<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Rush Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000155</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Kenure, Skerries Road, Rush, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 870 9684</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rushnursinghome@mowlamhealthcare.com">rushnursinghome@mowlamhealthcare.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Mowlam Healthcare Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Pat Shanahan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Michael Keating</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Shane Walsh</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>54</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 11 February 2015 10:10  To: 11 February 2015 18:30
12 February 2015 10:00  12 February 2015 15:30

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tr>
<td>Outcome 02: Governance and Management</td>
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<td>Outcome 03: Information for residents</td>
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<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 10: Notification of Incidents</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This report sets out the findings of an 18 outcome inspection, which took place following an application to the Health Information and Quality Authority (the Authority) to renew registration of this centre. As part of the inspection, the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, accidents and incidents forms, policies and procedures and staff files. Overall, the inspector found that the provider and the person in charge met the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. They promoted the safety of the residents, and monitored the
quality of the service provided to residents.

The inspectors reviewed resident and relative questionnaires submitted to the Authority prior to, during and subsequent to the inspection. These questionnaires all spoke positively of the service provided, and were highly complementary of the input of staff as well the level of activity and entertainment as well as the upkeep of the centre, particularly the outside space. However, a number of questionnaires also referred to a perceived shortage of staff at times. Information was also received through the Authorities' concerns department expressing to concerns in reduction in staffing, particularly at nighttime.

These concerns were found to be substantiated during this inspection. Inspectors found that frequently at nighttime there was an inadequate number of suitably skilled staff members on duty as one of the two nurses assessed by the centre as being required was replaced by a health care assistant. This was found to be in major non compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Two further outcomes were found to be moderately non compliant relating to documentation and the management of drug errors. The outcome of food and nutrition was found to be substantially complaint, with improvement required to ensure all residents were offered the choices available on the menu.

The remaining 14 out of 18 outcomes inspected against were deemed to be in substantial compliance with the Regulations. Outcomes judged to be fully compliant included the protection of residents' rights, dignity and consultation, health and social care needs, safeguarding and safety, end of life care, health safety and risk management, governance and management and the provision of a safe and suitable premises.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.
Compliance with Section 41(1)(c) of the Health Act 2007 and 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 Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspector found that the statement of purpose met the requirements of the Regulations, containing all of the information as listed within Schedule 1. It accurately described the service that was provided in the centre and was kept under review by the person in charge and the provider and was available to residents.

Staff were found to be familiar with the statement of purpose.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Overall it was found that the quality of care and experience of the residents were monitored and assessed on an ongoing basis. There was a clearly defined management
structure that identified the lines of authority and accountability.

The provider (their representative) and the person in charge worked together to address the needs of residents and together held the autonomy and authority to implement change in accordance with the assessed needs of residents.

There were systems in place to review and monitor the quality and safety of care and the quality of life of residents on a regular basis. Regular clinical governance meetings were held every three to four months where audits in the areas of hygiene and infection control, health and safety, training needs, catering, medication management, documentation, and care standards, initiated by the person in charge were reviewed by the management team from the perspective of progress and improvement.

As identified elsewhere within this report, under the outcomes of Medication Management and Staffing, further oversight was required to ensure that these key areas relating to patient care were effectively monitored and reviewed on an ongoing basis. These specific non compliances are actioned under the respective outcomes.

**Judgment:**
Compliant

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**Outcome 03: Information for residents**

*A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Each resident had access to a guide to the centre and received a written contract of care on admission.

The guide to the centre met the requirements set out in regulation 20. There was a copy of the guide in each resident's 'pack' located in each individual's room.

Each resident's contract dealt with the care and welfare of the resident in the centre. It also contained all required information regarding services and facilities provided by the centre, and any fees to be charged to the resident, both mandatory and additional.

The centre also had a residents' notice board containing relevant information regarding the day to day running of the centre, including any activities that had been planned for the month.
**Judgment:**
Compliant

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The person in charge was a registered nurse and worked full time within the centre. The person in charge had experience in the area of nursing older people as well as postgraduate qualifications in management. She had been working as director of nursing within the centre for a number of years and was well known to all residents.

The person in charge had been involved in developing policies as well as revising policies in line with best practice or the changing needs of residents. She was involved engaged in the governance and operational management and administration of the centre on a regular and consistent basis.

During the inspection she demonstrated her knowledge of the revised Regulations, the National Quality Standards for Residential Care Settings for Older People in Ireland and her statutory responsibilities.

**Judgment:**
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspectors were not satisfied that some the records as listed in Part 6 of the Regulations were well maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Evidence was found in care plans and presented to the assistant director of nursing that some health care records pertinent to individual care needs had not been filled out. In some cases 'two-hourly checks' had not been signed off as having been completed and the documentation did not refer to the specified need for the checks or support provided. For example, while reasons for regular checks included oral care, and pressure relieving positioning in bed, there was no documentation to confirm this had been completed.

The centre had all of the written operational policies which had been recently reviewed as required by Schedule 5 of the Regulations. However, evidence was found that the policy and procedures relating to drug omissions were not being appropriately followed. Actions to minimise the risk of repeat errors were inadequate. In addition there was no evidence that the policy of contacting a resident's general practitioner (GP) in relating to drug omission was followed. Further information relating to this non compliance is documented under Outcome 9: Medication Management.

A number of staff files were reviewed by inspectors and in most cases were found to contain all of the requirements as listed in Schedule 2 of the Regulations. However, one nurse's registration pin could not be found on the day of inspection.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a resident's property.

A directory of residents was maintained which contained all of the matters as set out under Regulation 19.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management
### Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

### Findings:

The provider was aware of his responsibility to notify the Authority of the absence of the person in charge. To date this had not been necessary. The person in charge was supported in her role by a deputising person in charge (assistant directors of nursing).

The deputising person in charge provided guidance to the inspectors throughout the inspection and was found to be knowledgeable on the operational management of the centre and was well informed of the support requirements of all residents.

The roster identified a nurse as in charge at all times if any of the persons in charge were not on duty.

### Judgment:

Compliant

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### Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

### Theme:

Safe care and support

### Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

### Findings:

The inspector found that measures were in place to protect residents from being harmed or abused. The inspector viewed training records and saw that all staff had received training on identifying and responding to elder abuse. The inspector found that staff were able to identify the different categories of abuse and what their responsibilities were if they suspected abuse or were uncomfortable with how a resident was being treated by a staff member.

The person in charge assisted residents with the management of their finances, and arrangements were in place to safeguard residents from the risk of financial abuse. The inspector saw that money was stored in a locked cabinet and was satisfied that resident’s finances were managed in a safe and transparent way.

Residents spoken with confirmed that they felt safe in the centre and primarily attributed this to being familiar with the staff on duty, and that staff supported them as
necessary in a very sensitive and professional manner.

A restraint free environment was promoted with relevant policies and procedures in place. Physical restraint was not used in the centre and there was a number of enabling restraints in operation within the centre. Bed-rails were used for nineteen residents. The use of these had been appropriately assessed and had involved multi-disciplinary input as well as the assessment of the capacity of the residents in question to be involved in the decision.

There were also evidence that efforts had been made since previous inspections to reduce the number of bed-rails used and low-low beds had been provided to some residents to enable this reduction. In addition, the goals identified in the operational governance report for 2015 identified an aim of further reducing the number of residents using bed rails.

Efforts were made to identify and alleviate the underlying causes of behaviour that is challenging. The inspector noted that there were comprehensive multi-disciplinary supports meetings taking place, where considerable efforts were made to identify the cause of increased patterns of behaviour for a very small number of residents who present with such challenges. Overall, this approach focused upon identifying the behaviour as a form of communication, finding ways in which to identify the cause of frustration for the individual concerned.

**Judgment:**
Compliant

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### Outcome 08: Health and Safety and Risk Management

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

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspector found that the health and safety of residents, visitors and staff was sufficiently promoted and protected.

The inspector noted that there was a health and safety statement in place. Environmental risk was addressed with health and safety policies implemented which included risk assessments on such areas as environmental hazards. A risk management policy was in place and met the requirements of the Regulations. Health and safety officers were identified and they met with the person in charge on an ongoing basis to discuss the management of risk. These staff members had been provided with specific training to be able to carry out their roles effectively. They had also introduced
imaginative and creative ways to ensure that staff were able to safely evacuate the premises if required.

For example, fire drills were held every two months and various scenarios were presented to the staff on duty during these drill such as blocking off exits or 'hiding' a staff member to ensure they were found during the staged evacuation scenario. Missing person drills were also carried out, with three recorded in the past 10 months. These also involved simulating an actual scenario, such as sending a staff member away from the centre to see if they could be located during the drill.

Fire precautions were prominently displayed throughout the centre. Service records showed that the emergency lighting, fire alarm activation buttons and fire alarm system were serviced annually. The inspector noted that the fire panels were in order, and the many fire exits, which had daily checks, were unobstructed. All staff had attended training and those spoken with were knowledgeable of the procedure to follow in the event of a fire, described within the centre as a compartmentalised method of evacuation, ensuring residents were moved away from any perceived risk.

There was an emergency plan in place with clear procedures to follow in the event of loss of electricity, flood, gas leak or other security concern. The inspectors spoke with staff and found they were familiar with the contents of the emergency plan and the reporting structures in case of any emergency. The emergency plan included a contingency plan for the total evacuation of residents to another local nursing home in the event of an emergency.

A review of the training records evidenced that all staff had attended mandatory training in moving and handling. Some staff were due refresher training however, the training programme in place identified that this need was being addressed over the coming months.

The centre had also been subjected to inspections from other statutory authorities such as Dublin Fire Brigade, Environmental health Officers and the Health and Safety Authority over the previous 12 months. Copies of these reports were read by inspectors, along with confirmation that any follow up actions had been completed.

**Judgment:**
Compliant

**Outcome 09: Medication Management**
Each resident is protected by the designated centre’s policies and procedures for medication management.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
There were written operational policies in place relating to the ordering, prescribing, storing and administration of medicines to residents. However, the inspectors found that there was no effective review of drug errors taking place to ensure there was additional control measures and evidence of learning in place to minimise the risk of repeated errors and to ensure all medicinal products are administered in accordance with the prescriber.

The inspector read a drug error report form detailing a drug error. It was noted that this was the only drug error reported during the previous 12 months. This report related to an incident where a resident went without prescribed medication over a four day period, with errors made by more than one staff member. This related to an issue relating to the use of pre-packaged medication relating to storage, as well as repeated administration errors. The 'action' identified on the form did not address either of these issues and did not identify any measures to minimise the risk and reduce the likelihood of a similar error reoccurring. In addition, the policy on drug omissions identified the need to report any omissions to the resident's GP. There was no evidence to say this had occurred in this case. The non compliance relating to not following the policy guidance is actioned under Outcome 5: Records and Documentation.

Residents were supported to maintain their own pharmacist of choice, and some residents had chosen to do so.

A full medication review took place every four months for each resident and this involved nursing staff, the GP and the pharmacist. Medication reviews viewed by the inspector included reductions in the dose of medications and changes to the type or frequency of pain medication, such as the use of transdermal patches for the management of severe pain.

From observing staff members administering medication it was found that they adhered to safe medication management practices. Staff were guided with a clear and up to date administration sheet, and all medication were signed for appropriately.

Medications that required strict control measures (MDA's) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of controlled drugs. The stock balance was checked and signed by two nurses at the handover of each shift. This register was viewed by the inspector.

A locked fridge was provided for medication which required temperature control and the inspector noted from the daily record sheet that the temperatures were within acceptable limits. There were appropriate procedures for the handling and disposal of unused and out of date medication. Crushed medication was only administered as prescribed by the doctor.

Judgment:
Non Compliant - Moderate
**Outcome 10: Notification of Incidents**  
*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

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<td>Safe care and support</td>
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<th>Outstanding requirement(s) from previous inspection(s):</th>
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<td>No actions were required from the previous inspection.</td>
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<th>Findings:</th>
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<tbody>
<tr>
<td>The inspector found that a record of all incidents occurring in the designated centre was maintained and where required notified to the Chief Inspector.</td>
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The person in charge was aware of the legal requirements to notify the chief inspector regarding accidents and incidents. The inspector read the accidents and incidents log and saw that all relevant details of each incident were recorded together with actions taken.

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**Outcome 11: Health and Social Care Needs**  
*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

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<td>Effective care and support</td>
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<th>Findings:</th>
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<tr>
<td>The inspector found that each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied healthcare. There were also opportunities for residents' to engage in meaningful activity.</td>
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The inspector saw that the arrangements to meet each resident's assessed needs were set out in individual care plans with evidence of resident involvement at development and review.
The inspector reviewed a sample of residents' health care plans which considered assessed need in relation to areas such as dental care, cognitive deficit, sleep patterns, short term medical interventions, skin care and wound management. Resident's could access medical specialists as required, for example plans evidenced recent visits to or by dietitians, physiotherapist, occupational therapy, and psychologists. Residents' had access to a GP as required, with a community GP attending the centre on average twice a week. Resident's were also supported to maintain their own GP as requested.

Assessors used validated tools to assess levels of risk of deterioration, for example vulnerability to falls, dependency levels, nutritional care and cognitive impairment. There was evidence that care plans were reviewed every four months or more frequently if required.

It was also noteworthy that residents had access to pets in the centre. A dog, rabbits and birds were resident in the centre and were clearly enjoyed by a number of residents.

Each resident had opportunities to participate in meaningful activity and the activity programme was based upon the residents' interests and hobbies. An activity coordinator was employed and residents were observed enjoying various activities during the inspection, including a live music session, an exercise class, and 'sonas' sessions. In addition, other therapists were brought in to support the activities programme, this included the exercise and stretching programmes. There was an activities planner displayed on the wall, highlighting the week's activity.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
This centre was purpose built as a nursing home almost ten years ago. The centre and was kept clean and well maintained and there had been no changes to the structure of the premises since the last inspection, or since its previous registration. The centre
conforms to all of the matters as set out in Schedule 6 of the Regulations.

The accommodation includes 50 spacious single rooms as well as three double or twin rooms. Accommodation was provided on two floors, and there was a serviced lift provided. All rooms had their own en suite facilities. The nursing home was generally spacious, and well laid out with plenty of communal space and room for private visits or consultations. Residents had personalised their bedrooms, and the communal areas such as the sitting and dining rooms as well as the corridors were very homely with pictures of residents and paintings by residents hanging throughout the centre.

The centre had many additional communal and therapeutic areas including a hairdressing saloon, coffee room, treatment room and a number of dining and day rooms. All of these facilities enhanced the living environment for residents and also helped ensure visitors had a chance for positive engagement with residents in a choice of communal areas or to spend time with them privately in their own rooms.

There was appropriate equipment provided to meet the needs of residents, hoists were maintained and used as required and there was an accessible bathroom and bath available for the use of residents on each floor.

The grounds of the premises were well maintained, and there were two enclosed courtyards that could be used by residents.

Kitchen and laundry facilities are discussed under Outcome 15 and 17.

Judgment:
Compliant

<table>
<thead>
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<th><strong>Outcome 13: Complaints procedures</strong></th>
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<tr>
<td>The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.</td>
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**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The complaints policy was in place and the inspector noted that it met the requirements of the Regulations. The complaints policy was on display within the reception area as well as an abridged version provided to each resident, contained within their residents’ pack. Residents, relatives and staff spoken with were aware of the procedure if they wished to make a complaint.

Complaints and feedback from residents were viewed positively by the provider and the
The inspector read records relating to eleven complaints which were logged over the previous 14 months. In all cases, they appeared to be addressed to the satisfaction of the person who made the complaint. The person in charge also spent time with each resident on a regular basis and visited the bedrooms of residents. This was found to be a way to engage more effectively with residents in relation to their satisfaction with the service provided.

A resident and relative satisfaction survey was completed in April 2014 and the results were made available to all residents and staff members. A number of findings emanated from this survey, including recommended changes to menu choice, and a finding that approximately 30% of relatives were not aware of the complaints process. As a result, the person in charge wrote to all families and informed them of the process.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**

*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**

The inspector found that caring for a resident at end-of-life was regarded as an integral part of the care service provided in the centre. This was evidenced by the detail provided within individual end of life care plans, and in reading the end of life care plans for the recently deceased. The practice was informed by the centre’s policy on end of life care which in turn was informed by national policy such as hospice friendly initiatives. The policy also referred to the use of specialist palliative care and on the use of subcutaneous fluids. The end of life care plans in place for all residents clearly documented residents' preferences.

A small number of residents were accommodated in twin rooms. However, for those residents who were considered to be approaching end of life, a single room was provided in recognition of maintaining the dignity and privacy of both parties previously sharing. End of life plans also referenced the maintaining of dignity of residents should one resident suffer an unexpected death. It was recognised that the practice of leaving the body of residents who had died suddenly in a shared room overnight, while awaiting clearance from the coroner was not respecting the privacy and dignity of either party. Therefore the person in charge had contacted the coroner to clarify the specific circumstances where this would need to be the case, and was updating this policy accordingly.
The policy on end of life care addressed all physical, emotional, spiritual and social needs of residents at end of life and promotes respect and dignity for dying residents. Residents were able to engage with the inspector about their individual end of life care plans. An annual ecumenical remembrance service was hosted each November acknowledging the lives of all those who passed away within the previous year. Relative questionnaires provided to the authority singled out this ceremony for praise.

Judgment:
Compliant

### Outcome 15: Food and Nutrition

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Mealtimes were observed by the inspectors and the food prepared in the centre was seen to be wholesome, nutritious and tasty. However, inspectors observed that residents were not always provided with a choice at mealtimes.

The inspectors observed mealtimes in two separate dining areas. The main dining room was allocated for residents with higher support needs. In this room an inspector observed residents being offered a choice in their meals. Assistance during the mealtime was provided to all residents who required it in a discrete and sensitive manner. The 'Day Room' dining area was allocated for low support residents. In this room the inspector observed staff serving pre-milked coffee to residents without asking if they would prefer tea of coffee, or if they would like milk. One resident did not drink the coffee served. Residents in the day room were also not offered any choice in dessert.

An inspector visited the kitchen and the chef showed the inspector that all of the necessary temperature checks for the safe preparation of food were taken and recorded using the 'write the record' process. All residents who were on fortified or diabetic diets were listed in the kitchen. The chef also had a list of residents' likes and dislikes. The chef showed the inspector the rolling menu and it was seen to be varied. Resident input into the menu was welcomed and any changes were review by the dietician before implemented. The chef informed the inspector that a number of snacks such as sandwiches, soup and rice pudding are prepared and left in the fridge following the chef's shift finishing to ensure residents have access to snacks if they wish. The inspectors also observed a vending machine on site for further snacks.
The care plans of residents who were losing weight were reviewed. Appropriate processes were in place to monitor their food intake and to try and ensure that these residents did not experience any further lack of nutrition. Weights of residents were monitored and recorded in their care plans.

All residents had access to fresh water. All jugs of water were replaced in each room before 11am each day.

Judgment:
Substantially Compliant

**Outcome 16: Residents’ Rights, Dignity and Consultation**

Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents were consulted with on the running of the centre and residents’ privacy and dignity was seen to be respected. Residents' meeting were regularly held and the minutes of these meetings were recorded. Each resident received a copy of the most recent meeting in their 'resident pack' located in their room. A resident satisfaction survey was reviewed by the inspectors. It contained points raised by residents about the running of the centre and their everyday lives. Management in the centre had addressed each point raised with a very clear action.

Staff informed the inspectors that residents had an input into the monthly activities plan. Inspectors observed that art was planned during the first morning of the inspection however, this was finished early as residents wished to play bingo instead and this choice was accommodated.

The religious rights of the residents were supported in the centre. Weekly mass was held on Thursdays in the centre. Ministers of other denominations also visited the centre to meet the spiritual needs of residents. An annual Christian ecumenical remembrance service was held in the centre, this was non-specific to one denomination. Residents were also enabled to vote in any local or general election if they were registered. This was carried out in the centre.
Resident's privacy was seen to be respected, staff members were observed to knock on doors before they entered them. Most residents had their own bedroom however, there were also other facilities to receive a visitor in private if required. All residents had access to a public telephone and the inspectors observed a number in residents' bedrooms. All resident's had access to advocacy contact details, the inspectors observed a number of posters around the centre displaying these details.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 17: Residents' clothing and personal property and possessions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.</em></td>
</tr>
</tbody>
</table>

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
A policy on residents' personal property and possessions was in place in the centre and was seen to be implemented. All residents could maintain control over their own personal belongings, and had sufficient space to store them. All residents had an adequately sized wardrobe and a lockable bedside locker provided. A record of each resident's personal belongings was maintained and was kept up to date.

The laundry facilities were seen to be adequate to meet the required needs of the residents. The Person in Charge explained to the inspectors that residents’ clothing was labelled with their room number on admission until labels with their name were ordered. This was seen to be the case.

**Judgment:**
Compliant
**Outcome 18: Suitable Staffing**

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Workforce</th>
</tr>
</thead>
</table>

| Outstanding requirement(s) from previous inspection(s): |
| The action(s) required from the previous inspection were satisfactorily implemented. |

| Findings: |
| Overall it was found that while staff were appropriately supervised however, inspectors found that there were insufficient staff available to meet the needs of residents at times. |

The person in charge had completed an assessment to measure the staffing need against the assessed needs of the residents the week preceding the inspection. This assessment stated 'as per the staff to patient ratio combined with the dependency levels we currently have 198 hours per day which is exactly at the minimum acceptable level for our dependencies'. In addition it identified the ratio of nursing staff to care staff hours required as being 35% to 65%.

This assessment did not take into account the size and layout of the building. For example, the night-time staffing requirement was determined as two nurses and two care staff on duty from 21:00 hours until 08:00 hours, with one nurse required on each floor. However, on review of rosters over the previous two months it was found that only one nurse had been on duty a total of 33 nights during December 2014 and January 2015. On occasion this was as a result of sick leave but on most occasions was rostered (planned) in this way. It was also noted that on these nights, an extra care staff member was on duty. However, this arrangement did not meet the assessed needs of the residents as there were insufficient staff with the appropriate skills, qualifications and experience on duty at night-time. It also did not meet their own required ratio of skill mix as referred to above. Unsolicited information regarding the lack of staffing particularly at night time had been brought to the attention of the Authority prior to the inspection which was discussed with the provider during the inspection.

There were found to be effective recruitment procedures that included the checking and recording of all required information and the requirements of Schedule 2 of the regulations had been met for all staff. The centre was also actively recruiting to fill vacancies for nurses and health care assistants. Nurses held up-to-date registrations with their professional body however, one nurse's pin could not be found on the day.
This issue is actioned under Outcome 5: Records and Documentation.

The person in charge had identified staff training requirements and a training programme was in place with refresher training planned over the next two months in areas such as patient moving and handling, food and safety, safeguarding vulnerable adults and fire safety.

Staff spoken with all reported that they felt supported and supervision was provided to all staff. The inspector read a number of staff performance reviews and a number of these had identified areas for improvement, with action plans in place to support development in these areas.

Staff were knowledgeable of policies operating within the centre, and showed awareness of the Heath Act 2007, Regulations and Standards, copies of which were available in the centre.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Michael Keating
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Rush Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000155</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>11/02/2015 and 12/02/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>03/04/2015</td>
</tr>
</tbody>
</table>

**Requirements**

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy and procedures relating to drug omissions were not being appropriately followed as actions to minimise the risk of repeat errors were inadequate. In addition there was no evidence that the policy of contacting a residents GP in relating to drug omission was followed.

**Action Required:**

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
The centre has a comprehensive range of policies on all matters set out in Schedule 5 of the Health Act, including medication management policies. Audits are undertaken on a quarterly basis to assess compliance with safe practices in medication management. The person-in-charge will ensure that if drug omissions occur, they are immediately reported appropriately (including informing the GP), recorded and investigated in accordance with the centre’s policy on medication incidents. Any such incidents will be analysed at the time they occur by undertaking reflective practice with nursing staff involved. All incidents are reviewed as part of the quarterly Quality & Governance meetings to ensure that there is a culture of learning lessons from adverse events, in order to reduce the risk of recurrence.

**Proposed Timescale:** 03/04/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records relating to individual residents as required under Schedule (4C) were not maintained in an accurate and up to date manner as checklists relating to regular checks on residents relating to specific care needs were not always filled in or up to date.

**Action Required:**
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

**Please state the actions you have taken or are planning to take:**
As acknowledged, all care plans are an accurate reflection of the individual care needs of each resident. The Clinical Nurse Manager and Person-in-Charge will ensure that all care, including the frequency of checks, are carried out in accordance with the documented plan of care.

**Proposed Timescale:** 03/04/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
One of the staff files reviewed by inspectors did not contain a copy of the current registration details of a staff nurse.

**Action Required:**
Under Regulation 21(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
All staff records are now in place in accordance with Schedule 2 of the Health Act, Statutory Instrument No. 415 (2013).

Proposed Timescale: 03/04/2015

Outcome 09: Medication Management
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An effective review of drug errors was not in place to ensure there was additional control measures and evidence of learning in place to minimise the risk of repeated errors and to ensure all medicinal products are administered in accordance with the prescriber.

Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
There is now an effective system in place to ensure that all medication incidents are reported, recorded and investigated appropriately, including a review process. Medication incidents are reviewed by nursing staff through a process of reflective practice to ensure that staff can identify factors that may have contributed to the incident, in order to minimise the risk of repeated errors. Audits are carried out regularly to assess compliance with safe practice in medication management. Action plans are implemented by the Person-in-Charge to address any non-compliant areas.
The centre has quarterly Quality & Governance meetings and there is a review of all incidents, including medication incidents so that lessons can be learned from adverse events and the risk of recurrence can be reduced.

Proposed Timescale: 03/04/2015

Outcome 15: Food and Nutrition
Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
A number of residents were not offered a choice of hot beverage or dessert.

Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
All residents are offered a choice of menu options at every mealtime, including the option of hot beverages or dessert. Staff have been reminded that all residents are to be offered a choice and compliance with this will be monitored by the Person-in-Charge and CNM.

Proposed Timescale: 03/04/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an inadequate skill-mix of staff on duty on many nights to meets the assessed needs of residents.

Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The centre is actively seeking to recruit additional nursing staff in order to ensure that there will be 2 nurses on duty on each shift. Since the inspection one nurse has been appointed. Staffing rosters will continue to be reviewed in order to ensure that there are 2 nurses on duty at all times. The number and skill mix of staff is appropriate to the assessed needs of residents, the size and layout of the centre, in accordance with Regulation 5.

Proposed Timescale: 30/06/2015