedded Suaimhneas unit, dedicated to the need of those with dementia.

There were concerns voiced to inspectors by residents, relatives, and staff, regarding staffing levels and turnover of staff. Concerns were also seen to have been raised by residents in minutes of residents' meetings, in the complaints book and in information received prior to the inspection and during the inspection, relating to perceived staff shortages.

Health care assistants (HCAs) spoken with, stated that they felt they were very busy, particularly when trying to support and induct groups of new staff, while also attending to their own assigned duties. Relatives spoken with felt "more could be happening" in relation to activities, particularly for those with dementia. One resident said that their call bell was sometimes not answered, which they put down to not having enough staff on duty.

Inspectors found that the staffing levels after 8pm at night were inadequate to provide supervision and attend to the care needs of residents, particularly taking into account the size and layout of the building and the aforementioned dementia specific unit. There were two nurses and three care assistants on duty after 8pm each night for the 63 residents. This meant that whenever residents required two people to meet their care needs, there was only one HCA available to provide care, while the nurses were administering medicines and taking the night handover report.

On the day of inspection there were 23 residents requiring two staff to attend to their care needs which indicated that the majority of residents required a very high level of care.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

Staff training and supervision was not adequate:

While mandatory training was up-to-date for staff, appropriate staff knowledge of this training, the lack of sufficient in-house training, inadequate mentoring and inadequate staff supervision appeared to have an adverse impact on residents' care.

Examples found on the day of the inspection included:

- on at least two occasions staff members were seen standing, supervising residents while not interacting with them in a social and person centred way
- nursing staff did not adequately supervise meal times, or did not adequately supervise residents' care needs, leading to residents not being washed appropriately, not having their clothes changed when required, and as previously described some staff not appearing to spend sufficient time supporting those who required help with their meals
- one person with very specific needs was wearing soiled outer clothes and their room had not been cleaned
- there were a number of residents who walked with purpose and regularly entered other residents bedrooms uninvited. This has caused distress to the residents and their relatives and there was an inadequate system of supervision or redirection of these residents to prevent reoccurrence
- call bells took a long time to be answered.

Judgment: Not compliant

## Regulation 21: Records

Not all the records required to be maintained for inspection purposes, as set out under Schedule 2,3 and 4 of the regulations were available for inspection:

- One staff file seen did not contain two references as required, and a curriculum vitae (CV) of the staff member was not complete. Two references are required for staff, to fulfil regulatory requirements and to support safeguarding arrangements for residents. One such reference should be provided by the person's last employer. This was not available on file.

- A resident with poor fluid and food intake did not have a fluid balance or food intake chart in place to ensure they had the appropriate nutrition.
- Healthcare records, such as records of required blood tests were not available where a resident had been identified as having a specific need.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Similar to findings on the previous inspection on 11 January 2023 some management systems were not sufficiently robust to ensure the service was safe and appropriately and effectively monitored. More robust systems were required to ensure additional oversight. The senior management team had experienced changes in the previous months and the provider confirmed that they had interviewed for a new assistant director of nursing (ADON) whose appointment was said to be imminent. Not all the issues identified on the previous inspection had been addressed or completed and in addition, the number of concerns raised prior to and during the inspection evidenced the need to enhance the team, the training and the supervision of staff.

The following issues were identified

On the day of inspection the governance and managements arrangements did not reflect the structure in the statement of purpose dated 30 March /2022.

- one clinical nurse manager CNM1 worked one day a week only
- one CNM2 worked two days a week.

The management systems in place were not sufficiently robust to ensure the service provided was safe, appropriate, consistent and effectively monitored.

- Staff roles in the centre needed to be more clearly defined and supervised, giving staff details of their responsibilities in areas of care provision, as described in detail under regulations 15 and 16.
- Staff induction and supervision issues were of concern and of particular concern at weekends, according to complaints expressed.
- Care planning, the provision of communication aids, the overview of care plans and health-care provision was not adequate, in relation to residents with very specific needs and following serious injury.
- Communication was described as poor in some areas and not all concerns were sufficiently addressed. This was further described under Regulations 5 and 6.
- All issues identified on the previous inspection had yet to be addressed, as outlined under Regulation 17: Premises (repeat finding).

- A number of key notifications had been submitted late, these included an allegation of staff misconduct and serious injuries to residents (repeat finding).
- Some aspects of infection control required action, as addressed under Regulation 27.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Three day notifications were not notified to the Chief Inspector in a timely manner in compliance with the regulations.

- These included two serious injuries and an allegation of staff misconduct.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The complaints procedure was not fully effective, to comply with regulatory requirements:

- This was evidenced by the fact that complaints, some of which were already in the complaints book, were repeated to inspectors by those involved, who expressed that they were not assured that the complaint had been dealt with, as they said that issues were reoccurring and their concerns were not adequately addressed.
- Complaints viewed in the complaints log were not recorded as resolved, to the satisfaction of the people involved, as required in the regulations.

Judgment: Substantially compliant

## Quality and safety

On this inspection of Oaklodge Nursing Home a number of residents expressed their satisfaction with the centre, their accommodation and the care. Nevertheless, another group of residents did not feel fully supported in their choices and their privacy needs and reported sometimes having to wait long periods to get assistance from staff. These concerns were supported by information received prior to the inspection, comments made by staff and relatives, in addition to findings on

inspection, which are detailed throughout the report. Inspectors found that, while in general, residents' health and social care needs were being met through access to care from a range of health care practitioners, not all aspects of health care provision provided assurance that residents had access to a high level of professional, best evidenced-based practice. This inspection found that significant improvements and actions were required in relation to dementia care, communication, premises, infection control, care planning, health care, residents' rights and protection, in this dimension of the report.

Some sections of the centre were nicely decorated with good quality curtains, furniture, pictures and ornaments. A number of residents' bedrooms were spacious, and equipped with full en-suite facilities. Bedroom accommodation was composed of 43 single occupancy rooms, four double rooms, two three-bedded rooms and two four-bedded rooms. There were a number of communal rooms available in the centre including, a dining room, sitting rooms, an oratory, a visitors' room and a quiet room. However, there was lack of suitable communal space in the Suaimhneas, the dementia specific unit, which was outlined under Regulation 17: Premises. There was a steady flow of people in and out of the centre all day. The spacious, central, hallway was popular with some residents, who liked to sit and observe visitors and staff. Nevertheless, there were a number of premises issues identified, particularly ongoing maintenance requiring action, which was discussed under Regulation 17.

The general practitioners (GPs) were described as attentive to residents. Quarterly reviews by GPs included a review of residents' medicines and assessment of the suitability of any medicine changes. Residents had access to the tissue viability nurse specialist (TVN) to support their wound care when required. Some care plans contained a lot of relevant information. However, there were some aspects of care planning and health care which required review. For example, there was a delay in the identification of serious health care issues on two occasions and pertinent care plans, for a number of residents with specific needs, had not been developed, as described under Regulation 5 and Regulation 6 in this report.

Infection control failings were identified on inspection. For example, areas of the centre were not clean and there was a musty smell in some rooms. There was a lack of audit and supervision of cleaning practices. These issues are addressed under Regulation 27: Infection control.

Feedback in relation to food was generally good. However, there were some issues to be addressed around the management and supervision of mealtimes and the preparation of modified diets, a number of which had been identified on the previous inspection. These were outlined under Regulation 16 and in the introduction to this report.

Some residents said they felt safe in the centre however, they added that they were concerned about staff shortages and not all residents were happy with the level of engagement from staff. Advocacy arrangements were seen to have been accessed for a number of residents. A further group of residents stated that they were unhappy when other residents walked uninvited into their rooms and interfered with

their belongings, and at these times they did not always feel safe. Residents' comments and records of meetings reviewed, indicated that issues raised at these meetings were not always addressed, for example, food preferences, staffing, activities, and privacy issues. This issue has been further discussed under Regulation 9: Resident's rights. Relatives' meetings had not been held for a long period of time, and this was an important aspect of communication, in relation to having a dementia specific unit where not all residents can express their concerns, and may rely on a family member to speak on their behalf and have their concerns addressed to their satisfaction.

## Regulation 10: Communication difficulties

The inspectors identified that a resident who had communication difficulties was not enabled and supported to communicate freely, having regard to their wellbeing, safety and health.

On the day of inspection the care plan on communication had yet to be developed, to guide staff on communication strategies, such as communication devices or best practice in addressing their specific communication needs.

Judgment: Substantially compliant

## Regulation 12: Personal possessions

Not all residents had access to their personal clothes and did not have adequate space to store their clothes.

This was evidenced by:

- some items of clothing and personal belongings were seen to be stored on top of wardrobes where residents had difficulty accessing them
- a number of wardrobes were found to be in a very untidy state
- personal clothes and personal items for one resident were stored in the linen press, to which every one had access, and their wardrobe was seen to be empty. They had special needs in this regard and the issue could have been resolved in a more person-centred way
- clothes and items belonging a deceased resident were found located in the staff office in an open plastic box, mixed in with various additional items belonging to other residents. Some of this person's clothes were also in their previous bedroom which, purportedly, had been deep cleaned for a new resident.

Judgment: Substantially compliant

## Regulation 17: Premises

The premises did not conform to the matters set out in Schedule 6 of the regulations:

Some of the following are repeat findings from the previous inspections:

- inspectors observed that there were a number of walls awaiting repainting throughout the centre and the external, paint rendering required cleaning and power-washing
- double doors x 1 not closing adequately, (this was addressed on the day of inspection)
- the conservatory in one hallway was not in use on the day of inspection. Inspectors asked for the bolt to be removed from outside of conservatory door which might may make it more inviting to residents (this was completed on the day of inspection)
- a number of handles and locks on some doors needed repair, this meant that the door would not close adequately
- a number of doors required review to ensure they were suitable for their designed use, for example to prevent the spread of smoke and fire for defined periods of time (the provider undertook to have all doors reviewed)
- there was a strong, musty, smell in some rooms which may indicate a plumbing, drainage or other issue (the provider undertook to resolve this issue)
- the back patios required weeding, hedging required cutting and the gardens generally needed a good tiding up as they looked unkempt
- a curtain rail was loose from the wall of one resident's bedroom, this had previously been pointed out by relatives: (this was addressed on the day).
- there were inadequate communal rooms in the 24 bedded dementia specific unit, for evening or daily use. This meant that the majority of those who could walk, congregated in the small hallway by the fire place. Other residents sat in their rooms, while two or three residents used the small dining/conservatory space on the unit.

Judgment: Substantially compliant

## Regulation 27: Infection control

The registered provider had failed to ensure that the procedures consistent with the standards for the prevention and control of healthcare associated infections had been implemented by staff.

- one bedroom and en-suite area had not been cleaned and the en suite area smelled very strongly of urine: there were a lot of crumbs under the bed and the bathroom floor was littered with pieces of paper
- the staff office was seen to be unclean and dusty, with a number of items on the floor which impeded adequate cleaning
- a locked bathroom was out of action and parts of the flooring was pulled up, as it was undergoing repair, which may have contributed to the 'musty' smell in a small number of bedrooms
- the curtains in one room were observed to be stained
- the inspectors were informed that one room had been 'deep-cleaned' however, the inspectors saw that a number of the previous resident's items were present in the room, this meant that the next occupant could not be assured that the room had been appropriately 'deep-cleaned' prior to admission
- grey parcel tape was used to seal the edges of toilet cistern cupboards, which meant that adequate cleaning could not be carried out.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Inspectors found that care plans in relation to residents with the behaviour and psychological symptoms of dementia (BPSD) or other responsive behaviours related to deficits in the function of the brain, were inadequate to guide staff practice.

For example:

- The sample of care plans seen for this aspect of care lacked evidence of best practice and details in how to appropriately manage and recognise when behaviour escalation was likely.

In addition:

- When any new care plans were developed it was not always apparent that all staff had been informed of any changes, or instructed in how to care for certain needs and conditions.
- There was lack of evidence that all residents, or their relative where appropriate, had been involved in developing and updating the care plans for their family member.

Judgment: Substantially compliant

## Regulation 6: Health care

On this inspection inspectors found lack of evidence that a high standard of evidence-based nursing care, in line with professional guidelines issued by An Bord Altranais agus Cnaimhseachais na hEireann, was made available to residents, as required under the regulations:

- For example, there had been a small number of late regulatory notifications of serious injury, which indicated that staff, seemingly, failed to recognise, in a timely manner, when a serious injury had occurred. Despite medical intervention, this resulted in a prolonged period prior to an x-ray being ordered, resulting in pain requiring additional pain relief, and possible deterioration to the resident
- there was not sufficient evidence that residents with complex medical needs were appropriately referred to specialists in a timely manner
- the inspectors found that some residents had unexplained weight loss and one resident had an unexplained bruise and skin tear.
- the inspectors identified that prescribed blood tests were not taken when due for one particular resident with an identified need

Judgment: Not compliant

## Regulation 7: Managing behaviour that is challenging

While staff had received training in the management of responsive behaviour, the training was accessed on line and did not always include discussion on best, evidence-based strategies to manage and respond appropriately to responsive behaviours.

All staff spoken with were not confident in how to manage escalations in behaviour associated with dementia and there was poor supervision around this aspect of care. Specific interventions for dementia care, were not available at present. This was discussed at the feedback meeting as to the impact on the social and well-being care needs of residents with dementia. The person in charge stated training would be reviewed in order to improve staff knowledge and strategies.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider had not taken all reasonable measures to safeguard residents:

This was evidenced by:

- comments from residents who did not feel safe when other residents came into their rooms without staff intervening
- healthcare staff had an altercation in the hallway, as witnessed by visitors and residents
- some staff who spoke with the inspectors did not demonstrate sufficient knowledge in relation to dealing with safeguarding issues.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

Inspectors identified that residents' rights and choices were not being fully protected in the centre as follows:

- Activities on the day of inspection were not adequate or personalised
- The residents living in the dementia unit required meaningful, person-centred activities which staff and relatives said was not being provided on a consistent basis.
- The specific social, spiritual, psychological or physical care needs of one resident was not provided for, and their known hobbies and previous interests were not made available to them.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication difficulties | Substantially compliant |
| Regulation 12: Personal possessions | Substantially compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 7: Managing behaviour that is challenging | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Oaklodge Nursing Home OSV-0000261

## Inspection ID: MON-0040936

## Date of inspection: 27/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
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| Regulation 15: Staffing | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 15: Staffing:

Oaklodge uses the Modified Barthel Index, a nationally validated nursing assessment tool which measures care hours required from the assessed needs of residents and compares that to the care hours provided from staff hours. The tool has been adapted for use in Oaklodge to assess the staffing levels on each unit and is updated monthly. This demonstrates that we are consistently in excess of the care hours required to meet the needs of the residents in occupancy. We will continue to utilize this tool to monitor and adapt staffing levels in conjunction with employing clinical judgement when rostering staff. – complete and ongoing.

Nevertheless, we convened a senior management meeting on 28/07/2023 to review staffing levels and have rostered a fourth HCA to stay on duty until 10pm. to cover the period when the nurses are administering medications and taking handover. This commenced and is reflected on the roster from early August – complete and ongoing.

We have appointed an Operations Manager and an Assistant Director of Nursing, both of whom will provide additional governance and management oversight to monitor staff performance – commencing in early September and early October respectively.

In relation to call bell response times, we have carried out some observational audits and will carry out a focused audit at various times throughout the month of October to monitor call bell response times. The results of this will be analysed at the clinical governance meetings and will be communicated to all staff. – Commencing 2 October 2023.

A quality improvement committee dedicated to activities was formed on 31/07/2023, led by a senior nurse with involvement from activity personnel, HCAs and residents/ family representation. Life stories of residents, together with their likes and dislikes and previous hobbies were incorporated into a new schedule of activities which commenced

in August and we are changing the roster to ensure an expanded timetable and more activities during evenings and weekends.

| Regulation 16: Training and staff development | Not Compliant |
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Oaklodge uses a combination of on-line training, external trainers in-house and staff feedback at the point of care. There have been c.32 in-house training sessions conducted in the last year. To address the issues found on inspection we have:
• Assigned a nurse daily to supervise mealtimes and provide feedback and mentorship to staff directly on aspects of their performance. – Complete and ongoing.
• Scheduled Quality of Interaction Schedule (QUIS) observational audits to monitor the quality of staff interactions with residents. The results of which will be discussed at clinical governance meetings, provided to individual staff members as feedback and discussed at staff meetings. These will also direct any further staff training that may be required. – Commencing 2 October 2023.
• Reassessed each resident known to walk with purpose and updated their care plans with additional meaningful activities and diversional therapies – to be completed by end of September. In addition, a staff member has been assigned daily to monitor these residents on each unit to redirect them should they attempt to enter other resident's rooms.
• Focused call bell audits will be conducted throughout the month of October – commencing 2 October 2023.
In addition, we have introduced a training needs analysis platform to identify and respond to individual and whole staff training needs. – complete and ongoing.

Furthermore, the PIC has introduced discussion sessions which provide at the point of care training for staff on various different topics – commenced from 25th September.

| Regulation 21: Records | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 21: Records:

• An audit on staff files was conducted on 08/08/2023 and will be repeated quarterly – complete and ongoing. In addition, the RPR and PIC will sign off on all new employee's personel files before commencing in employment.

• An audit on resident files was conducted on 12/08/2023 and staff feedback and training on documentation was provided during a discussion session on 20/09/2023.
• All blood test records are now scanned up into our electronic resident record for ease of tracking and retrieval – complete and ongoing.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Oaklodge has had a successful recruitment drive in recent months and have appointed:
• An Operations Manager
• An Assistant Director of Nursing
• A staff nurse
• Several healthcare assistants

These will all be in post by mid October to further strengthen the clinical and operational governance.

A new organogram and refinement of roles and responsibilities has been completed to reflect changes to the senior management staff. – complete.

The two CNMs have now completed their periods of scheduled leave and are now rostered for their full complement of contracted hours – complete.

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Three notifications identified have been submitted as required – complete.

External training completed by Clinical Nurse Manager 2 on incident reporting and recordings in August and feedback provided to all staff – complete.

All incidents that may require notification will now be escalated to RPR and PIC on the day of event and all notifications will be submitted in line with statutory timelines – ongoing.

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| Regulation 34: Complaints procedure | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Complaints procedure review was commenced by the clinical governance team on 28/07/2023 – complete. Follow up Actions will be implemented and the review completed by 30th October.

Staff training on complaint management commenced from 25/09/2023 – ongoing.

Review of complaints log and all possible complaints closed out – complete.

Complaints management role now assigned to Operations Manager to complement and support complaints management function with root cause analysis etc. This will be overseen by RPR/ PIC to ensure complaints are resolved to the satisfaction of the complainant and records are maintained of such – ongoing. A quality improvement project team including relative representation will commence in October to proactively address any issues. October 30th

Relatives' meeting held in early August and will be scheduled quarterly – complete and ongoing.

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| Regulation 10: Communication difficulties | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:

A new communication committee has been convened which is led by a senior nurse and membership includes activity staff and HCA representation from each of the units. The purpose of this committee is to review each resident with communication and responsive behaviours to ensure they have individualized care plans developed to meet their specific needs. – commenced from 29/08/23 and ongoing.

A comprehensive communication care plan was developed for the individual resident with communication difficulties, which includes use of assistive devices such as picture aids, assisted technology such as google translate, type to speak software, dedicated android

tablet etc. In addition, advocacy services were requested to complement this process using personnel who have relevant expertise and an OT review for this resident was arranged – complete and ongoing.

Additional communication training was provided to all staff in July by an external expert – complete.

| Regulation 12: Personal possessions | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:

Initial room audits were completed by CNM2 and a Senior HCA and all issues rectified. The senior HCA now completes these monthly and completes random spot checks on residents' rooms daily and provides feedback to staff – complete and ongoing.

New and additional chest of drawers, storage presses and other storage solutions were obtained for rooms that required them – complete.

Possessions belonging to deceased residents are now overseen by senior management to ensure these are packed and stored appropriately whilst awaiting collection – ongoing.

| Regulation 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:

A complete schedule of works, listed in order of prioritization has been developed by the RPR, PIC and maintenance staff following a walkaround audit. Status updates are provided weekly and are being overseen at clinical governance meetings and a number of items have already been completed – complete and ongoing.

A competent person was engaged to advise on the review of all fire doors and an audit was completed. The programme of works was scheduled and completed. We have also engaged an external expert /competent person to review our overall overall fire compliance and we expect to have a final report in October. Any Immediate safety measures were remedied and the remaining items will be completed once the final report is available. Complete and ongoing.

Rooms that were repurposed during the Covid pandemic have now been reinstated and

staff are actively encouraging residents to utilize these spaces. Some residents in the South unit are now coming to the central unit main sitting area spaces with staff assigned for their assistance and supervision – commenced from September and ongoing.

| Regulation 27: Infection control | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:

Monthly senior HCA room audits and daily random spot checks - commenced from 20/08/23 and ongoing.

Monthly Housekeeping audits - commenced from 01/09/23 and ongoing.

Daily walkaround observational audits by the PIC and senior nursing staff have commenced and will provide additional oversight of cleaning practices and storage issues – commenced 20/08/2023 and ongoing.

Terminal cleaning audits will be conducted and signed off by the nurse on duty following completion of the cleaning process. Single rooms will be then locked to prevent re-entry – commenced from 01/09/2023 and ongoing.

Bedroom curtains have been cleaned and all curtains are on a schedule of cleaning – complete and ongoing.

The bathroom has been repaired and toilet cistern cupboards will be repaired or replaced 30th October.

Additional shelving/ racking has been purchased for the staff office and items are no longer stored on the floor – complete.

| Regulation 5: Individual assessment and care plan | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Staff consultation and training of assessment and care planning was provided by the PIC to all staff nurses, following which a care plan audit was conducted on 16th August and additional training was delivered – commenced 31/08/ 2023 and ongoing.

All families (with resident's consent) have been invited to participate in care plan reviews in consultation with the resident and named nurse. Changes will be communicated during staff handover and staff nurses will be responsible for informing HCA staff daily – reviews will be complete by 30/10/2023 and ongoing updates as required.

Blood results are now scanned into the electronic resident record to ensure timely scheduling of blood tests accordingly – complete and ongoing.

| Regulation 6: Health care | Not Compliant |
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Outline how you are going to come into compliance with Regulation 6: Health care:

Each resident's individual case was reviewed and a root cause analysis conducted and the learning was shared among staff – complete.

Weight loss for all residents is reviewed weekly as part of our Key Performance Indicators in the clinical governance meetings. All residents identified as having unexplained weight loss have had their MUST tool and care plans updated and they have been referred to the dietician – complete and ongoing.

Nursing staff have completed updated training on assessing and managing the pain of an older person with dementia - completed.

The return to contractual CNM hours and the imminent commencement of the ADON has now enhanced the level of clinical oversight of residents.

| Regulation 7: Managing behaviour that is challenging | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

The senior nurse who leads the new Communication committee is scheduled to undergo specialist training in managing responsive behaviours and will act as the lead nurse in this area to upskill staff through additional in-house training and mentorship – training

scheduled for October.
Dementia specific training for all staff h as been provided in-house initially and is organized with an external trainer for October.

Scheduled Quality of Interaction Schedule (QUIS) observational audits are scheduled to monitor the quality of staff interactions with residents. The results of which will be discussed at clinical governance meetings, provided to individual staff members as feedback and discussed at staff meetings. These will also direct any further staff training that may be required. – Commencing 2 October 2023.

| Regulation 8: Protection | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:

• Safeguarding training will be provided in-house to complement the online HSEland training – commencing 1st September.

• PIC met with the two residents individually who had reported they did not feel safe and discussed multiple options including relocation to another room/ unit within the nursing home but this was declined. Complete.

• Each resident known to walk with purpose was reassessed and updated their care plans with additional meaningful activities and diversional therapies – complete. In addition, a staff member has been assigned daily to monitor these residents on each unit to redirect them should they attempt to enter other resident's rooms.
• Focused call bell audits will be conducted throughout the month of October – commencing 2 October 2023.
• Staff have received additional instruction on timely communications with families post any incident or changes in the resident's status – complete.

| Regulation 9: Residents' rights | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

A quality improvement committee dedicated to activities was formed on 31/07/2023, led by a senior nurse with involvement from activity personnel, HCAs and residents/ family representation. Life stories of residents, together with their likes and dislikes and previous hobbies were incorporated into a new schedule of activities which commenced on 1 September.

Each resident will have a more developed updated individualized activities care plan which outlines their preferences and acts as a further guide to activities staff and nurses/ HCAs responding to residents needs on a daily basis – complete by 30th October.

A nurse has been assigned to oversee mealtimes and provide feedback and mentorship to staff directly on aspects of their performance. – Complete and ongoing.

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
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| Regulation 10(1) | The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely. | Substantially Compliant | Yellow | 27/09/2023 |
| Regulation 10(2) | The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5. | Substantially Compliant | Yellow | 27/09/2023 |
| Regulation 12(a) | The person in charge shall, in so far as is reasonably | Substantially Compliant | Yellow | 27/09/2023 |

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| | practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes. | | | |
| Regulation 12(c) | The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions. | Substantially Compliant | Yellow | 27/09/2023 |
| Regulation 15(1) | The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned. | Substantially Compliant | Yellow | 27/09/2023 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to | Substantially Compliant | Yellow | 30/10/2023 |

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| | appropriate training. | | | |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 30/10/2023 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/11/2023 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Substantially Compliant | Yellow | 27/09/2023 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. | Substantially Compliant | Yellow | 30/10/2023 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, | Not Compliant | Orange | 30/10/2023 |

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| | appropriate, consistent and effectively monitored. | | | |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. | Substantially Compliant | Yellow | 30/10/2023 |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Not Compliant | Orange | 30/08/2023 |
| Regulation 34(1)(a) | The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned. | Substantially Compliant | Yellow | 30/10/2023 |

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| Regulation 34(2)(b) | The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint. | Substantially Compliant | Yellow | 30/10/2023 |
| Regulation 34(6)(a) | The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan. | Substantially Compliant | Yellow | 30/10/2023 |
| Regulation 5(1) | The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2). | Substantially Compliant | Yellow | 30/10/2023 |
| Regulation 5(4) | The person in charge shall | Substantially Compliant | Yellow | 30/10/2023 |

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| | formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | | | |
| Regulation 6(1) | The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | Not Compliant | Orange | 30/10/2023 |
| Regulation 6(2)(c) | The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional | Not Compliant | Orange | 30/10/2023 |

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| | expertise, access to such treatment. | | | |
| Regulation 7(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. | Substantially Compliant | Yellow | 28/07/2023 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Substantially Compliant | Yellow | 30/10/2023 |
| Regulation 9(2)(a) | The registered provider shall provide for residents facilities for occupation and recreation. | Substantially Compliant | Yellow | 31/07/2023 |
| Regulation 9(2)(b) | The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities. | Substantially Compliant | Yellow | 31/07/2023 |
| Regulation 9(3)(d) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned. | Substantially Compliant | Yellow | 31/07/2023 |